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Center for Medicare
Medicare Plan Payment Group

Date: April 30, 2010

To: All Part D Plan Sponsors

From: Cheri Rice, Deputy Director, Medicare Plan Payment Group

Subject: Prescription Drug Event (PDE) Record Changes required to Close the Coverage Gap

The purpose of this memorandum is to provide Part D sponsors with draft guidance regarding PDE record changes for 2011. Specifically, the guidance includes PDE record changes necessary to implement the Medicare Coverage Gap Discount Program, as required under Section §1860D-14A and §1860D-43 of the Social Security Act (the Act). We release this guidance simultaneously with the companion draft implementation guidance, "Medicare Coverage Gap Discount Program beginning in 2011", published in HPMS on April 30, 2010.

The guidance also includes PDE record changes necessary to implement coverage for generic drugs in the coverage gap, as required under Section §1860D-14A(b)(1)(C) of the Act. The guidance includes one additional PDE record change in anticipation of forthcoming revisions in the HIPAA standard for retail pharmacy transactions. Finally, the guidance includes PDE record changes that improve our ability to evaluate data quality, for the Gap Discount program and for overall payment accuracy as well.

The Centers for Medicare and Medicaid Services (CMS) is issuing this draft guidance for public comment through the close of business on May 14, 2010. We invite sponsors and their PBMS to submit comments, questions and suggestions to CMS at PDEJan2011@cms.hhs.gov. CMS will issue final guidance after considering all comments. CMS will also publish follow-on guidance giving detailed instructions for PDE reporting, including data element definitions, file layouts and edits at a later date.

Changes to PDE Record Layout

For dates of service on or after January 1, 2011, CMS will add the following new data elements to the PDE record.

Field Name	Picture	Length	Values
Date Original Claim Received	9(8)	8	CCYYMMDD
Claim Adjudication Began Timestamp	X(26)	26	CCYY-MM-DD-HH.MM.SS.MMMMMM
Total Gross Covered Drug Cost Accumulator[P]	S9(7)V99	9	$9,999,999.00
True Out-of-Pocket Accumulator[P]	S9(6)V99	8	$999,999.00
Brand/Generic Code	X(1)	1	B, G, V (vaccine administration fee only)
Beginning Benefit Phase[P]	X(1)	1	D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic
Ending Benefit Phase[P]	X(1)	1	D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic
Tier[P]	X(1)	1	
Formulary Code[P]	X(1)	1	F, N, V (vaccine administration fee only)
Reported Gap Discount[P]	S9(6)V99	8	$999,999.00
CMS Calculated Gap Discount[P]	S9(6)V99	8	$999,999.00
Gap Discount Plan Override Code[P]	X(1)	1	blank, additional values to be defined
Prescription Service Reference No	9(12)	12	This field currently exists as 9 positions and will be expanded to 12 positions.

Table Notes:
[P] Not Reported for Program of All Inclusive Care for the Elderly (PACE) Organizations

Below is a description of each new PDE data element.

Date Original Claim Received: Date Original Claim Received is the date the sponsor received the original claim. When a corrected PDE is submitted to document a claim correction, Date Original Claim Received does not change. (Sponsors correct PDEs either by submitting an adjustment PDE or by submitting a delete PDE followed by a new original PDE that replaces the previous record.)

CMS will compare Date of Service, Date Original Claim Received and the Adjudication Began Time Stamp (described below) to identify claims with processing lags. Processing lags sometimes indicate questionable data that warrants follow-up. CMS will also use Date Original Claim Received to reconcile Limited Income New Eligible Transition (LiNet) plans because the LiNet reconciliation is based on claims received during a year instead of year of service.

Claim Adjudication Began Timestamp: The Claim Adjudication Began Timestamp reports the date and time adjudication of the claim began in timestamp format, using Greenwich Mean Time. The Claim Adjudication Began Time Stamp reported in a corrected PDE documents the time stamp when the claim was corrected.

An essential step in beneficiary-level data validation is replicating the order in which the sponsor adjudicated claims. To validate benefit phase for coverage gap claims, as well as other claims in other benefit phases, we must replicate claims processing by sorting PDEs in processing order (i.e. ascending order by the Claim Adjudication Began Time Stamp.) Currently CMS uses date of service to replicate processing order. That approach is inadequate when a beneficiary has multiple PDEs on a single date of service, when a claim is adjusted or when a claim is processed late, after claims with subsequent dates of service were processed.

Total Gross Covered Drug Cost Accumulator: The Total Gross Covered Drug Cost (TGCDC) Accumulator is one of two values Part D sponsors maintain real time in order to adjudicate a beneficiary's claim in the correct benefit phase. Total Gross Covered Drug Cost Accumulator is the sum of the beneficiary's covered drug costs for the benefit year known immediately before the sponsor begins adjudication of an individual claim. The Total Gross Covered Drug Cost Accumulator value moves the beneficiary through the deductible phase (if any), the initial coverage period, and into the Coverage Gap. We use The Total Gross Covered Drug Cost Accumulator in combination with the True Out-of-Pocket(TrOOP) Accumulator described below to validate benefit phase.

True Out-of-Pocket(TrOOP) Accumulator: The TrOOP Accumulator is the second value Part D sponsors maintain real time in order to adjudicate a beneficiary's claim in the correct benefit phase. The TrOOP Accumulator is the sum of the beneficiary's incurred costs for the benefit year known immediately before the sponsor begins adjudication of an individual claim. Incurred costs are reported in the existing PDE as Patient Pay, Low Income Cost-Sharing Subsidy (LICS) and Other TrOOP and will include the newly Reported Gap Discount. By definition, TrOOP costs apply only to Part D Covered drugs. After the TrOOP Accumulator reaches the out-of-pocket threshold, the beneficiary enters the catastrophic phase of the benefit. The TrOOP balance does not increase after the beneficiary reaches the out-of-pocket threshold.

Brand/Generic Code: Brand/Generic Code is the plan reported value indicating that the plan adjudicated the claim as a brand drug or a generic drug.

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

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.

With the addition of Beginning and Ending Benefit Phase, CMS can readily identify PDEs that straddle benefit phases and therefore will assist in our review of the accuracy of the PDE data.

Tier: Tier is the formulary tier in which the sponsor adjudicated the claim. CMS will use tier to validate cost-sharing.

Formulary Code: The Formulary Code indicates if the drug is on the plan's formulary. The Gap Discount applies to a drug that is on the plan's formulary or is provided through an exception or appeal.

PDE Data for Gap Discount - Please see Attachment A for examples of Gap Discount calculations.

Reported Gap Discount: Reported Gap Discount is the reported amount that the sponsor advanced at point-of-sale for the Gap Discount. Part D sponsors advance the Gap Discount at point-of-sale to applicable beneficiaries who purchase an applicable drug that falls, in part or in full, in the Coverage Gap. The Gap Discount is based on the plan-defined benefit phase. The Gap Discount applies to the negotiated price as defined in §1860D-14A(g)(6) (excludes dispensing fee). For purposes of the Gap Discount, the negotiated price is the sum of the Ingredient Cost Paid, Total Amount Attributed to Sales Tax, and Vaccine Administration Fee.

CMS Calculated Gap Discount: CMS Calculated Gap Discount is the Gap Discount amount calculated by CMS during on-line PDE editing, based on the facts reported in the PDE. CMS will populate the CMS Calculated Gap Discount in the return file sent back to submitters after PDE records are edited. CMS will evaluate differences between the Reported Gap Discount submitted by the sponsor and the CMS Calculated Gap Discount and base the decision to accept or reject the PDE on discrepancies between these two amounts.

Gap Discount Plan Override Code: The Gap Discount Plan Override Code is a field reserved for future use. It will potentially provide sponsors and CMS the flexibility to report additional information that resolves differences between CMS Calculated Gap Discount and Reported Gap Discount. For example, if CMS rejected a PDE because Reported Gap Discount submitted by the plan and the CMS Calculated Gap Discount differed, the sponsor could use the Gap Discount Plan Override Code to explain a valid reason for the difference. CMS reserves this field for future use because we need experience with Reported Gap Discount to maximize the utility of this approach.

Prescription Service Reference No: Effective January 2012, the National Council for Prescription Drug Programs (NCPDP) will update the current Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard format for retail pharmacy transactions. The update expands the current Prescription Service Reference No to twelve positions. The Prescription Service Reference No is one of several PDE fields that originate in NCPDP billing transactions. Therefore CMS must make the same change. In addition to increasing field length, we must shift adjacent fields three positions to the right. This format change affects the PDE detail record only. We are consolidating the Prescription Service Reference No expansion with other format changes discussed in this guidance to minimize workload for CMS, sponsors and their processors.

Today, because the NCPDP format for Prescription Service Reference No is 9(7) and the PDE format is 9(9), we instruct sponsors to report leading zeros in the two leftmost positions of the PDE field. Effective January 1, 2011, CMS instructs sponsors to report leading zeros in the five leftmost positions. The example below shows how Prescription Service Reference No is currently reported in 2010 and how it will be reported in 2011.

Prescription Service Reference No – 2010

0	0	7	7	7	7	7	7	7

Prescription Service Reference No – 2011

0	0	0	0	0	7	7	7	7	7	7	7

Data Reporting Changes for Existing PDE Fields

Dispensing Status: CMS will no longer accept 'P' for partial claim or 'C' for complete claim as valid values for Dispensing Status for dates of service on or after January 1, 2011. At program start-up, CMS collected Dispensing Status as a key field in order to align with industry practice. Based on our analysis of recent PDE data, the number of PDEs with Dispensing Status values of 'P' or 'C' is negligible. It is cost prohibitive to continue collecting and testing data that is seldom used. Effective for dates of service on or after January 1, 2011, CMS will reject PDEs reporting Dispensing Status values of 'P' or 'C'. If sponsors accept partial and complete claims from pharmacies, CMS instructs sponsors to combine the partial and complete claims and report a single PDE summarizing both billing transactions. Sponsors shall continue reporting Dispensing Status values of 'P' or 'C' on PDEs for dates of service before January 1, 2011.

Catastrophic Coverage Code: The newly added Beginning Benefit Phase and Ending Benefit Phase fields will replicate data currently reported in the Catastrophic Coverage Code field. Therefore sponsors will have the option to discontinue reporting Catastrophic Coverage Code for dates of service on or after January 1, 2011. If reported for dates of service on or after January 1, 2011, CMS will disregard Catastrophic Coverage Code values. Sponsors shall continue reporting Catastrophic Coverage Code on PDEs for dates of service before January 1, 2011.

Coverage for Generic Drugs in the Coverage Gap for Non-Low Income Subsidy (LIS) Beneficiaries

Effective January 1, 2011, generic coinsurance is reduced for non-LI eligible beneficiaries with claims that fall, in part or in full, in the coverage gap. On January 1, 2011, generic co-insurance for non-LI eligible beneficiaries with drugs that fall in the Coverage Gap will be 93 percent. The sponsor will pay the remaining seven percent. By 2020 the coverage gap will effectively be closed for generics; beneficiary cost-sharing for generics in the gap will be 25% which is equivalent to initial coverage period cost-sharing. Sponsors will report the plan's cost-share in the PDE in the Covered Plan Paid (CPP) amount which will be subject to risk-sharing.

Below we provide beneficiary and plan generic cost-sharing in the coverage gap by year from 2011 through 2020. Please note that generic cost-sharing applies to the full negotiated price.

Year	Beneficiary Cost-Sharing	Plan Cost-Sharing
2011	93%	7%
2012	86%	14%
2013	79%	21%
2014	72%	28%
2015	65%	35%
2016	58%	42%
2017	51%	49%
2018	44%	56%
2019	37%	63%
2020	25%	75%

CMS requires no additional PDE data to implement reduced beneficiary cost-sharing for generic drugs in the Coverage Gap. In accordance with current guidance, sponsors report beneficiary cost-sharing in the existing Patient Pay Amount field (and Other TrOOP Amount or Patient Liability Reduction Due to Other Payer Amount (PLRO), if applicable) and plan cost-sharing in the existing CPP field. Unlike Gap Discount calculations that apply to the sum of the Ingredient Cost Paid, Total Amount Attributed to Sales Tax, and Vaccine Administration, generic cost-sharing in the gap applies to the sum of the aforementioned fields plus the Dispensing Fee Paid.

However, reduced beneficiary cost-sharing for generic drugs in the Coverage Gap does alter PDE reporting rules for Enhanced Alternative (EA) plans. CMS uses CPP to calculate risk-sharing. In order to apply risk-sharing uniformly across all plan types, we instruct EA plans to map CPP consistent with the defined standard benefit. EA plans apply mapping rules based on total gross covered drug cost, without regard to plan-defined benefit phases, to calculate the covered portion and the non-covered portion of plan payments. For additional information see Module 8: Calculating and Reporting Enhanced Alternative Benefit in the Participant training Guide available at http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html.

The mapping rules must change to account for the impact of generic utilization in the Coverage Gap. We require two different mapping methodologies.

Beneficiaries eligible for LIS: We extend the current methodology for beneficiaries eligible for LIS because cost-sharing for generic drugs in the Coverage Gap does not apply.

Beneficiaries who are not eligible for LIS: Because cost-sharing reduces beneficiary payments that count towards TrOOP, the beneficiary has additional drug spending before reaching the OOP threshold. Mapping rules 3 and 4 use the total gross covered drug cost at the OOP threshold for the defined standard beneficiary (with no other health insurance) to determine the

percentage to calculate the defined standard benefit. In 2011, that amount is $6,447.50. To account for additional generic drug spending to reach the OOP threshold, we increase that amount from $6,447.50 to 6483.72. Please see mapping charts below.

MAPPING TO THE DEFINED STANDARD BENEFIT
TO CALCULATE CPP AMOUNT 2011
LIS ELIGIBLE BENEFICIARIES

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	<= $310	0%
2	>$310 and <= $2,840	75%
3	>$2,840 and <= $6,447.50	0%
4	>$6,447.50 and <= OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Gross Covered Drug Cost -$2/$5)

MAPPING TO THE DEFINED STANDARD BENEFIT
TO CALCULATE CPP AMOUNT 2011
BENEFICIARIES INELIGIBLE FOR LIS

RULE #	YEAR-TO-DATE (YTD) GROSS COVERED DRUG COSTS	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
1	<= $310	0%
2	>$310 and <= $2,840	75%
3	>$2,840 and <= $6,483.72	0%
4	>$6,483.72 and <= OOP threshold	15%
5	> OOP threshold	Lesser of 95% or (Gross Covered Drug Cost -$2/$5)

Attachment A – PDE examples with Gap Discount Calculations

The following examples describe Gap Discount Calculations and Prescription Drug Event (PDE) reporting. Please note that the Gap Discount is included in TrOOP. For additional information about PDE fields not defined in this guidance, see the PDE Participant Guide available at http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html.

The examples explain Gap Discount calculations in the following situations:

- The claim falls squarely inside the coverage gap (Example #1)
- The claim involves an Other Health Insurance (OHI) Payer that pays secondary. (Example #2)
- The claim straddles the coverage gap and the initial coverage period (Example #3)

To simplify the examples, the Ingredient Cost, Dispensing Fee Amount, Sales Tax, and Vaccine Administration Fee remain the same in all examples (see Chart 1). The drug is a covered drug that is applicable for the Gap Discount. The examples apply to a Defined Standard plan.

Chart 1: Financial Amounts Used in all Examples

Field	Amount
Ingredient Cost	$195.00
Dispensing Fee Amount	$2.00
Sales Tax Amount	$5.00
Vaccine Administration Fee	$0.00
Total Drug Cost	$202.00

The gap discount applies when all of the following situations occur: the beneficiary is non-LI, the drug is a covered drug, the NDC is an applicable drug, and the ingredient cost, sales tax and vaccine administration fee fall either fully or partially in the coverage gap.

To simplify discussion, we introduce the term "Discount Eligible Cost". Discount Eligible Cost is the sum of ingredient cost, sales tax and vaccine administration fee (as reported in PDE fields Ingredient Cost Paid, Amount Attributable to Sales Tax, and Vaccine Administration Fee) that falls in the Coverage Gap. Discount Eligible Cost excludes dispensing fee. The Gap Discount is calculated as Discount Eligible Cost * .5

Gap Discount = Discount Eligible Cost * .5

The steps to calculate gap discount are:

1. **Determine costs that fall in the Coverage Gap** (using existing adjudication logic): Claims that begin and end in the coverage gap fall squarely in the gap. Straddle claims are claims that fall in two or more benefit phases. In the case of straddle claims apply dispensing fee, to the greatest extent possible, outside the coverage gap. This maximizes the Gap Discount and hence, reduces beneficiary cost-sharing.

2. **Determine Discount Eligible Cost:** Discount Eligible Cost is cost falling in the coverage gap, excluding dispensing fee.

3. **Calculate Gap Discount:** The gap discount is 50% of Discount Eligible Cost**.**

4. **Determine beneficiary cost-sharing.** For claims falling squarely in the coverage gap with no other secondary health insurance, beneficiary cost-sharing is Total Drug Cost less Gap Discount. (See Example #1.) If the beneficiary has other secondary health insurance, the other secondary health insurance reduces beneficiary cost-sharing remaining after the Gap Discount is applied. (See Example #2.) In Straddle claims Beneficiary Cost-Sharing is the sum of beneficiary cost-sharing in the gap plus beneficiary cost-sharing from other benefit phases. (See Example #3.)

5. **Calculate Covered and non-Covered Portion of Plan Paid cost-sharing :** (using existing calculations)

Example #1: The Claim Falls Squarely inside the Coverage Gap

Step 1 Determine costs that fall in the Coverage Gap*:* Confirms that that claim falls squarely in the coverage gap. The beneficiary's Gross Covered Drug Cost has exceeded the Initial Coverage Limit (TGDC > ICL), and the beneficiary's True Out of Pocket Costs (TrOOP) remain below the TrOOP threshold (Accumulated TrOOP < TrOOP threshold) throughout the processing of the claim. When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $3,000 and the TrOOP Accumulator is $1,100. The beginning benefit phase is the coverage gap and the ending benefit phase is also the coverage gap.

PDE Fields	**Claim Total**
Total Gross Covered Drug Cost Accumulator	**$3,000.00**
True Out of Pocket Accumulator	**$1,110.00**
Beginning Benefit Phase	**G**
Ending Benefit Phase	**G**

Step 2 Determine Discount Eligible Cost: Discount Eligible Cost is $200.00.

PDE Fields	**Claim Total**
Ingredient Cost Paid	**$195.00**
Total Amount Attributed to Sales Tax	**$5.00**
Vaccine Administration Fee	**$0.00**
Discount Eligible Cost	**$200.00**

Step 3 Calculate Gap Discount: The Gap Discount $100.00; $200 * .5 = $100.00.

Step 4 Determine beneficiary cost-sharing: The beneficiary pays any cost in the gap (including the dispensing fee) that remains after the discount is applied. Beneficiary cost-sharing is $102.00, which is calculated as $202.00 minus $100.00.

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	Value
Reported Gap Discount	**$100.00**
Patient Pay Amount	**$102.00**
Other TrOOP Amount	**$0.00**
(LICS)	**$0.00**
(PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$0.00**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

The Beginning and Ending Benefit phase values and the TGCDC ACC and TrOOP ACC values validate that the claim falls squarely in the coverage gap. After the claim is processed, the TGCDC Accumulator increases by $202.00 from $3,000.00 to $3,202.00; the TrOOP Accumulator increases by $202.00 from $1100.00 to $1302.00.

Example #2: The claim has an Other Health Insurance (OHI) Payer (OHI pays secondary to Part D)

This example is identical to Example #1 with one exception. In this example, a secondary OHI payer reduces the beneficiary's cost-sharing by $25.00. The purpose of this example is to show that the gap discount applies first before any secondary OHI payer receives the claim, regardless of whether the OHI payer is included or excluded in TrOOP. The $100.00 Reported Gap Discount is the same in Example 1 and Example 2. The OHI payment reduces beneficiary cost-sharing from $102.00 to $77.

PDE Fields	Example 1	Example 2
Reported Gap Discount	**$100.00**	**$100.00**
Patient Pay Amount	**$102.00**	**$77.00**
Other TrOOP Amount	**$0.00**	**$25.00**
(LICS)	**$0.00**	**$0.00**
(PLRO)	**$0.00**	**$0.00**
Covered D Plan Paid Amount (CPP)	**$0.00**	**$0.00**
Non Covered Plan Paid Amount (NPP)	**$0.00**	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**	**$0.00**

Example #3: Straddle Claim

In this example the claim straddles the Initial Coverage Period and the Coverage Gap. In a defined standard plan the beneficiary enters the coverage gap when Total Gross Covered Drug Cost Accumulator exceeds the initial coverage limit or $2,840.00 in 2011.)

Step #1 Determine costs that fall in the Coverage Gap*:*
When claim adjudication begins the Total Gross Covered Drug Cost Accumulator is $2,788.00 and the TrOOP Accumulator is $929.50; the beginning benefit phase is the initial coverage period. The first $52.00 of the claim falls in the initial coverage period. The amount is calculated as ICL – beginning value in Total Gross Covered Drug Cost Accumulator or $2,840.00 – $2,788.00. Because, the beneficiary has not met the TrOOP threshold the remaining $150.00 of the claim falls in the coverage gap. The Ending Benefit phase is the Coverage Gap.

PDE Fields	**Claim Total**
Total Gross Covered Drug Cost Accumulator	$2,788.00
True Out of Pocket Accumulator	$929.50
Beginning Benefit Phase	**N**
Ending Benefit Phase	**G**

PDE Field	**Reported on the PDE Record**		**Initial Coverage Period**	**Coverage Gap**
Ingredient Cost Paid	**$200.00**		$50.00	$150.00
Dispensing Fee Paid	**$2.00**		$2.00	$0.00
Total Amount Attributed to Sales Tax	**$0.00**		$0.00	$0.00
Vaccine Administration Fee	**$0.00**		$0.00	$0.00
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**			
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**			

Step #2 Determine Discount Eligible Cost: The $2.00 Dispensing Fee Paid was applied outside the coverage gap. Therefore **Discount Eligible Cost** is $150.00, the coverage gap amount.

Step #3 Calculate Gap Discount: The gap discount is 50% of the $150.00 Discount Eligible Cost or $75.

Step #4 Determine beneficiary cost-sharing: The beneficiary is responsible for cost-sharing in each benefit phase the claim straddles. Initial Coverage Period cost-sharing is 25%; coverage gap cost-sharing is 100% of the coverage gap costs, less Gap Discount.

Initial Coverage Period cost-sharing is $13.00 ($52 .00 * .25). (The plan pays the remaining $39.00)
Coverage cap is cost-sharing is $75,00 ($150.00 - $75.00)

The beneficiary's total cost-sharing is $88.00**.**

PDE Reporting*:* Populate Reported Gap discount and existing financial fields as indicated below.

PDE Fields	**Value**
Reported Gap Discount	**$75.00**
Patient Pay Amount	**$88.00**
Other TrOOP Amount	**$0.00**
(LICS)	**$0.00**
(PLRO)	**$0.00**
Covered D Plan Paid Amount (CPP)	**$39.00**
Non Covered Plan Paid Amount (NPP)	**$0.00**
Gross Covered Drug Cost Below Out-of-Pocket Threshold (GDCB)	**$202.00**
Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA)	**$0.00**

The Beginning and Ending Benefit phase values and the TGCDC Accumulator and TrOOP Accumulator values validate that the claim straddles the initial coverage period and the coverage gap. After the claim is processed, the TGCDC Accumulator increases by $202.00 from $2,788.00 to $2,990.00; the TrOOP Accumulator increases by $163.00 from $929.50 to $1092.50.