CMSDEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

DATE: May 25, 2023

TO: All Part D Sponsors

FROM: Amy Larrick Chavez-Valdez
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SUBJECT: Contract Year 2022 Cost Sharing Administration Analysis (CSAA)

The purpose of the Cost Sharing Administration Analysis (CSAA) is to evaluate whether Part D sponsors have appropriately adjudicated the cost sharing of Part D drugs consistent with their approved plan design. Part D sponsors are responsible for ensuring that prescription drug coverage is being adjudicated consistent with their approved plan design. Many beneficiaries use the published cost sharing to make plan selections and estimate annual drug costs. Thus, it can be significantly impactful if the cost sharing on a prescription-drug claim is adjudicated incorrectly. Consistent with 42 CFR § 423.505(n)(1), CMS may determine that a Part D plan sponsor is out of compliance with a Part D requirement when a sponsor fails to meet performance standards articulated in the Part D statutes, regulations, or guidance.

Contract Year (CY) 2020 CSAA Results

The CY 2020 CSAA examined retail prescription drug events (PDE) during the coverage gap and catastrophic phases, then compared the adjudicated beneficiary cost to the expected cost sharing based on the approved formulary and benefits design. CMS focused our review on instances where beneficiaries appeared to have paid more than the expected cost sharing. There were 179 instances where potential beneficiary overpayment occurred, and from these, CMS identified high-value overpayments that 1) fell within the 95th percentile of overpayment amount, and 2) claims from the parent organizations with the highest proportion of overpayments to create a sample of 144 claims. The sample claims were shared with the applicable plans, and we requested that the plans address why the identified claim(s) appeared to have resulted in beneficiary overpayment.

Of the 144 claims sent for plan response, CMS found that 13 claims were true discrepant claims.

- Thirteen (13) claims were found to be discrepant due to midyear LIS status changes resulting in beneficiary overpayment, where LIS status changes were not incorporated by the plan in a timely manner and/or processes to retroactively reimburse these beneficiaries were not in place. As best practice, plans should have procedures in place to identify midyear LIS status changes. Per 42 CFR § 423.800(e), sponsors must process retroactive adjustments to cost-sharing for low-income subsidy eligible individuals and

any resulting refunds and recoveries within 45 days of the sponsor's receipt of complete information regarding claims adjustment.

- The remaining claims were found not to be discrepant, due to calculation scenarios not considered during CMS analysis. This included PDEs submitted with Medicare as Secondary Payer, PDEs with day supplies greater than the plan defined one-month supply resulting in higher cost-sharing, and PDEs incorporating proportional liability of dispensing fees in the coverage gap. CMS appreciates the responses that sponsors provided to fully explain these scenarios and will incorporate lessons learned to improve on study design for future years.

For more information on the methodology and initial results of the CY 2020 analysis, refer to the HPMS memorandum titled "Contract Year (CY) 2020 Cost Sharing Administration Analysis" released July 22, 2022.

CY 2022 CSAA Methodology

Due to the retrospective timing of the initial CY 2020 analysis, we opted to move ahead to CY 2022 for the second annual analysis. Given the accuracy of Part D sponsors' claim adjudication in CY 2020, CMS sought to investigate other aspects of the submitted Part D benefits. For the CY 2022 CSAA, we focused on the cost-sharing for non-formulary drugs during the initial coverage phase. The analysis examined retail pharmacy PDEs and compared the adjudicated beneficiary paid amount to the expected cost sharing based on the approved formulary and benefits design. This took into account beneficiary LIS status and the designated formulary exception tier(s). We identified PDE for Part D eligible drugs not included on plan formularies by examining approved plan formularies for the target month and subsequent two months to determine formulary status.

Medicare-Medicaid Plans (MMPs), Program of All-inclusive Care of the Elderly (PACE) plans, Employer Group Waiver Plans (EGWPs), and plans participating in the Value-Based Insurance Design (VBID) model were excluded. Additional restrictions are outlined in Table 1. We identified the sample-eligible PDEs by selecting those PDE that contained a cost-sharing discrepancy where the adjudicated beneficiary payment amount was different from the expected cost-sharing amount calculated based on the approved formulary and benefit design and information provided on the PDE. The discrepancy could be an overpayment or underpayment.

Table 1. CSAA PDE Inclusion Criteria

Date of service on or between 01/01/2022 and 06/30/2022	Drugs not eligible for a free first fill
Falls completely in the Initial Coverage Phase (ICP)	Non-compound drug
Covered under Part D and present in at least one CY 2022 formulary reference file	Occurred in a retail pharmacy setting

Plan on the PDE for the enrollee aligns with the plan listed in the CME[1] for the enrollee	PDE for non-formulary NDCs (must be non-formulary for the month of service and the subsequent two months)
PDE with a one-month supply as entered in the Plan Benefit Package (PBP)	PDE where adjudicated beneficiary cost-sharing or payment amount is different from the expected cost-sharing amount from the plan's bids

CY 2022 CSAA Initial Results

CMS identified a total of 1,421,245 PDEs for non-formulary drugs that were eligible for inclusion in the analysis. Of these claims, there were 22,848 instances (1.61% of eligible PDE) where the adjudicated beneficiary payment amount was different from the expected cost-sharing amount. The discrepancy could be an underpayment or overpayment, as detailed in Table 2. Tables 3 and 4 show the magnitude of the discrepancy by presenting the distribution of the underpayments (Table 3) and overpayments (Table 4).

Table 2. Summary of Sample-Eligible PDEs

Parameter	Number of PDE	Error Rate (percentage of claims out of the total PDEs included in the analysis)
PDEs included in the analysis	1,421,245	N/A
Discrepant claims	22,848	1.61%
Sample-Eligible PDE where the beneficiary underpaid	20,808	1.46%
Sample-Eligible PDE where the beneficiary overpaid	2,040	0.14%

Table 3. Distribution of Beneficiary Underpayment Claims

Total Underpaid Claims	Minimum Underpayment	Maximum Underpayment	Median Underpayment
20,808	-$0.02	-$1,385.27	-$19.29

Table 4. Distribution of Beneficiary Overpayment Claims

Total Overpaid Claims	Minimum Overpayment	Maximum Overpayment	Median Overpayment
2,040	$0.07	$1,224.87	$45.72

We were generally pleased to see that Part D sponsors are adjudicating non-formulary prescription drug claims consistent with the approved benefit design. Out of the eligible claims reviewed, we only identified 1.61% that appeared inconsistent with the approved plan design. This discrepancy rate is comparable to our previous findings, and these results suggest that Part D sponsors largely have effective and efficient processes in place to ensure accurate point-of-service adjudication of prescription drug claims with respect to beneficiary cost sharing.

[1] CME is the Common Medicare Environment data

From the 22,848 (1.61%) of claims identified with discrepancies resulting in apparent overpayment or underpayment by the beneficiary, CMS further assessed two areas of concern. First, we identified parent organizations with a relatively high proportion of claims that resulted in beneficiary overpayment or underpayment at the 90th percentile compared to all parent organizations analyzed (i.e., significant outliers). Second, we identified parent organizations that had beneficiaries who experienced an overpayment or underpayment in the 99th percentile of our data (i.e., a high-value discrepancy). Based on these criteria, CMS identified 49 parent organizations for outreach in the analysis.

As a next step, we will provide the Part D sponsors we selected for outreach with file(s) containing the claims identified as significant outliers and/or a high value discrepancy. Each parent organization will receive a maximum sample of 20 PDEs, across a maximum of 4 contracts. Selected contracts will receive a selection notice and must complete the CSAA Response Form in its entirety before uploading the form to the Web Portal. We also expect Part D sponsors to investigate the identified PDE and include any actions taken with respect to beneficiary reimbursement or recoupment, if applicable in their response. CMS review of complete responses from selected Part D sponsors will conclude the CY 2022 CSAA. We intend to repeat a similar analysis annually and plan to share CMS findings along with notification to selected plans, as appropriate.

For questions regarding the Cost Sharing Administration Analysis please contact the Part D Formularies mailbox at PartDFormularies@cms.hhs.gov. For questions related to the secure web portal please contact Acumen at FormularyBenefits@acumenllc.com