Centers for Medicare & Medicaid Services, HHS § 423.315

administrative costs, but including dispensing fees, during the coverage year. They equal the sum of the following:

(1) The share of actual costs (as defined by § 423.100 of this part) actually paid by the Part D plan that is received as reimbursement by the pharmacy, or other dispensing entity, reimbursement paid to indemnify an enrollee when the reimbursement is associated with an enrollee obtaining covered Part D drugs under the Part D plan, or payments made by the Part D sponsor to other parties listed in § 423.464(f)(1) of this part with which the Part D sponsor must coordinate benefits, including other Part D plans, or as the result of any reconciliation process developed by CMS under § 423.464 of this part.

(2) Nominal cost-sharing paid by or on behalf of an enrollee which is associated with drugs that would otherwise be covered Part D drugs, as defined in § 423.100 of this part, but are instead paid for, with the exception of said nominal cost-sharing, by a patient assistance program providing assistance outside the Part D benefit, provided that documentation of such nominal cost-sharing has been submitted to the Part D plan consistent with the plan processes and instructions for the submission of such information.

(3) All amounts paid under the Part D plan by or on behalf of an enrollee (such as the deductible, coinsurance, cost sharing, or amounts between the initial coverage limit and the out-of-pocket threshold) in order to obtain Part D drugs that are covered under the Part D plan. If an enrollee who is paying 100 percent cost sharing (as a result of paying a deductible or because the enrollee is between the initial coverage limit and the out-of-pocket threshold) obtains a covered Part D drug at a lower cost than is available under the Part D plan, such cost-sharing will be considered an amount paid under the plan by or on behalf of an enrollee under the previous sentence of this definition, if the enrollee’s costs are incurred costs as defined under § 423.100 of this part and documentation of the incurred costs has been submitted to the Part D plan consistent with plan processes and instructions for the submission of such information.

These costs are determined regardless of whether the coverage under the plan exceeds basic prescription drug coverage.

Target amount means the total amount of payments (from both CMS and by or on behalf of enrollees) to a Part D plan for the coverage year for all standardized bid amounts as risk adjusted under § 423.329(b)(1) of this part, less the administrative expenses (including return on investment) assumed in the standardized bids.

§ 423.315 General payment provisions.

(a) Source of payments. CMS payments under this section are made from the Medicare Prescription Drug Account.

(b) Monthly payments. CMS provides a direct subsidy in the form of advance monthly payments equal to the Part D plan’s standardized bid, risk adjusted for health status as provided in § 423.329(b), minus the monthly beneficiary premium as determined in § 423.286.

(c) Reinsurance subsidies. CMS provides reinsurance subsidy payments described in § 423.329(c) on a monthly basis during a year based on either estimated or incurred allowable reinsurance costs as provided under § 423.329(c)(2)(i), and final reconciliation to actual allowable reinsurance costs as provided in § 423.343.

(d) Low-income subsidies. CMS makes payments for premium and cost-sharing subsidies, including additional coverage above the initial coverage limit, on behalf of certain subsidy-eligible individuals as provided in §§ 423.780 and 423.782. CMS provides low-income cost-sharing subsidy payments described in § 423.782 through interim payments of amounts as provided under § 423.329(d)(2)(i) and reconciliation to actual allowable reinsurance costs as provided in § 423.343(d).

(e) Risk-sharing arrangements. CMS may issue lump-sum payments or adjust monthly payments in the following payment year based on the relationship of the Part D plan’s adjusted allowable risk corridor costs to predetermined risk corridor thresholds in
§ 423.322 Requirement for disclosure of information.

(a) Payment conditional upon provision of information. Payments to a Part D sponsor are conditioned upon provision of information to CMS that is necessary to carry out this subpart, or as required by law.

(b) Restrictions on use of information. Officers, employees and contractors of the Department of Health and Human Services may use the information disclosed or obtained in accordance with this provision of this subpart only for the purposes of, and to the extent necessary in, carrying out this subpart including, but not limited to, determination of payments, and payment-related oversight, and program integrity activities.

(1) This restriction does not limit OIG’s authority to fulfill the Inspector General’s responsibilities in accordance with applicable Federal law.

(2) This restriction does not limit CMS’ ability to use data regarding drug claims in accordance with section 1848(m) of the Act.

§ 423.329 Determination of payments.

(a) Subsidy payments—(1) Direct subsidy. CMS makes a direct subsidy payment for each Part D eligible beneficiary enrolled in a Part D plan for a month equal to the amount of the plan’s approved standardized bid, adjusted for health status (as determined under §423.329(b)(1)), and reduced by the base beneficiary premium for the plan (as determined under §423.286(c) and adjusted in §423.286(d)(1)). The direct subsidy payment may be increased by the excess amount of a negative premium as described in §423.286(d)(1), if applicable.

(2) Subsidy through reinsurance. CMS makes reinsurance subsidy payments as provided under paragraph (c) of this section.

(b) Health status risk adjustment—(1) Establishment of risk factors. CMS establishes an appropriate methodology for adjusting the standardized bid amount to take into account variation in costs for basic prescription drug coverage among Part D plans based on the differences in actuarial risk of different enrollees being served. Any risk adjustment is designed in a manner so as to be budget neutral in the aggregate to the risk of the Part D eligible individuals who enroll in Part D plans.

(2) Considerations. In establishing the methodology under paragraph (b)(1) of this section, CMS takes into account the similar methodologies used under §422.308(c) of this chapter to adjust payments to MA organizations for benefits under the original Medicare fee-for-service program option.

(3) Data collection. In order to carry out this paragraph, CMS requires—

(i) PDP sponsors to submit data regarding drug claims that can be linked at the individual level to Part A and Part B data in a form and manner similar to the process provided under §422.310 of this chapter and other information as CMS determines necessary; and

(ii) MA organizations that offer MA-PD plans to submit data regarding drug claims that can be linked at the individual level to other data that the organizations are required to submit to CMS in a form and manner similar to the process provided under §422.310 of this chapter and other information as CMS determines necessary.

(4) Publication. At the time of publication of risk adjustment factors under...