

qualified prescription drug coverage may request from CMS in writing—

(i) A waiver of those requirements under this part otherwise applicable to cost plans or PACE organizations that are duplicative of, or that are in conflict with, provisions otherwise applicable to cost plans or PACE organizations.

(ii) A waiver of a requirement under this part otherwise applicable to cost plans or PACE organizations, if such waiver improves coordination of benefits provided by the cost plan under section 1876 of the Act, or by the PACE organization under sections 1894 and 1934 of the Act, with the benefits under Part D.

[70 FR 4525, Jan. 28, 2005, as amended at 73 FR 20506, Apr. 15, 2008; 77 FR 1882, Jan. 12, 2012; 77 FR 22170, Apr. 12, 2012]

§ 423.462 Medicare secondary payer procedures.

(a) *General rule.* The provisions of § 422.108 of this chapter regarding Medicare secondary payer procedures apply to Part D sponsors and Part D plans (with respect to the offering of qualified prescription drug coverage) in the same way as they apply to MA organizations and MA plans under Part C of title XVIII of the Act, except all references to MA organizations and MA plans are considered references to Part D sponsors and Part D plans.

(b) *Reporting requirements.* A Part D sponsor must report credible new or changed primary payer information to the CMS Coordination of Benefits Contractor in accordance with the processes and timeframes specified by CMS.

[70 FR 4525, Jan. 28, 2005, as amended at 75 FR 19819, Apr. 15, 2010]

§ 423.464 Coordination of benefits with other providers of prescription drug coverage.

(a) *General rule.* A Part D plan must permit SPAPs (described in paragraph (e)(1) of this section) and entities providing other prescription drug coverage (described in paragraph (f)(1) of this section) to coordinate benefits with such plan. A Part D plan must comply with all administrative processes and requirements established by CMS to ensure effective exchange of information and coordination between such

plan and SPAPs and entities providing other prescription drug coverage for—

(1) Payment of premiums and coverage; and

(2) Payment for supplemental prescription drug benefits as described in § 423.104(f)(1)(ii) (including payment to a Part D plan on a lump sum per capita basis) for Part D eligible individuals enrolled in the Part D plan and the SPAP or entity providing other prescription drug coverage.

(3) Retroactive claims adjustments, underpayment reimbursements, and overpayment recoveries as described in paragraph (g) of this section and § 423.466(a) of this subpart.

(b) *Medicare as primary payer.* The requirements of this subpart do not change or affect the primary or secondary payer status of a Part D plan and a SPAP or other prescription drug coverage. A Part D plan is always the primary payer relative to a State Pharmaceutical Assistance Program.

(c) *User fees.* CMS may impose user fees on Part D plans for the transmittal of information necessary for benefit coordination in accordance with administrative processes and requirements established by CMS to ensure effective exchange of information and coordination between a Part D plan and SPAPs and entities providing other prescription drug coverage in a manner similar to the manner in which user fees are imposed under section 1842(h)(3)(B) of the Act, except that CMS may retain a portion of user fees to defray its costs in carrying out such procedures. CMS will not impose user fees under this subpart on a SPAP or entities providing other prescription drug coverage.

(d) *Cost management tools.* The requirements of this subpart do not prevent a Part D sponsor from using cost management tools (including differential payments) under all methods of operation.

(e) *Coordination with State Pharmaceutical Assistance Programs—(1) Requirements to be a State Pharmaceutical Assistance Program (SPAP).* A State program is considered to be a State Pharmaceutical Assistance Program for purposes of this part if it—