



Centers for Medicare & Medicaid Services

Module 04:
Calculating and Reporting the Basic Benefit
2025 Prescription Drug Event (PDE) Participant
Guide

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1. Purpose

All Part D plans are required to provide a minimum set of prescription drug benefits, typically referred to as the “Basic Benefit”. Prescription Drug Event (PDE) data reports how a plan has administered this benefit and provides information to the Centers for Medicare & Medicaid Services (CMS) that is essential to making payment. This module defines the Basic benefit, and the three types of Basic benefit plans and then illustrates how plans will populate a PDE record for each plan type.

2. Objective

The information contained within this module applies to benefit years 2025 and forward. For benefit years prior to 2025, refer to the [2011 Prescription Drug Event \(PDE\) Participant Guide](#) located on the Customer Service and Support Center (CSSC) website.

The information provided in this module will help participants to:

- Explain the characteristics of the Basic benefit and the three types of Basic benefit plans.
- Illustrate how the Defined Standard (DS) benefit is the foundation of all other Basic benefit plans.
- Define covered and non-covered drugs.
- Apply business rules associated with calculating PDE data elements that reflect the administration of the benefit design.
- Describe how plans populate a PDE record with data essential for payment and provisions in the Inflation Reduction Act (IRA), including the Manufacturer Discount Program (MDP).
- Demonstrate how to modify PDE data and apply Adjustment/Deletion logic.

3. The Basic Benefit

The Medicare Prescription Drug Benefit, Improvement, and Modernization Act of 2003 (MMA) amended the Social Security Act (the Act) by adding Part D to Title XVIII. Part D requires all plans to provide a minimum set of prescription drug benefits, typically referred to as the Basic benefit or basic prescription drug coverage.

Resource: 42 CFR 423.100

The statute designates a specific Basic benefit structure called the Defined Standard (DS) and allows two alternate structures that have met certain tests of actuarial equivalence to the DS, the Actuarially Equivalent (AE) plan and the Basic Alternative (BA) plan.

Resource: Section 1860D-2 of the Social Security Act; 42 CFR 423.104

Definition: Actuarial equivalence – A state of equivalent value demonstrated through the use of generally accepted actuarial principles and in accordance with section 1860D-11(c) of the Act and CMS actuarial guidelines — refers to a determination that the overall value of drug coverage for a set of beneficiaries under one plan can be shown to be equal to the overall value for those same beneficiaries under another plan.

Resource: 42 CFR 423.4

Regardless of the plan type, the Basic benefit only pays for drugs that meet the statutory definition of a Part D drug and are covered under a Part D plan’s benefit package (see Module

01: Part D Payment Methodology). These drugs are referred to as covered Part D drugs. CMS classifies drugs for payment using the following terminology:

Part D drug – A Part D drug includes the following if used for a medically accepted indication (as defined in section 1860D-2(e)(4) of the Social Security Act (the Act)):

If used for a medically accepted indication (as defined in section 1860D-2(e)(4) of the Act)—

- (i) A drug that may be dispensed only upon a prescription and that is described in sections 1927(k)(2)(A)(i) through (iii) of the Act.
- (ii) A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Act.
- (iii) Insulin described in section 1927(k)(2)(C) of the Act.
- (iv) Medical supplies associated with the injection of insulin, including syringes, needles, alcohol swabs, and gauze.
- (v) A vaccine licensed under section 351 of the Public Health Service Act and for vaccine administration on or after January 1, 2008, its administration.
- (vi) Supplies that are directly associated with delivering insulin into the body, such as an inhalation chamber used to deliver the insulin through inhalation.
- (vii) A combination product approved and regulated by the FDA as a drug, vaccine, or biologic described in paragraphs (1)(i), (ii), (iii), or (v) of this definition.

Except – A Part D drug does NOT include:

- (i) Drugs for which payment as so prescribed and dispensed or administered to an individual is available for that individual under Part A or Part B (even though a deductible may apply, or even though the individual is eligible for coverage under Part A or Part B but has declined to enroll in Part A or Part B).
- (ii) Drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Medicaid under sections 1927(d)(2) or (d)(3) of the Act, except for smoking cessation agents.
- (iii) Medical foods, defined as a food that is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation, and that are not regulated as drugs under section 505 of the Federal Food, Drug, and Cosmetic Act.

Definition: Covered Part D drug – A Part D drug that is eligible for coverage under a specific Plan Benefit Package (PBP) including Part D drugs that are approved under exceptions, transitions, grievances, appeals, and other coverage determination processes. As of January 1, 2025, applicable drugs may be covered under the Part D program only if they are covered by a signed MDP Agreement between CMS and the manufacturer or if CMS has used its authority to make an exception under section 1860D-43(c) of the Act.

Definition: Applicable drug – A covered Part D drug that is approved or licensed by the Food and Drug Administration (FDA) under a New Drug Application (NDA) or Biologic License Application (BLA). Supplemental drugs are not defined as applicable drugs. The definition does not include a selected drug (as defined in section 1192(c) of the Act) during a price applicability period (as defined in section 1191(b)(2) of the Act) with respect to such drug.

Definition: Non-Applicable drug – Any Part D drug that is not an applicable drug and not a selected drug (as defined in section 1192(c) of the Act) during a price applicability period (as defined in section 1191(b)(2) of the Act) with respect to such drug.

Definition: Selected drug – As defined in section 1192(c) of the Act, a selected drug is a negotiation-eligible drug included on a list published under section 1192(a) of the Act with respect to an initial price applicability year.

(1) In general—

For purposes of this part, in accordance with subsection (e)(2) and subject to paragraph (2), each negotiation-eligible drug included on the list published under subsection (a) with respect to an initial price applicability year shall be referred to as a ‘selected drug’ with respect to such year and each subsequent year beginning before the first year that begins at least 9 months after the date on which the Secretary determines at least one drug or biological product—

(A) is approved or licensed (as applicable)—

(i) under section 505(j) of the Federal Food, Drug, and Cosmetic Act using such drug as the listed drug; or

(ii) under section 351(k) of the Public Health Service Act using such drug as the reference product; and

(B) is marketed pursuant to such approval or

(2) Clarification—A negotiation-eligible drug—

(A) that is included on the list published under subsection (a) with respect to an initial price applicability year; and

(B) for which the Secretary makes a determination described in paragraph (1) before or during the negotiation period with respect to such initial price applicability year; shall not be subject to the negotiation process under section 1194 with respect to such negotiation period and shall continue to be considered a selected drug under this part with respect to the number of negotiation-eligible drugs published on the list under subsection (a) with respect to such initial price applicability year.

Definition: Covered insulin product – An insulin product that is a covered Part D drug covered under the prescription drug plan or MA–PD plan that is approved under section 505 of the Federal Food, Drug, and Cosmetic Act or licensed under section 351 of the Public Health Service Act and marketed pursuant to such approval or licensure, including any covered insulin product that has been deemed to be licensed under section 351 of the Public Health Service Act pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009 and marketed pursuant to such section.

Definition: Adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP) – A covered Part D drug that is a vaccine licensed under section 351 of the Public Health Service Act for use by adult populations and administered in accordance with recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

3.1 The Defined Standard Benefit

The DS benefit is the foundation for all other plan types. The MMA mandates specific cost-sharing and benefit parameters for the DS benefit. The MMA also mandates that the values associated with the DS benefit be indexed annually to account for inflation and average annual per capita Part D expenditure. Table 1 illustrates the CY 2025 phases, parameters, cost-

sharing, and plan liability in a DS benefit plan, excluding cost-sharing for covered insulin products and ACIP-recommended vaccines and cost-sharing for low-income subsidy (LIS) eligible beneficiaries. (See Module 06: Calculating and Reporting LICS for details about the DS benefit for LIS eligible beneficiaries.)

Reminder: The annual Announcement of Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies provide sponsors with the benefit parameters for the Part D program. The Announcements for each calendar year (CY) are available on the [Announcements and Documents](#) page of the CMS website.

Table 1: 2025 Defined Standard Benefit

Benefit Phase	Year-to Date TrOOP Costs	Beneficiary Cost-Sharing	Plan Liability	Manufacturer Discount
Deductible Phase	< \$590.00	100% coinsurance	0%	0%
Initial Coverage Phase	≥ 590.00 < \$2,000.00	25% coinsurance	<ul style="list-style-type: none"> • Non-Applicable Drug – 75% • Applicable Drug – 65% • MDP Phase-in Eligible Applicable Drug – 74% 	<ul style="list-style-type: none"> • Non-Applicable Drug – 0% • Applicable Drug – 10% • MDP Phase-in Eligible Applicable Drug – 1%
Catastrophic Phase	= \$2,000.00 (Out-of-Pocket (OOP) threshold)	0% coinsurance	<ul style="list-style-type: none"> • Non-Applicable Drug – 100% • Applicable Drug – 80% • MDP Phase-in Eligible Applicable Drug – 99% 	<ul style="list-style-type: none"> • Non-Applicable Drug – 0% • Applicable Drug – 20% • MDP Phase-in Eligible Applicable Drug – 1%

3.1.1 Notes for Table 1

1. This table excludes cost-sharing for covered insulin products and ACIP-recommended vaccines and excludes cost-sharing for LIS beneficiaries.
2. The plan liability column refers to the Covered D Plan Paid Amount (CPP) reported on the PDE and does not account for the Medicare Reinsurance amount, which in CY 2025 is 20% for applicable drugs and 40% for non-applicable drugs in the Catastrophic Phase.
3. See Attachment III of the Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies and Section 20 of the Final CY 2025 Part D Redesign Program Instructions for a detailed discussion of the benefit phase changes in place in 2025.
4. Beginning in CY 2026, if the drug is a selected drug, the selected drug subsidy will be 10% in the Initial Coverage Phase (ICP) and the plan liability will be 65% in the ICP.

3.2 Actuarially Equivalent and Basic Alternative Plans

The statute allows two options for Basic plans other than the DS: AE and BA plans. These optional plan types share many characteristics with the DS benefit, for example, movement among benefit phases is accomplished in the same way. Year-to-Date (YTD) True Out-of-Pocket (TrOOP) determines the beneficiary's placement in the benefit. Entry into the

Catastrophic Phase is determined by YTD TrOOP costs of \$2,000.00 (2025). Most fundamentally, all three plans provide basic prescription drug coverage. In accordance with the statute, AE and BA plans differ from the DS benefit and from each other by the structure of their cost-sharing. Table 2 compares the cost-sharing characteristics of the three types of Basic benefit plans.

Table 2: Basic Benefit Plans

Benefit Plan	Characteristic
Defined Standard (DS)	<ul style="list-style-type: none"> • Statutorily mandated cost-sharing and benefit parameters that the plan sponsor cannot change (see Table 1).
Actuarially Equivalent (AE)	<ul style="list-style-type: none"> • Cannot reduce the deductible • Can change cost-sharing in the Initial Coverage Phase from the DS amounts, including use of tiers. • The actuarial value remains equivalent to a DS benefit plan such that no supplemental premium is required.
Basic Alternative (BA)	<ul style="list-style-type: none"> • Can reduce the deductible • Can change cost-sharing in the Initial Coverage Phase, including use of tiers. • The actuarial value remains equivalent to a DS benefit plan such that no supplemental premium is required.

The characteristics of any given AE or BA plan will depend on the ability of the benefit design to meet multiple tests of actuarial equivalence to the DS benefit. The plan can choose among the options in Table 2 as long it can pass the tests.

3.2.1 Basic Benefit Plans Tiered Cost-Sharing

Tiering is a common alternative way to implement cost-sharing. The DS benefit has strictly delineated cost-sharing. AE and BA plans may vary the way they implement cost-sharing, including tiering. Tiering is allowed provided that the cost-sharing passes certain actuarial tests for being equivalent to the DS benefit.

When a plan implements tiered cost-sharing, the plan categorizes all drugs on its formulary into tiers and then assigns a flat copay amount or coinsurance percentage to each tier. Table 3 is an example of a tiered benefit that employs copays and coinsurance. The amounts are only for purposes of illustration and are not necessarily representative of an approved benefit.

Table 3: Example of Tiered Cost-Sharing

Tier	Cost-sharing (Copay)	Description / Drug Types
1	\$5.00	Generic Drugs
2	\$45.00	Preferred Brand Drugs
3	\$75.00	All Other Brand Name Drugs
4	25%	Specialty Drugs

4. Basic Benefit Data Elements

While there are many fields for plans to populate in the PDE record, the following data elements are used to calculate the Basic benefit and should be carefully considered when administering the Part D drug benefit. These data elements apply to the Basic benefit plan as well as all other benefit plan types and will be reviewed in four broad categories: TrOOP, financial fields

reporting costs, financial fields reporting payments, and all other supporting PDE data elements. (All PDE fields are discussed in Module 03: Data Format.)

4.1 True Out-of-Pocket (TrOOP)

True Out-of-Pocket (TrOOP) Accumulator: The TrOOP Accumulator is maintained in real time by Part D sponsors to adjudicate claims in the correct benefit phase. The TrOOP Accumulator is the sum of the incurred costs for the benefit year known immediately before the sponsor begins adjudication of an individual claim. For additional information including the definition of incurred costs, refer to Module 05: Calculating and Reporting TrOOP.

YTD TrOOP moves the beneficiary through all phases of the Part D benefit. By definition, TrOOP costs apply only to Part D covered drugs. Once incurred, TrOOP reaches the OOP threshold (\$2,000.00 in 2025), the beneficiary enters the Catastrophic Phase of the benefit. The TrOOP Accumulator field should be populated as zeroes on PDEs for Over-the-Counter (OTC) or Enhanced drugs. (Enhanced drugs are discussed in Module 07: Calculating and Reporting the Enhanced Alternative (EA) Benefit.) The TrOOP Accumulator does not increase after the beneficiary reaches the OOP threshold.

The Accumulator values will be described in greater detail in Module 05: Calculating and Reporting TrOOP.

Delta True Out-of-Pocket (TrOOP): Delta TrOOP is defined as total TrOOP-eligible costs that are accrued on the individual PDE being reported, excluding the TrOOP Accumulator value, and represents the change in TrOOP from the preceding PDE.

4.2 Cost Fields

For a given PDE, DDPS edits typically ensure that the sum of the cost fields equals the sum of the payment fields. Several of the payment fields document payment by other sources of coverage or LICS payment on a beneficiary's behalf; this module does not address these fields but rather begins with the PDE fields that apply to the simplest case where the beneficiary is in a Basic plan and has no other source of payment.

4.2.1 Gross Drug Cost

Plans must follow regulatory and sub-regulatory guidance issued by CMS when determining the total cost of the drug to report on the PDE record. For a covered drug, regulatory guidance refers to this cost as "gross covered prescription drug cost". The participant guide will use the term "gross covered drug cost" in place of "gross covered prescription drug cost".

The term "gross drug cost" is also used in applicable situations to refer to the total cost of a covered or non-covered drug on the PDE. On the PDE record, there are detailed and summary cost fields that report the gross drug cost (i.e., inclusive of covered and non-covered drugs).

4.2.2 Detail Cost Fields

There are four detail cost fields: Ingredient Cost Paid, Dispensing Fee Paid, Total Amount Attributed to Sales Tax, and Vaccine Administration Fee or Additional Dispensing Fee. For all events, the gross drug cost is a sum total of these detail fields in the PDE record.

Gross Drug Cost = Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax. If the PDE includes a Vaccine Administration Fee or Additional Dispensing Fee, this field will be included in the sum of gross drug cost.

4.2.3 Summary Cost Fields

For covered drugs, the gross covered drug cost is also represented in two summary cost fields: Gross Drug Cost Below OOP Threshold (GDCB) and Gross Drug Cost Above OOP Threshold (GDCA). These two fields distinguish costs for covered drugs that fall above or below the OOP threshold, so that covered drug costs above the OOP threshold are identified for payment under the reinsurance subsidy.

To determine where costs fall, the TrOOP Accumulator is the sum of the incurred costs for the benefit year known immediately prior to the adjudication of a claim. Delta TrOOP, which is the sum of TrOOP eligible costs on the current claim, is added to the TrOOP Accumulator to determine if costs fall above or below the OOP threshold.

Reminder: For non-covered drugs, both GDCA and GDCB must be populated with a zero dollar amount (\$0.00). GDCA and GDCB only track the cost of covered drugs to note their location and indicate the beneficiary's status with respect to the OOP threshold.

4.2.3.1 Gross Drug Cost Below OOP Threshold (GDCB)

The GDCB field represents the covered drug cost that is below the OOP threshold. For covered drugs, the GDCB field always has a positive dollar amount if the OOP threshold is not yet reached or if the threshold is reached during this event. Once the beneficiary is fully in the Catastrophic Phase, plans must populate the GDCB field with a zero dollar value.

4.2.3.2 Gross Drug Cost Above OOP Threshold (GDCA)

The GDCA field reports covered drug cost above the OOP threshold. For covered drugs, this field is always populated with a positive dollar amount once the OOP threshold is met. If the threshold is met during this event, GDCA will usually have a positive value. If the beneficiary has not met the OOP threshold, the GDCA field will have a zero dollar value entered.

Table 4 illustrates the summary cost fields and their relationship to the TrOOP Accumulator field and Delta TrOOP on the PDE

Table 4: Summary Drug Cost and the TrOOP Accumulator Field

TrOOP Accumulator Field	GDCB	GDCA
TrOOP Accumulator < OOP and (TrOOP Accumulator + Delta TrOOP) < OOP Threshold	> \$0.00	= \$0.00
TrOOP Accumulator < OOP and (TrOOP Accumulator + Delta TrOOP) = OOP Threshold	> \$0.00	≥ \$0.00
TrOOP Accumulator = OOP Threshold	= \$0.00	> \$0.00

Note: Typically, a beneficiary reaches the OOP threshold only once in any given coverage year. Since any given dollar amount for a PDE will rarely bring TrOOP costs to exactly \$2,000.00 (2025 value), the event in which the OOP threshold is met will typically straddle the phases of the benefit on either side of the OOP threshold (the Initial Coverage Phase and the Catastrophic Phase). Therefore, for this event, GDCB will **always** have a positive dollar amount and GDCA will **typically** have a positive dollar amount. It is possible, but not likely, that GDCA will equal \$0.00 for the event where the OOP threshold is exactly met.

Reminder: When the PDE reports that the OOP threshold has not been met, DDPS validates that the plan assigned the gross covered drug cost to the GDCB field. When the PDE reports that the OOP threshold was reached on this event, DDPS validates that the plan assigned a portion of the gross covered drug cost to the GDCB field. When the PDE reports that the OOP

threshold was reached in previous events, DDPS validates that the plan assigned the gross covered drug cost to the GDCA field.

Reminder: On every PDE for a covered drug, DDPS totals and compares the dollars in the detail cost fields (Ingredient Cost Paid, Dispensing Fee Paid, Total Amount Attributed to Sales Tax, and Vaccine Administration Fee or Additional Dispensing Fee) and the dollars in the summary cost fields (GDCB and GDCA). DDPS rejects PDEs for covered drugs when the total detail and total summary costs differ.

4.3 Payment Fields

4.3.1 Patient Pay Amount

The Patient Pay Amount field registers payments made by the beneficiary or by persons paying on behalf of the beneficiary. It excludes amounts paid by other parties on behalf of the beneficiary. For covered drugs, this amount contributes to a beneficiary's TrOOP costs.

Plans are responsible for ensuring that beneficiaries are charged amounts consistent with the benefit packages approved in the bidding process.

4.3.2 Covered D Plan Paid Amount (CPP)

The Covered D Plan Paid Amount (CPP) field contains the amount the plan paid for a covered Part D drug under the Basic benefit.

4.3.3 Non-covered Plan Paid Amount (NPP)

The Non-covered Plan Paid Amount (NPP) field is designed to report plan-paid amounts that are attributed to benefits beyond the Basic benefit in Enhanced Alternative (EA) and Employer Group Waiver Plans (EGWPs). Basic benefit plans always populate NPP with \$0.00 except for OTC drugs covered under step therapy on an approved formulary. OTC drug costs are reported in full in NPP because they are paid under a plan's administrative costs for the Basic benefit, not under the direct subsidy, reinsurance, or risk sharing. OTC drug costs are primarily reported on the PDE record for purposes of monitoring cost and utilization.

Reminder: When the PDE reports an OTC drug, DDPS validates that the plan assigned all payment fields to zero, except for the NPP field.

Reminder: Plans must report OTC drug costs in the Ingredient Cost Paid field and, if applicable, in the Dispensing Fee Paid and Total Amount Attributed to Sales Tax fields. If there is no dispensing fee or sales tax, plans will report the gross OTC costs in the Ingredient Cost Paid field.

4.3.4 Reported Manufacturer Discount

Effective January 1, 2025, Reported Manufacturer Discount is a new field on the PDE. The new field was added to implement the MDP, as required under Section §1860D-14C and §1860D-43 of the Social Security Act. Reported Manufacturer Discount is the reported amount that the sponsor advanced at point of sale (POS) for the manufacturer discount. Part D sponsors advance the manufacturer discount at POS to applicable beneficiaries (as defined at 1860D-14C(g)(1)) who purchase an applicable drug that falls, in part or in full, in either the Initial Coverage Phase or Catastrophic Phase based on TrOOP exceeding the DS deductible. The manufacturer discount applies to the negotiated price as defined in §1860D-14C(g)(6) and includes dispensing fee paid and Vaccine Administration or Additional Dispensing fee starting in

2025. For purposes of calculating the manufacturer discount, the negotiated price is the sum of the Ingredient Cost Paid, Total Amount Attributed to Sales Tax, Dispensing Fee, and Vaccine Administration or Additional Dispensing Fee.

The steps to populate the PDE fields on a claim for an applicable drug are:

- **Calculate Remaining TrOOP:** The remaining TrOOP amount required for the beneficiary to meet the definition of an applicable beneficiary and be eligible for the MDP is calculated by subtracting the TrOOP Accumulator from the DS deductible amount.
- **Determine Beneficiary Cost-Sharing and Delta TrOOP:** Calculate Beneficiary cost-sharing, along with Delta TrOOP for the current claim.
- **Determine MDP Eligibility:** Compare Delta TrOOP on the current claim to the remaining TrOOP to see if any portion of the claim exceeds the DS Deductible.
- **Calculate Manufacturer Discount:** The manufacturer discount is 10% of costs in the Initial Coverage Phase and 20% of costs in the Catastrophic Phase for an applicable beneficiary and drug not eligible for a Phase-in. For an MDP Phase-in eligible applicable drug and beneficiary, the manufacturer discount is 1% of costs in the Initial Coverage and Catastrophic Phases.
- **Calculate Covered Plan Paid Cost-Sharing:** (Using existing calculations.)
- **Calculate Non-Covered Portion of Plan Paid Cost-Sharing:** (Determined on a per claim basis using existing calculations.)
- **Update TGCDC Accumulator, TrOOP Accumulator and populate Beginning and End Benefit Phases on the PDE:** The TGCDC Accumulator and TrOOP Accumulator are updated in preparation for adjudicating the next claim for the beneficiary. The PDE record is populated with the appropriate Beginning Benefit Phase and Ending Benefit Phase values.

4.4 Other Supporting PDE Data Elements

4.4.1 Drug Coverage Status Code

The Drug Coverage Status Code indicates whether a drug is covered and eligible for payment under the Basic benefit. Basic benefit plans populate the Drug Coverage Status Code with a 'C' representing a covered Part D drug, or an 'O' representing an OTC drug. Basic benefit plans are not able to report a Drug Coverage Status Code of 'E' representing enhanced drugs.

Definition: Covered Part D Drug – a Part D drug that is eligible for coverage under a specific PBP including Part D drugs that are approved under exceptions, transitions, grievances, appeals, and other coverage determination processes. As of January 1, 2025, applicable drugs may be covered under the Part D program only if they are covered by a signed MDP Agreement between CMS and the manufacturer or if CMS has used its authority to make an exception under Section 1960D-43(c) of the Act.

Only PDE records with 'C' in the Drug Coverage Status Code field are included under the reinsurance subsidy, risk corridor calculations, low-income cost-sharing subsidy amount (LICS), the MDP, and TrOOP costs.

Definition: Over-the-Counter Drug – OTC drug, paid by a plan under their administrative cost structure either as (1) part of general drug utilization management or (2) as part of an approved step therapy protocol.

OTC drugs are the only non-Part D drugs allowable in DS, AE, or BA plans. Plans must submit PDE records to the Drug Data Processing System (DDPS) for OTC drugs, but the drugs are paid for under plan administrative costs as reported in the bid and are excluded from other Part D payment calculations based on PDE records. Plans may not charge the beneficiary any part of an OTC drug's cost. The OTC Drug Coverage Status Code is 'O'.

Note: When the plan reports an OTC drug, DDPS validates that the National Drug Code (NDC) is categorized as an OTC drug on the DDPS reference table.

4.5 Total Gross Covered Drug Cost Accumulator

The Total Gross Covered Drug Cost (TGCDC) Accumulator is one of two values Part D sponsors maintain in real time. The TGCDC Accumulator is the sum of the covered drug costs for the benefit year known immediately before the sponsor begins adjudication of an individual claim. The TGCDC Accumulator is reported on the PDE along with the TrOOP Accumulator described in the next paragraph, but it is not used to determine the benefit phase. The TGCDC Accumulator field should be populated as \$0.00 on PDEs for OTC or Enhanced drugs.

4.6 Benefit Phase Indicators

Beginning Benefit Phase: The Beginning Benefit Phase is the plan-defined benefit phase that is in effect for the beneficiary at the time the sponsor begins adjudication of the individual claim being reported. For example, the Beginning Benefit Phase for the first claim in the benefit year is the Initial Coverage Phase in a plan with no deductible. In a DS plan, the Beginning Benefit Phase for the first claim in the benefit year is the Deductible Phase.

Drugs not subject to a deductible such as covered insulin products and ACIP-recommended vaccines are reported with a Beginning Benefit Phase of 'N' when the DS deductible has not been met. The Beginning Benefit Phase applies to covered drugs only.

Ending Benefit Phase: The Ending Benefit Phase is the plan-defined benefit phase that is in effect at the time the sponsor completes adjudication of the individual claim being reported. The Ending Benefit Phase should always be a benefit phase equal to or later than the Beginning Benefit Phase. For example, for a claim starting in the deductible phase and ending in the Initial Coverage Phase, the PDE should report a Beginning Benefit Phase of 'D' and an Ending Benefit Phase of 'N.' The Ending Benefit Phase applies to covered drugs only.

Note that Program of the All-Inclusive Care for the Elderly (PACE) plans do not report Beginning Benefit Phase or Ending Benefit Phase on the PDE.

The benefit phase indicators will be described in greater detail in Module 05: Calculating and Reporting TrOOP.

5. Prescription Drug Event Examples – Basic Benefit

DS, AE, and BA plans accumulate YTD TrOOP Cost, which determines if the beneficiary is in the Deductible Phase, Initial Coverage Phase or Catastrophic Phase of the benefit (see Module 01: Part D Payment Methodology).

The following sections demonstrate rules for populating the appropriate fields based on the beneficiary's benefit phase. In particular, amounts reported in CPP and Patient Pay Amount will vary based on the beneficiary's position in the benefit.

Resource: Health Plan Management System (HPMS) memorandum, Prescription Drug Event Record Reporting Instructions for the Implementation of the Inflation Reduction Act for Contract Year 2025, April 15, 2024.

5.1 Defined Standard Plan – Simplest Case

Understanding the benefit for a beneficiary with the simplest case of coverage establishes the foundation for understanding how to populate PDE records under more complex benefits. The simplest case of coverage is a beneficiary with the following characteristics:

- No Low-Income Cost-Sharing Subsidy Amount.
- No Other Health Insurance (OHI) or other source of coverage.
- Enrolled in a Part D plan with a DS benefit design.

The following examples illustrate how to populate a PDE in each benefit phase of a DS plan, simplest case.

5.1.1 Defined Standard Plan – Deductible Phase

This example demonstrates how to report a PDE when a beneficiary in a DS plan purchases a \$200.00 covered Part D drug that falls entirely within the Deductible Phase. The drug is the first prescription purchased in the benefit year.

When the claim adjudication begins, the Total Gross Covered Drug Cost (TGCDC) Accumulator is \$0.00, and the TrOOP Accumulator is \$0.00. The beneficiary is in the Deductible Phase of the benefit (TrOOP Accumulator + Delta TrOOP ≤ \$590.00); the Deductible Phase is the beginning and ending benefit phase. In the Deductible Phase, the beneficiary pays 100% coinsurance, and the plan pays 0%. The Patient Pay Amount is \$200.00 (\$200.00 * 1.00) and Covered D Plan Paid Amount (CPP) is \$0.00 (\$200.00 * 0.00).

After the claim is processed, the TGCDC Accumulator and the TrOOP Accumulator increase by \$200.00.

Table 5 illustrates how the plan populates the following data elements for this sample PDE in the Deductible Phase.

Table 5: 2025 DS Deductible Phase

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$200.00
Dispensing Fee Paid	\$0.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GD CB)	\$200.00
Gross Drug Cost Above Out-of-Pocket Threshold (GD CA)	\$0.00
Patient Pay Amount	\$200.00
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$0.00

PDE Field	Value
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$0.00
Total Gross Covered Drug Cost Accumulator	\$0.00
True Out-of-Pocket Accumulator	\$0.00
Beginning Benefit Phase	D
Ending Benefit Phase	D

5.1.2 Defined Standard Plan – Initial Coverage Phase

This example demonstrates how to report a PDE when a beneficiary in a DS plan purchases a \$320.00 covered Part D applicable drug with a \$315.00 ingredient cost and a \$5.00 dispensing fee. When the claim adjudication begins, the TGCDC Accumulator is \$700.00, and the TrOOP Accumulator is \$617.50. The beneficiary is in the ICP of the benefit (TrOOP Accumulator \geq \$590.00 and TrOOP Accumulator + Delta TrOOP $<$ \$2,000.00); the ICP is the beginning and ending benefit phase. In the ICP, the manufacturer discount is 10% of the total drug cost ($\$320.00 * 0.10 = \32.00), the beneficiary pays 25% coinsurance ($\$320.00 * 0.25 = \80.00) and CPP is 65% ($\$320.00 * 0.65 = \208.00).

After the claim is processed, the TGCDC Accumulator increases by \$320.00, and the TrOOP Accumulator increases by \$80.00.

Table 6 illustrates how the plan populates the following data elements for this sample PDE in the Initial Coverage Phase.

Table 6: 2025 DS Initial Coverage Phase, Applicable Drug

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$320.00
Dispensing Fee Paid	\$0.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)	\$320.00
Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)	\$0.00
Patient Pay Amount	\$80.00
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$208.00
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$32.00
Total Gross Covered Drug Cost Accumulator	\$700.00
True Out-of-Pocket Accumulator	\$617.50
Beginning Benefit Phase	N
Ending Benefit Phase	N

5.1.3 Defined Standard Plan – Catastrophic Phase

This example demonstrates how to report a PDE when a beneficiary in a DS plan purchases a \$250.00 covered Part D drug that falls entirely within the Catastrophic Phase. When the claim adjudication begins, the TGCDC Accumulator is \$9,432.00, and the TrOOP Accumulator is \$2,000.00. The beneficiary is in the Catastrophic Phase of the benefit (TrOOP Accumulator = \$2,000.00); the Catastrophic Phase is the beginning and ending benefit phase.

In the Catastrophic Phase, the manufacturer discount is 20% of the total drug cost ($\$250.00 * 0.20 = \50.00), the beneficiary pays 0% coinsurance ($\$250.00 * 0.00 = \0.00) and CPP is 80% ($\$250.00 * 0.80 = \200.00).

After the claim is processed, the TGCDC Accumulator increases by \$250.00, and the TrOOP Accumulator remains unchanged.

Table 7 illustrates how the Part D sponsor would populate the PDE record.

Table 7: 2025 DS Catastrophic Phase, Applicable Drug

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$250.00
Dispensing Fee Paid	\$0.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GDCEB)	\$0.00
Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)	\$250.00
Patient Pay Amount	\$0.00
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$200.00
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$50.00
Total Gross Covered Drug Cost Accumulator	\$9432.00
True Out-of-Pocket Accumulator	\$2000.00
Beginning Benefit Phase	C
Ending Benefit Phase	C

5.1.4 Defined Standard Plan – Over-the-Counter (OTC) Drug

Plans must submit PDE records for formulary OTC drugs. The costs of OTC drugs are included in a plan's administrative costs for the Basic benefit and are excluded from other Part D payment calculations that derive from PDE records. Costs associated with OTC drugs do not move the beneficiary through the Part D benefit.

This example demonstrates how to report a PDE when a beneficiary in a DS plan purchases a formulary OTC drug as part of step therapy and the negotiated price is \$15.00. The beneficiary is in the Initial Coverage Phase of the benefit in 2025 and has YTD gross covered drug costs of \$600.00.

The Patient Pay Amount is \$0.00 because plans cannot charge beneficiaries for OTC costs. The GDCB and GDCA fields on the PDE report \$0.00 since this drug is a non-covered drug and is excluded from payment. The gross drug cost of \$15.00 is reported in Non-covered Plan Paid Amount (NPP).

The Drug Coverage Status Code is populated as 'O' on the PDE indicating an OTC drug. The TGDCDC Accumulator, TrOOP Accumulator, Beginning Benefit Phase and Ending Benefit Phase are reported as spaces.

After the claim is processed, the TGDCDC Accumulator and the TrOOP Accumulator remain unchanged, as NPP for OTC drugs does not count towards TrOOP.

Table 8 illustrates how the plan populates the following data elements for this sample OTC drug PDE.

Table 8: 2025 DS Over-the-Counter Drug

PDE Field	Value
Drug Coverage Status Code	O
Ingredient Cost Paid	\$15.00
Dispensing Fee Paid	\$0.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)	\$0.00
Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)	\$0.00
Patient Pay Amount	\$0.00
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$0.00
Non-covered Plan Paid Amount (NPP)	\$15.00
Reported Manufacturer Discount	\$0.00
Total Gross Covered Drug Cost Accumulator	<SPACE>
True Out-of-Pocket Accumulator	<SPACE>
Beginning Benefit Phase	<SPACE>
Ending Benefit Phase	<SPACE>

5.2 Tiered Cost-Sharing Examples

Plans that implement tiers use plan-specific adjudication logic to determine beneficiary cost-sharing, following Part D guidelines. Whether a plan implements tiered or uniform cost-sharing, the plan populates the PDE fields in the same manner. Since tiering is the more common alternative, the following examples illustrate each type of alternate Basic plan.

5.2.1 Basic Alternative Plan – Deductible

This example demonstrates how to report a PDE for a beneficiary enrolled in a BA plan that uses the tiered copay structure outlined in Table 3 and has a \$150.00 Deductible. This is the

first drug purchase of the year. The beneficiary purchases a \$100.00 covered drug in Tier 3 with a \$40.00 copay.

When the claim adjudication begins, the Total Gross Covered Drug Cost (TGCDC) Accumulator is \$0.00, and the TrOOP Accumulator is \$0.00. The beneficiary is in the Deductible Phase of the benefit (TrOOP Accumulator + Delta TrOOP \leq \$590.00); the Deductible Phase is the beginning and ending benefit phase. In the Deductible Phase, the beneficiary pays 100% coinsurance, and the plan pays 0%. The Patient Pay Amount is \$100.00 ($\$100.00 * 1.00$) and Covered D Plan Paid Amount (CPP) is \$0.00 ($\$100.00 * 0.00$).

After the claim is processed, the TGCDC Accumulator and the TrOOP Accumulator increase by \$100.00.

Table 9 illustrates how the plan populates the following data elements for this sample PDE in the Deductible Phase of a tiered benefit.

Table 9: 2025 Tiered Basic Plan – Deductible Phase

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$100.00
Dispensing Fee Paid	\$0.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GD CB)	\$100.00
Gross Drug Cost Above Out-of-Pocket Threshold (GD CA)	\$0.00
Patient Pay Amount	\$100.00
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$0.00
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$0.00
Total Gross Covered Drug Cost Accumulator	\$0.00
True Out-of-Pocket Accumulator	\$0.00
Beginning Benefit Phase	D
Ending Benefit Phase	D

5.2.2 Actuarial Equivalent Plan – Initial Coverage Phase

This example demonstrates how to report a PDE for a beneficiary in an AE plan who purchases a \$320.00 covered Part D applicable drug with a \$315.00 ingredient cost and a \$5.00 dispensing fee. The AE plan charges a \$10.00 copay in the ICP for this drug using the tiered copay structure outlined in Table 3. When the claim adjudication begins, the TGCDC Accumulator is \$700.00, and the TrOOP Accumulator is \$610.00. The beneficiary is in the ICP of the benefit (TrOOP Accumulator \geq \$590.00 and TrOOP Accumulator + Delta TrOOP $<$ \$2,000.00); the ICP is the beginning and ending benefit phase.

In the ICP, the manufacturer discount is 10% of the total drug cost ($\$320.00 * 0.10 = \32.00), the beneficiary pays their ICP copay of \$10.00, and the plan pays the remaining drug cost of \$278.00 ($\$320.00 - \$32.00 - \10.00) and reports this amount as CPP.

After the claim is processed, the TGDCDC Accumulator increases by \$320.00, and the TrOOP Accumulator increases by \$10.00.

Table 10 illustrates how the plan populates the following data elements for this sample PDE in the Initial Coverage Phase of a tiered benefit.

Table 10: 2025 Tiered Basic Plan – Initial Coverage Phase, Applicable Drug

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$315.00
Dispensing Fee Paid	\$5.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)	\$320.00
Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)	\$0.00
Patient Pay Amount	\$10.00
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$278.00
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$32.00
Total Gross Covered Drug Cost Accumulator	\$700.00
True Out-of-Pocket Accumulator	\$610.00
Beginning Benefit Phase	N
Ending Benefit Phase	N

5.2.3 Basic Alternative Plan – ICP where the Beneficiary Copay is Capped at the Drug Cost minus the Manufacturer Discount (MDP Phase-In Eligible Applicable Drug)

This example demonstrates how to report a PDE for a beneficiary in a BA plan who purchases a \$45.00 covered Part D MDP phase-in eligible applicable drug, and the beneficiary copay is capped at the drug cost minus the manufacturer discount. The BA plan charges a \$45.00 copay in the ICP for this drug. When the claim adjudication begins, the TGDCDC Accumulator is \$790.00, and the TrOOP Accumulator is \$615.00. The beneficiary is in the ICP of the benefit (TrOOP Accumulator \geq \$590.00 and TrOOP Accumulator + Delta TrOOP $<$ \$2,000.00); the ICP is the beginning and ending benefit phase.

In the ICP, because this is a drug eligible for the MDP phase-in in CY 2025, the manufacturer discount is 1% of the total drug cost ($\$45.00 * 0.01 = \0.45) in 2025. The beneficiary pays a capped ICP copay of \$44.55 because the beneficiary can never pay more than the drug cost in the ICP minus the manufacturer discount in the ICP. CPP is \$0.00 because there is no drug cost remaining after the manufacturer discount and beneficiary cost-sharing have been applied.

After the claim is processed, the TGDCDC Accumulator increases by \$45.00, and the TrOOP Accumulator increases by \$44.55.

Table 11 illustrates how the plan populates the following data elements for this sample PDE in the Initial Coverage Phase of a tiered benefit where the Beneficiary Copay is capped at Drug Cost minus Manufacturer Discount.

Table 11: 2025 Tiered Basic Plan – ICP where Beneficiary Copay is Capped at Drug Cost minus Manufacturer Discount

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$45.00
Dispensing Fee Paid	\$0.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GD CB)	\$45.00
Gross Drug Cost Above Out-of-Pocket Threshold (GD CA)	\$0.00
Patient Pay Amount	\$44.55
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$278.00
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$0.45
Total Gross Covered Drug Cost Accumulator	\$790.00
True Out-of-Pocket Accumulator	\$615.00
Beginning Benefit Phase	N
Ending Benefit Phase	N

6. Straddle Claims

Straddle claims are claims that cross phases of the benefit. This logic is similar to traditional adjudication logic that splits a single claim that crosses a deductible limit. This introductory section explains how to administer the benefit and report a PDE when a claim crosses different phases of the benefit.

Depending on the plan benefit design, straddle claims usually occur in two instances, when claims cross:

- The Deductible in which coinsurance applies and the Initial Coverage Phase in which a copayment structure applies.
- The Initial Coverage Phase in which a copayment or coinsurance applies and the Catastrophic Phase in which patient liability does not apply.

6.1 Defined Standard Plan Straddle Claims

The following examples demonstrate how to administer the benefit and calculate and report PDE values for straddle claims in a DS plan.

6.1.1 Defined Standard Plan: Straddle of Deductible and Initial Coverage Phase

This example demonstrates how to report a PDE when a purchase of a \$100.00 covered Part D applicable drug moves a beneficiary from the Deductible Phase to the ICP in a DS plan. When the claim adjudication begins, the TGDCDC Accumulator is \$560.00, and the TrOOP Accumulator is \$560.00. Because the beneficiary meets the DS deductible midway through the processing of this claim, the beginning benefit phase is the Deductible Phase, and the ending benefit phase is the ICP. The remaining TrOOP amount required for the beneficiary to meet the definition of an applicable beneficiary and be eligible for the MDP is calculated by subtracting the TrOOP Accumulator from the DS deductible amount and is \$30.00 (\$590.00 - \$560.00).

The beneficiary pays 100% of the drug cost until the DS deductible is met ($\$30.00 * 1.00 = \30.00) plus 25% coinsurance in the ICP ($\$70.00 * 0.25 = \17.50), which equals \$47.50. The Delta TrOOP on this claim is equal to \$47.50, which exceeds the \$30.00 of remaining TrOOP required for the beneficiary to be eligible for the MDP. The manufacturer discount is 10% of the drug cost falling in the ICP ($\$70.00 * 0.10 = \7.00), the Patient Pay Amount is \$47.50, and CPP is 0% of drug costs in the Deductible Phase ($\$30.00 * 0.00 = \0.00) plus 65% of drug costs in the ICP ($\$70.00 * 0.65 = \45.50), which equals \$45.50. After the claim is processed, the TGDCDC Accumulator increases by \$100.00, and the TrOOP Accumulator increases by \$47.50.

Table 12 illustrates how the plan populates the following data elements on the PDE for this example that straddles the Deductible and the Initial Coverage Phase.

Table 12: DS 2025 – Deductible to Initial Coverage Phase, Applicable Drug

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$100.00
Dispensing Fee Paid	\$0.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GD CB)	\$100.00
Gross Drug Cost Above Out-of-Pocket Threshold (GD CA)	\$0.00
Patient Pay Amount	\$47.50
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$45.50
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$7.00
Total Gross Covered Drug Cost Accumulator	\$560.00
True Out-of-Pocket Accumulator	\$560.00
Beginning Benefit Phase	D
Ending Benefit Phase	N

6.1.2 Defined Standard Plan: Straddle of Initial Coverage Phase and Catastrophic Phase

This example demonstrates how to report a PDE when a purchase of a \$400.00 covered Part D applicable drug with a \$390.00 ingredient cost and a \$10.00 dispensing fee moves a beneficiary in a DS plan from the ICP to the Catastrophic Phase. When the claim adjudication begins, the TGDCDC Accumulator is \$5,990.00, and the TrOOP Accumulator is \$1,940.00. Because the beneficiary meets the annual OOP threshold midway through the processing of this claim, the beginning benefit phase is the ICP, and the ending benefit phase is the Catastrophic Phase. The TrOOP amount remaining in the ICP is \$60.00 (\$2,000.00 - \$1,940.00). When a claim begins in the ICP, the following formula can be used to determine the drug cost remaining in the ICP:

Remaining TrOOP Amount / TrOOP-eligible cost-sharing percentage in the ICP

In the ICP of a DS plan, only the beneficiary cost-sharing of 25% is TrOOP-eligible, so the TrOOP-eligible cost-sharing percentage in this example is 25%. On this PDE, using the formula in the previous paragraph to calculate the drug cost remaining in the ICP (based on the amount of TrOOP remaining (\$60.00 / 0.25)), yields \$240.00 and is reported as GDCEB. The remaining drug cost of \$160.00 falls in the Catastrophic Phase and is reported as GDCA.

The manufacturer discount is 10% of the drug cost falling in the ICP ($\$240.00 \times 0.10 = \24.00) plus 20% of the drug cost falling in the Catastrophic Phase ($\$160.00 \times 0.20 = \32.00), which equals \$56.00. The beneficiary pays 25% coinsurance in the ICP ($\$240.00 \times 0.25 = \60.00) and 0% coinsurance in the Catastrophic Phase ($\$160.00 \times 0.00 = \0.00), which equals \$60.00. CPP is 65% of drug costs in the ICP ($\$240.00 \times 0.65 = \156.00) plus 80% of drug costs falling in the Catastrophic Phase ($\$160.00 \times 0.80 = \128.00), which equals \$284.00.

After the claim is processed, the TGDCDC Accumulator increases by \$400.00, and the TrOOP Accumulator increases by \$60.00.

Table 13 illustrates how the plan populates the following data elements on the PDE for this example that straddles the Initial Coverage Phase and the Catastrophic Phase.

Table 13: DS 2025 – Initial Coverage Phase to Catastrophic Phase

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$390.00
Dispensing Fee Paid	\$10.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GDCEB)	\$240.00
Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)	\$160.00
Patient Pay Amount	\$60.00
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$284.00
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$56.00

PDE Field	Value
Total Gross Covered Drug Cost Accumulator	\$5990.00
True Out-of-Pocket Accumulator	\$1940.00
Beginning Benefit Phase	N
Ending Benefit Phase	C

6.1.3 Defined Standard Plan: Straddle of Deductible through Catastrophic Phase

This example demonstrates how to report a PDE when a purchase of an \$8,000.00 covered Part D applicable drug moves a beneficiary in a DS plan from the Deductible Phase to the Catastrophic Phase. When the claim adjudication begins, the TGCDC Accumulator is \$0.00, and the TrOOP Accumulator is \$0.00. Because the beneficiary meets the DS deductible and the annual OOP threshold midway through the processing of this claim, the beginning benefit phase is the Deductible Phase, and the ending benefit phase is the Catastrophic Phase. Once the DS deductible is met, the TrOOP amount remaining in the ICP is \$1,410.00 (\$2,000.00 - \$590.00) and the following formula can be used to determine the drug cost remaining in the ICP:

Remaining TrOOP Amount / TrOOP-eligible cost-sharing percentage in the ICP

In the ICP of a DS plan, only the beneficiary cost-sharing of 25% is TrOOP-eligible, so the TrOOP-eligible cost-sharing percentage in this example is 25%. On this PDE, using the formula above to calculate the drug cost remaining in the ICP based on the amount of TrOOP remaining in the ICP ($\$1,410.00 / 0.25$) yields \$5,640.00. The drug cost in the Deductible Phase (\$590.00) plus the drug cost in the ICP (\$5,640.00) equals \$6,230.00 and is reported as GDCB. The remaining drug cost of \$1,770.00 falls in the Catastrophic Phase and is reported as GDCA.

The manufacturer discount is 10% of the drug cost falling in the ICP ($\$5,640.00 * 0.10 = \564.00) plus 20% of the drug cost falling in the Catastrophic Phase ($\$1,770.00 * 0.20 = \354.00), which equals \$918.00. The beneficiary pays 100% coinsurance in the Deductible Phase ($\$590.00 * 1.0 = \590.00), 25% coinsurance in the ICP ($\$5,640.00 * 0.25 = \$1,410.00$), and 0% coinsurance in the Catastrophic Phase ($\$1,770.00 * 0.00 = \0.00), which equals \$2,000.00. CPP is 65% of drug costs in the ICP ($\$5,640.00 * 0.65 = \$3,666.00$) plus 80% of drug costs falling in the Catastrophic Phase ($\$1,770.00 * 0.80 = \$1,416.00$), which equals \$5,082.00.

After the claim is processed, the TGCDC Accumulator increases by \$8,000.00, and the TrOOP Accumulator increases by \$2,000.00

Table 14 illustrates how the plan must populate the following data elements on the PDE for this example that straddles the Deductible Phase, the Initial Coverage Phase and the Catastrophic Phase.

Table 14: DS 2025 – Deductible Phase to Catastrophic Phase

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$8000.00
Dispensing Fee Paid	\$0.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)	\$6230.00
Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)	\$1770.00

PDE Field	Value
Patient Pay Amount	\$2000.00
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$5082.00
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$918.00
Total Gross Covered Drug Cost Accumulator	\$0.00
True Out-of-Pocket Accumulator	\$0.00
Beginning Benefit Phase	D
Ending Benefit Phase	C

6.2 Tiered Benefit Straddle Claims

While the calculations for a coinsurance model (such as a DS plan) are relatively simple, the calculations for a tiered copay structure require use of additional rules. If not calculated correctly, the total beneficiary liability for a straddle claim in a tiered benefit can exceed the gross drug cost. To prevent this error, plans calculate the drug cost remaining in the ICP based on the amount of TrOOP remaining when adjudicating straddle claims that have copay amounts; the beneficiary pays the ICP copay if greater than remaining TrOOP, otherwise the remaining TrOOP left in the ICP. (See Module 07: Calculating and Reporting the EA Benefit, sections 7.6.7 and 7.6.8 for examples.)

6.2.1 Basic Alternative Plan: Straddle of Deductible Phase and Initial Coverage Phase

This example demonstrates how to report a PDE when a purchase of a \$400.00 covered Part D applicable drug moves a beneficiary, who is in a BA plan, from the Deductible Phase to the ICP. When the claim adjudication begins, the TGDCDC Accumulator is \$380.00, and the TrOOP Accumulator is \$380.00. This BA plan has reduced the deductible to \$400.00 and has a \$30.00 copay in the ICP. Because the beneficiary meets the plan deductible midway through the processing of this claim, the beginning benefit phase is the Deductible Phase, and the ending benefit phase is the ICP (the plan reports the benefit phase indicators in alignment with the plan-defined phase). The remaining TrOOP amount required for the beneficiary to meet the definition of an applicable beneficiary and be eligible for the MDP is calculated by subtracting the TrOOP Accumulator from the DS deductible amount and is \$210.00 (\$590.00 - \$380.00).

The beneficiary pays 100% of the drug cost until the plan-defined deductible is met ($\$20.00 * 1.00$) plus the plan-defined ICP copay of \$30.00, which equals \$50.00. The Delta TrOOP on this claim is equal to \$50.00, which does not exceed the \$210.00 of remaining TrOOP required for the beneficiary to be eligible for the MDP. Therefore, a manufacturer discount is not calculated for this claim. The Patient Pay Amount is \$50.00, and the plan pays the remaining \$350.00 and reports this amount as CPP.

After the claim is processed, the TGDCDC Accumulator increases by \$400.00, and the TrOOP Accumulator increases by \$50.00.

Table 15 illustrates how the plan must populate the following data elements on the PDE for this Basic Alternative example with a tiered benefit that straddles the Deductible Phase and the Initial Coverage Phase.

Table 15: BA 2025 – Deductible to Initial Coverage Phase Straddle with Tiered Benefit

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$400.00
Dispensing Fee Paid	\$0.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GD CB)	\$400.00
Gross Drug Cost Above Out-of-Pocket Threshold (GD CA)	\$0.00
Patient Pay Amount	\$50.00
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$350.00
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$0.00
Total Gross Covered Drug Cost Accumulator	\$380.00
True Out-of-Pocket Accumulator	\$380.00
Beginning Benefit Phase	D
Ending Benefit Phase	N

6.2.2 Actuarially Equivalent Plan: ICP to Catastrophic Phase (Applicable Drug)

This example demonstrates how to report a PDE when a purchase of a \$400.00 covered Part D applicable drug with a \$390.00 ingredient cost and a \$10.00 dispensing fee moves a beneficiary, who is in an AE plan, from the ICP to the Catastrophic Phase. When the claim adjudication begins, the TGDCDC Accumulator is \$7,200.00, and the TrOOP Accumulator is \$1,995.00. Because the beneficiary meets the annual OOP threshold midway through the processing of this claim, the beginning benefit phase is the ICP, and the ending benefit phase is the Catastrophic Phase. The TrOOP amount remaining in the ICP is \$5.00 (\$2,000.00 - \$1,995.00). This AE plan has a \$40.00 copay in the ICP. When a claim begins in the ICP, the following formula can be used to determine the drug cost remaining in the ICP:

Remaining TrOOP Amount / TrOOP-eligible cost-sharing percentage in the ICP

In the ICP of an AE plan, only the beneficiary cost-sharing percentage is TrOOP-eligible. When the beneficiary has a copay in the ICP of an AE plan, it must first be converted to a cost-sharing percentage. The TrOOP-eligible cost-sharing percentage can be determined using the following formula:

TrOOP-eligible cost-sharing percentage in the ICP = plan-specified ICP copay/TGDCDC

Therefore, the TrOOP-eligible cost-sharing percentage in the ICP for this example is 10% (\$40.00 / \$400.00). This amount is used to calculate the drug cost remaining in the ICP based

on the amount of TrOOP remaining ($\$5.00 / 0.10$) and yields $\$50.00$, which is reported as GDCB. The remaining drug cost of $\$350.00$ falls in the Catastrophic Phase and is reported as GDCA. The manufacturer discount is 10% of the drug cost falling in the ICP ($\$50.00 * 0.10 = \5.00) plus 20% of the drug cost falling in the Catastrophic Phase ($\$350.00 * 0.20 = \70.00), which equals $\$75.00$. Although under the AE plan's benefit design, the beneficiary's ICP copay is $\$40.00$, there is only $\$5.00$ of remaining TrOOP left in the ICP, so the beneficiary pays this amount to meet the annual OOP threshold. The plan reports the remaining drug cost in the ICP ($\$50.00 - \$5.00 - \$5.00 = \40.00) and 80% of drug costs in the Catastrophic Phase ($\$350.00 * 0.80 = \280.00), which is $\$320.00$, as CPP.

After the claim is processed, the TGDCD Accumulator increases by $\$400.00$, and the TrOOP Accumulator increases by $\$5.00$.

Table 16 illustrates how the plan must populate the following data elements on the PDE for this Basic Alternative example with a tiered benefit that straddles the Initial Coverage Phase and the Catastrophic Phase.

Table 16: BA 2025 – Deductible to Initial Coverage Phase Straddle with Tiered Benefit – PDE Reporting

PDE Field	Value
Drug Coverage Status Code	C
Ingredient Cost Paid	\$400.00
Dispensing Fee Paid	\$0.00
Total Amount Attributed to Sales Tax	\$0.00
Vaccine Administration Fee or Additional Dispensing Fee	\$0.00
Gross Drug Cost Below Out-of-Pocket Threshold (GDCB)	\$50.00
Gross Drug Cost Above Out-of-Pocket Threshold (GDCA)	\$350.00
Patient Pay Amount	\$5.00
Other TrOOP Amount	\$0.00
Low Income Cost Sharing Subsidy Amount (LICS)	\$0.00
Patient Liability Reduction Due to Other Payer Amount (PLRO)	\$0.00
Covered D Plan Paid Amount (CPP)	\$320.00
Non-covered Plan Paid Amount (NPP)	\$0.00
Reported Manufacturer Discount	\$0.00
Total Gross Covered Drug Cost Accumulator	\$7200.00
True Out-of-Pocket Accumulator	\$1995.00
Beginning Benefit Phase	N
Ending Benefit Phase	C

7. Adjustments and Deletions

This Section describes situations that frequently cause adjustments and deletions and then discusses how a change affects benefit administration and finally gives examples including adjustment and deletion PDEs (Module 03: Data Format provides information on adjustment/deletion values that trigger adjustment/deletion processing in DDPS).

7.1 Situations That May Cause Adjustments and Deletions

Sometimes claims data changes after the POS transaction. When post POS changes occur, the plan must first consider how the change affects benefit administration. The plan then determines if PDEs must be updated. We have identified three types of errors and the expected course of action for addressing the errors. Sponsors are expected to use their judgment to determine which error a specific scenario falls within and take the appropriate course of action.

Administrative Errors: An administrative error is an error that does not affect the financial calculation of a claim. An example of an administrative error is the wrong prescription origin code. If an administrative error is discovered, a sponsor should correct the field(s) on the PDE related to the administrative error and resubmit the PDE. Because the adjustment is related to non-financial fields, the TG CDC and Tr OOP accumulators remain the same.

Financial Errors: A financial error is an error that results in incorrect payment calculations on claims that were otherwise appropriate for coverage. An example of a financial error is the National Drug Code (NDC) submitted on the claim is not the NDC dispensed. For example, a sponsor submits an NDC for a brand drug, but a generic drug was dispensed. The sponsor would resubmit the PDE with the correct NDC along with the correct financial fields that correspond to the generic NDC. Because there is a change to financial fields, the TG CDC and Tr OOP accumulators must be adjusted.

Coverage Errors: There are four types of coverage errors, and each type requires a different course of action.

- The pharmacy billed the sponsor for a drug, but the drug was never dispensed. In this case, recoup the cost and delete the PDE. If the event never happened, then a PDE should not exist for the event. There will be no Direct and indirect Remuneration (DIR) to report in this scenario. The TG CDC and Tr OOP accumulators will need to be adjusted. An example of this type of error would be a duplicate claim.
- The dispensing event happened, and the event was correct, but the claim was wrong. In this situation, adjust the claim so that it reflects the dispensing event. The PDE must reflect the dispensing event. The accumulators must be adjusted. For example, the claim was processed for Prozac when in fact Prilosec was dispensed.
- The dispensing event happened, the event was in error (i.e., the drug should not have been dispensed), and the drug is a Part D drug. In this situation, recoup the cost for the drug and submit a \$0.00 PDE. Adjust the accumulators since the event should not have occurred.
- The dispensing event happened, the event was in error (i.e., the drug should not have been dispensed), and the drug is a non-Part D drug. For example, the claim was for Cialis but was prescribed for a condition other than benign prostatic hyperplasia (BPH). In this case, recoup the claim, delete the PDE, and adjust the accumulators.

Below are different approaches to recalculate the accumulators due to financial or coverage errors.

Definition: Reversal – A reversal deletes the billing transaction it reverses. In effect, the pharmacy refunds the plan for the reversal claim. Reversals involve accounting updates at both the pharmacy and the Part D plan. Pharmacies must reverse claims when the billed transaction did not actually happen (e.g., beneficiary did not pick up prescription).

Part D beneficiary cost-sharing varies by benefit phase. To maintain the integrity of the benefit, plans must account for these cost-sharing differences when processing reversals.

Section 7.1.1 Reversals with No Subsequent Claims – applies when the beneficiary has no claims with dates of service after the reversed claim.

Section 7.1.2 Reversal with Subsequent Claims – applies when a reversal affects claims submitted after the reversed claim.

7.1.1 Reversals with No Subsequent Claims

Benefit Administration: When the plan receives the reversal for a covered drug, the plan immediately adjusts two accumulators the plan uses to administer the Part D benefit, the TGCDC Accumulator and the TrOOP Accumulator. The plan depends on accurate timely values in these accumulators to correctly administer the Part D benefit in a real time environment.

TGCDC Accumulator: The plan subtracts the cost of the covered drug from the YTD Gross Covered Drug Cost accumulator.

TrOOP Accumulator: The plan subtracts the Patient Pay Amount (and other TrOOP qualifying amounts to be discussed in other modules) from the YTD TrOOP balance.

When there are no subsequent claims, the plan simply reports the reversal in its internal system. There is no re-calculation.

PDE Reporting: If the plan had successfully reported a PDE for the reversed claim, the plan would also submit a deletion PDE as described in section 7.1. If the PDE is not on file in DDPS, either because the plan did not submit it or because DDPS rejected the PDE, no PDE reporting requirement applies.

7.1.2 Reversal with Subsequent Claims

Benefit Administration: Sometimes a reversed claim advances the beneficiary into the next benefit phase with different beneficiary cost-sharing. Until the reversal is reported, the plan adjudicates claims with the best information available. When a plan receives a reversal, the plan must complete all the processing necessary for the reversal and determine if there is a requirement to pay back the phase of the benefit. Most of the time the plan has two options to pay back the benefit. In option one, the plan pays back the benefit (i.e., applies the difference in cost-sharing) on future claims and there is no cash transfer between the plan and the beneficiary. Instead, the plan applies cost-sharing for the reversed claim on future claims. In option two, the plan recalculates claims affected by the reversal. When the plan does not expect sufficient claims volume to repay the benefit or when LICS is involved (see Module 07: Calculating and Reporting the Enhanced Alternative (EA) Benefit), the plan must recalculate the affected claims and settle with the beneficiary either by establishing a payable/receivable or by directly charging/refunding the beneficiary. For example, if a reversal is reported at the end of the benefit year, the plan must repay (or collect from) the beneficiary directly because plans cannot carry cost-sharing balances across benefit years.

PDE Reporting: The way plans report PDEs depends on the method the plan uses to pay back the benefit. When the plan pays back the benefit on future claims, the plan can report PDEs “as administered”. When the plan reports on an “as administered” basis, PDEs document the actual beneficiary cost-sharing applied at POS. By the end of the benefit year, the sum of cost-sharing on all PDEs will be correct. However, during the benefit year PDEs will document beneficiary cost-sharing that “appears” non-sequential. If the PDEs were sorted by Claim Adjudication Began Timestamp, PDEs would show beneficiary cost-sharing in one benefit phase interrupted by cost-sharing in an earlier phase. In addition, the relationship between the TGCDC

Accumulator and TrOOP Accumulator, the benefit phases, and the cost-sharing terms will appear to be out of order.

When the plan recalculates and settles directly with the beneficiary, the plan must report the PDE “as adjusted”. “As adjusted” PDEs must report the recalculated beneficiary cost-sharing. If the plan has a PDE on file with the original cost-sharing, the plan must submit an adjustment PDE reporting the recalculated cost-sharing. Plans must submit the adjustment (corrected) PDE within 90 days following the date the reversal is received. If the PDE was not accepted in DDPS before, the plan must report the recalculated cost-sharing when it submits the original PDE.

7.1.2.1 Example: Reversal with Benefit Phase Change

Example: The beneficiary enrolled in a BA plan with a \$175.00 deductible. The beneficiary purchases three covered drugs. On January 10 the beneficiary’s physician calls in a \$100.00 prescription to the pharmacy. The pharmacy fills the prescription immediately and bills the plan. On January 15 the beneficiary purchases a \$75.00 drug. Then on January 20 the beneficiary purchases a third covered drug for \$100.00. Based on the information the plan knows on January 20, the plan adjudicates the claim in the Initial Coverage Phase because the beneficiary’s first two claims satisfied the \$175.00 deductible. A \$30.00 copay applies. On January 21 the pharmacy reverses the January 10 claim and refunds the plan. The plan immediately updates its accumulators. The reversal affects the January 20 claim. The claim should have been adjudicated as a deductible claim. The beneficiary should have paid \$100.00 instead of \$30.00. To repay the benefit, the beneficiary will pay 100% cost-sharing on the next \$70.00 of gross covered drug cost.

PDE Reporting (Report as administered): The PDE for the January 20 claim will report \$30.00 in the Patient Pay field. For ease of illustration, assume that the next covered drug purchase costs \$70.00. The PDE for the next claim will report \$70.00 in the Patient Pay field and \$0.00 in the CPP field. Table 17 illustrates “Plan Accumulators and Report as Administered”.

Table 17: Plan Accumulators and Report as Administered

Claim Date	Current Claim (Gross Covered Drug Cost)	Current Claim (Patient Pay Amount)	Accumulators (YTD Gross Covered Drug Cost)	Accumulators (YTD TrOOP Balance)	Benefit Phase Indicators (Beginning Benefit Phase)	Benefit Phase Indicators (Ending Benefit Phase)
January 10	\$100.00	\$100.00	\$0.00	\$0.00	D	D
January 15	\$75.00	\$75.00	\$100.00	\$100.00	D	D
January 20	\$100.00	\$30.00	\$175.00	\$175.00	D	N
January 10 reversal (effective January 21)	<\$100.00>	<\$100.00>	\$75.00	\$75.00	–	–
January 25	\$70.00	\$70.00	\$75.00	\$75.00	D	D

PDE Reporting (Report as adjusted): If this same scenario occurred late in the benefit year and the reversal was reported after December 31 or if the reversal were reported after the beneficiary disenrolled, the plan would recalculate. The plan would collect the \$70.00 directly from the beneficiary and the plan would adjust each PDE after the January 10 reversed PDE (either the original or the adjusted PDE) would report \$100.00 in the Patient Pay field. Table 18 illustrates “Plan Accumulators and Report as Adjusted”.

Table 18: Plan Accumulators and Report as Adjusted

Claim Date	Current Claim (Gross Covered Drug Cost)	Current Claim (Patient Pay Amount)	Accumulators (YTD Gross Covered Drug Cost)	Accumulators (YTD TrOOP Balance)	Benefit Phase Indicators (Beginning Benefit Phase)	Benefit Phase Indicators (Ending Benefit Phase)
January 10	\$100.00	\$100.00	\$0.00	\$0.00	D	D
January 15	\$75.00	\$75.00	\$100.00	\$100.00	D	D
January 20	\$100.00	\$30.00	\$175.00	\$175.00	D	N
January 10 reversal (effective January 21)	<\$100.00>	<\$100.00>	\$75.00	\$75.00	–	–
January 15 (PDE adjustments after reversal)	\$75.00	\$75.00	\$0.00	\$0.00	D	D
January 20 (PDE adjustments after reversal)	\$100.00	\$100.00	\$75.00	\$75.00	D	D
January 25 (PDE adjustments after reversal)	\$70.00	\$30.00	\$175.00	\$175.00	D	N

This section outlines two ways to address the reversal with benefit change. These examples are for purposes of illustration; they are not prescriptive. Plans may implement an alternate process, provided it maintains the integrity of the benefit. For example, a plan may routinely adjust all affected claims and establish a beneficiary payable/receivable account with which it defrays/repays beneficiary cost-sharing on subsequent claims.

Straddle Claims: Sometimes the calculation to pay back the benefit will be complicated because the payback amount is a portion of the total claim cost. Straddle claim logic applies in this situation. To show the effect of a straddle claim we modify the example in Table 18 by making the gross covered drug cost on the pay back claim \$100.00. The plan calculates that \$70.00 of cost falls in the Deductible with 100% coinsurance. The remaining \$30.00 of cost falls in the Initial Coverage Phase, so the \$30.00 copay applies. The beneficiary pays \$100.00 (the sum of \$70.00 and \$30.00). Please note that the calculated cost share does not exceed the negotiated price of \$100.00. CMS includes this example to emphasize that plans cannot bypass straddle calculations; they cannot simplify calculations for pay back claims by applying cost-

sharing from one benefit phase only. For example, the plan cannot simplify the calculation and report only \$70.00 of cost-sharing.

Appendix A: Acronyms

Table 19: Acronyms

Acronym	Literal Translation
ACIP	Advisory Committee on Immunization Practices
AE	Actuarially Equivalent
BA	Basic Alternative
BLA	Biologic License Application
BPH	Benign Prostatic Hyperplasia
CMS	Centers for Medicare & Medicaid Services
CPP	Covered D Plan Paid Amount
CY	Calendar Year
DDPS	Drug Data Processing System
DIR	Direct and indirect Remuneration
DS	Defined Standard
EA	Enhanced Alternative
FDA	Food and Drug Administration
GDCA	Gross Drug Cost Above OOP Threshold
GDCB	Gross Drug Cost Below OOP Threshold
HPMS	Health Plan Management System
ICP	Initial Coverage Phase
IRA	Inflation Reduction Act
LICS	Low-Income Cost-Sharing Subsidy Amount
LIS	Low-Income Subsidy
MA	Medicare Advantage
MDP	Manufacturer Discount Program
MMA	Medicare Modernization Act
NDA	New Drug Application
NDC	National Drug Code
NPP	Non-covered Plan Paid Amount
OHI	Other Health Insurance
OOP	Out-of-Pocket
OTC	Over-the-Counter
PACE	Program of the All-Inclusive Care for the Elderly
PBP	Plan Benefit Package
PDE	Prescription Drug Event

Acronym	Literal Translation
PLRO	Patient Liability Reduction Due to Other Payer Amount
POS	Point of sale
TGCDC	Total Gross Covered Drug Cost
TrOOP	True Out-of-Pocket
YTD	Year-to-Date