Policy:	MA.6109
Title:	**True Out-of-Pocket (TrOOP) Expenditures**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	*/s/ Michael Hunn 12/16/2024*
Effective Date:	01/01/2006
Revised Date:	12/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy documents the process to track a Member's True Out-Of-Pocket (TrOOP) Expenditures for Covered Part D Drugs.

II. POLICY

A. CalOptima Health's Pharmacy Benefit Manager (PBM) shall track a Member's TrOOP Expenditures in real-time using the current Health Insurance Portability and Accountability Act (HIPAA), as amended, approved National Council for Prescription Drug Programs (NCPDP) standard.

B. CalOptima Health shall collect information from a Member regarding Other Health Coverage (OHC), in accordance with CalOptima Health Policy MA.6108: Medication Coordination of Benefits.

C. On a monthly basis, CalOptima Health shall send an Explanation of Benefits (EOB) to a Member, in accordance with CalOptima Health Policy MA.4007: Member Disclosures. The EOB shall indicate how much the Member has spent during a program year on Covered Part D Drugs, and where the Member stands in relation to the TrOOP Threshold.

D. A Member may access their current TrOOP Expenditures status daily through CalOptima Health's toll-free customer service phone number.

E. CalOptima Health shall accept data concerning OHC in a format specified by the Centers for Medicare & Medicaid Services (CMS) for use in a Member's TrOOP Expenditures calculation. CalOptima Health shall forward such data to the PBM.

F. CalOptima Health shall ensure TrOOP and gross covered drug spending balances are transferred to a new plan if a Member disenrolls and re-enrolls at any time before the end of a coverage year.

G. CalOptima Health shall accept data concerning Financial Information Reporting (FIR) in a format specified by the Centers for Medicare & Medicaid Services (CMS) for use in a Member's TrOOP and total drug cost expenditures calculation. CalOptima Health shall forward such data to the PBM.

III. PROCEDURE

A. CalOptima Health shall count payments for Covered Part D Drugs toward a Member's TrOOP Threshold if all of the following conditions are met:

1. Costs are incurred against:

   a. Any annual deductible;

   b. Any applicable cost-sharing for costs above the deductible and up to the initial coverage limit; and

   c. Any applicable cost-sharing for costs above the initial coverage limit and up to the annual out-of-pocket threshold.

2. Costs are incurred for Covered Part D Drugs that are either included in the CalOptima Health Formulary, or treated as included in the CalOptima Health Formulary, as a result of a favorable Coverage Determination, Redetermination, or Reconsideration.

3. Costs are:

   a. Incurred by the Member;

   b. Incurred by another individual on behalf of the Member (e.g., a family Member or friend);

   c. Incurred by a bona fide charity unaffiliated with employers or unions;

   d. Paid by Medicare on behalf of a low-income individual under the Part D subsidy provisions described in Title 42, Code of Federal Regulations, Section 423.782;

   e. Discounts paid by manufacturers as part of the Medicare Coverage Gap Discount program, when applicable;

   f. Paid on behalf of the Member under a qualified State Pharmaceutical Assistance Program (SPAP) as described in Title 42, Code of Federal Regulations, Section 423.454;

   g. Paid by the Indian Health Service (IHS), an Indian tribe or tribal organization, or an urban Indian organization (as defined in Section 4 of the Indian Health Care Improvement Act);

   h. Paid by AIDS Drug Assistant Program (ADAP) under Part B of Title XXVI of the Public Health Service Act; or

   i. Waived or reduced by pharmacies for Part D cost-sharing amounts.

4. Costs are incurred at a network pharmacy or an Out-of-Network (OON) pharmacy when the following conditions are met:

   a. Billed at the network allowable charge; and

   b. The Out-of-Network requirements described in Title 42, Code of Federal Regulations, Section 423.124 are met.

B. CalOptima Health shall not count payments made by any entity that has an obligation to pay for Covered Part D Drugs on behalf of a Member, or which voluntarily elects to use public funds in whole or in part, for Covered Part D Drugs toward a Member's TrOOP Threshold. Such entities include:

1. Group health plans;

2. Government programs (e.g., TRICARE, Black Lung, Veterans Affairs);

3. Another third-party payment arrangement;

4. Workers' compensation;

5. Automobile, no-fault, or liability insurances; and

6. Supplemental benefit portions of a Medicare Part D plan.

C. CalOptima Health shall not count payments made for the following drugs towards a Member's TrOOP Threshold:

1. Costs for non-formulary Part D drugs unless treated by the Part D CalOptima Health as being included in the CalOptima Health's Formulary as a result of a favorable Coverage Determination, Redetermination, or Reconsideration;

2. Drugs that are not Covered Part D Drugs;

3. Costs that are paid for or for which a Member is reimbursed by insurance or otherwise, including a government-funded health program;

4. Drugs obtained at an Out-of-Network pharmacy;

5. Costs that are paid for or for which a Member is reimbursed by a group health plan; and

6. Costs that are paid for or for which a Member is reimbursed by another third-party payment arrangement.

D. If CalOptima Health receives notice through the coordination of benefits process that an amount should not count toward a Member's TrOOP Threshold, CalOptima Health shall notify the PBM and instruct the PBM to subtract and recalculate such amount from the Member's TrOOP Expenditures total.

E. CalOptima Health shall retroactively adjust claims and TrOOP balances as a result of CalOptima Health's receipt of retroactive secondary payer information or an error in pay order.

F. If CalOptima Health learns that it made an erroneous payment due to inaccurate or incomplete information regarding a Member's TrOOP Expenditures:

1. CalOptima Health may recover such costs directly from the Member on whose behalf it made such payments; and

2. The Member shall reimburse CalOptima Health for payment made for these costs.

G. If a Member is disenrolled from a CalOptima Health program, CalOptima Health shall provide the Member with their TrOOP Expenditures status and gross drug spend balances as of the effective date of disenrollment.

H. CalOptima Health shall actively sample claims on a monthly basis to ensure TrOOP accumulation is accurate and consistent with the Policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Policy MA.4007: Member Disclosures
C. CalOptima Health Policy MA.6108: Medication Coordination of Benefits
D. CMS Issue Paper #23, Beneficiaries and True Out-of-Pocket Costs (TrOOP), January 21, 2005
E. Federal Register, Vol. 70, No. 18, January 28, 2005, pp. 4325, 4330
F. Medicare Modernization Act, Section 1860D-(2)(b)
G. Medicare Prescription Drug Benefit Manual, Chapter 5: Benefits and Beneficiary Protections, Revised September 20, 2011
H. Patient Protection and Affordable Care Act (2010), Section 3314
I. Prescription Drug Benefit Manual, Chapters 13: Premium and Cost-Sharing Subsidies for Low-Income Individuals, Revised October 1, 2018
J. Prescription Drug Benefit Manual, Chapter 14: Coordination of Benefits, Revised September 17, 2018
K. Social Security Act, Section 1860D-2
L. Title 42, Code of Federal Regulations (C.F.R.), § 411.9
M. Title 42, Code of Federal Regulations (C.F.R.), § 423 Subpart J
N. Application from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2006	MA.6109	True Out-Of-Pocket Expenditures	OneCare
Revised	08/01/2008	MA.6109	True Out-Of-Pocket Expenditures	OneCare
Revised	06/01/2015	MA.6109	True Out-Of-Pocket Expenditures	OneCare OneCare Connect
Revised	11/01/2016	MA.6109	True Out-Of-Pocket Expenditures	OneCare OneCare Connect
Revised	11/01/2017	MA.6109	True Out-Of-Pocket Expenditures	OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2018	MA.6109	True Out-Of-Pocket Expenditures	OneCare OneCare Connect
Revised	11/01/2019	MA.6109	True Out-Of-Pocket Expenditures	OneCare OneCare Connect
Revised	07/01/2020	MA.6109	True Out-Of-Pocket Expenditures	OneCare OneCare Connect
Revised	09/01/2021	MA.6109	True Out-Of-Pocket Expenditures	OneCare OneCare Connect
Revised	12/31/2022	MA.6109	True Out-Of-Pocket Expenditures	OneCare
Revised	09/01/2023	MA.6109	True Out-Of-Pocket (TrOOP) Expenditures	OneCare
Revised	12/01/2024	MA.6109	True Out-Of-Pocket (TrOOP) Expenditures	OneCare

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Coverage Determination (CD)	Any decision made by CalOptima Health regarding: 1. Receipt of, or payment for, a prescription drug that a Member believes may be covered; 2. A tiering or Formulary Exception request; 3. The amount that the plan sponsor requires a Member to pay for a Part D prescription drug and the Member disagrees with the plan sponsor; 4. A limit on the quantity (or dose) of a requested drug and the Member disagrees with the requirement or dosage limitation; 5. A requirement that a Member try another drug before the plan sponsor will pay for the requested drug and the Member disagrees with the requirement; and 6. A decision whether a Member has, or has not, satisfied a Prior Authorization or other Utilization Management requirement.
Covered Part D Drugs	A Covered Part D Drug includes: 1. A drug that may be dispensed only upon a Prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication as set forth in Section 1927(k)(2)(A) of the Social Security Act; 2. A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Social Security Act; 3. Insulin described in section 1927(k)(2)(C) of the Social Security Act; 4. Medical supplies associated with the delivery of insulin; and 5. A vaccine licensed under section 351 of the Public Health Service Act and its administration.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Member	A beneficiary enrolled in a CalOptima Health program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Provider (Part D)	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who are licensed to furnish Covered Services.
Reconsideration	For the purposes of this policy, the second level of the appeal process, which involves the Independent Review Entity (IRE) conducting a review of an adverse Redetermination, the evidence and findings upon which it was based, and any other evidence that the parties submit or that is obtained by the IRE.

Term	Definition
Redetermination	For the purposes of this policy, the first level of the appeal process, which involves a Part D plan sponsor reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.
True Out-Of-Pocket (TrOOP) Cost	True out-of-pocket (TrOOP) costs are the payments that count toward a Part D beneficiary's Medicare drug plan out-of-pocket threshold. TrOOP costs determine when a beneficiary's catastrophic coverage will begin.
TrOOP Expenditures	A Member's out-of-pocket expenditures that will count toward the TrOOP Threshold.
TrOOP Threshold	The annual amount a Member must spend on Covered Part D Drugs to reach the catastrophic cap: 1. In 2006, the TrOOP Threshold is equal to three thousand six hundred dollars ($3,600). 2. In subsequent years, the TrOOP Threshold is equal to the amount for the previous year increased by an annual percentage as specified in the Medicare Modernization Act, Section 1860D-(2)(b)(6).