



DATE: September 28, 2020

TO: All Prescription Drug Plan Sponsors, Medicare Advantage-
Prescription Drug Plan Sponsors, and Medicare-Medicaid Plans
serving Massachusetts

FROM: Sharon Donovan, Director
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SUBJECT: Part D Low-Income Subsidy Copayment Corrections for Beneficiaries in
Massachusetts

The Massachusetts Medicaid program (called “MassHealth”) recently identified a number of individuals who are dually eligible for full Medicaid benefits and Medicare, but for whom MassHealth had not indicated as such on data to CMS. As a result of these data omissions, some beneficiaries may not be deemed appropriately for the Low-Income Subsidy (LIS).

MassHealth has sent a series of correction files, with the first in February 2020 with 18 months’ worth of retroactive corrections, and a second file in April 2020 with 36 months of retroactive corrections. They are sending a third correction file in late September, 2020, to resolve the corrections for January-March 2017; we expect this to be the final correction file for the identified issue.

CMS Account Managers will alert the Medicare drug plans when to expect to see the corrections on their MARx Daily Transaction Reply Report (DTRR) in September. Please note this may include current as well as former enrollees. Plans can query updated address via the Batch Eligibility Query (BEQ) or MARx User Interface (UI).

Expectations of Prescription Drug Plans

CMS expects plans will follow current timelines for acting on LIS copayment level changes transmitted on these DTRRs, based on the date of receiving the notification from CMS, including:

- Issuing revised model Low-Income Subsidy Rider (LIS Rider; see Attachment 1) within 30 calendar days to affected beneficiaries (*Medicare Prescription Drug Benefit Manual Chapter 13 - Premium and Cost-Sharing Subsidies for Low-Income Individuals* (Rev. 14, 10-01-18),
- Paying beneficiary refunds within 45 days of receipt of correction on the DTRR (see 42 CFR 423.4669(a) Timeframes for coordination of benefits and claims adjustments), with model cover letter (see Attachment 2), and
- Resubmitting PDEs with corrected copayment levels within 90 calendar days (see HPMS memo dated October 6, 2011, Revision to Previous Guidance Titled “Timely Submission of Prescription Drug Event (PDE) Records and Resolution of Rejected PDEs”).

Plan sponsors should ensure they meet requirements to accept and then show the correct cost sharing for LIS eligibility status in their systems when they relied on Best Available Evidence per 42 CFR 432.800(d) (*Medicare Prescription Drug Benefit Manual Chapter 13 - Premium and Cost-Sharing Subsidies for Low-Income Individuals* (Rev. 14, 10-01-18), section 70.5.2).

Finally, we remind plan sponsors that because a decision on the amount of cost sharing for a drug is considered a coverage determination by 42 CFR 423.566(b)(5), enrollees have the right to appeal if they dispute the cost-sharing amount or copayments (see also 42 CFR 423.580 for enrollees right to dispute copayments). Additionally, enrollees have the right to request a redetermination of a coverage determination per 42 CFR 423.580.

Ensuring Customer Service Representatives are Prepared to Support Dually Eligible Enrollees

We recommend that plans equip customer service representatives with call center scripts and resources to support current and former enrollees who are affected by this correction. CMS and MassHealth will likewise share information with organizations to whom beneficiaries may turn for support, including 1-800-MEDICARE and SHINE (the Massachusetts SHIP) at 1-800-243-4636.

Conclusion

We appreciate Part D sponsors’ prompt attention to these issues, including effectuating needed communications with and refunds to affected current and former enrollees.

If you have any questions, please contact your Account Manager.

Attachment 1 - Revised Model LIS Rider for Corrections for Certain Massachusetts Enrollees

Attachment 2 - Model Cover Letter for Refund

Attachment 1 – Revised Model LIS Rider for Corrections for
Certain Massachusetts Enrollees

[Legend for Model LIS Rider:

- *Variable Placeholders are located within < >.*
- *Language that a sponsor may include or remove in its entirety, based on benefit design, is located within [].*
- *Language in italics is instructions to sponsors.*
- *SNPs that provide prescription drug benefits exclusively to people dually eligible for Medicare and Medicaid and do not charge any cost sharing in excess of the LIS cost-sharing levels must reflect their plan amounts in the LIS Rider.*

In all instances throughout this document in which dollar or percentage values appear (for instance, deductibles or copays), sponsors must provide the one (not multiple) value that applies to the enrollee who will receive this copy of the LIS Rider.]

Effective Date: *[Insert Date as Month Day, Calendar Year or Date Range]*

Evidence of Coverage Rider
for People Who Get Extra Help Paying for Prescription Drugs
(also called a Low-Income Subsidy Rider or LIS Rider)

[OPTIONAL: Sponsors may insert member's Rx BIN/PCN]

Keep this notice - it is part of <Plan Name>'s Evidence of Coverage <MMPs: use Member Handbook>.

We have new information that shows that you qualify for extra help paying for your prescription drug coverage. This means that you will get help paying your monthly premium, yearly deductible, and prescription drug cost sharing. Your prescription drug coverage will not change.

See the chart below for a description of your prescription drug coverage:

Your monthly plan premium is	Your yearly deductible is	Your cost-sharing amount for generic/preferred multi-source drugs is no more than	Your cost-sharing amount for all other drugs is no more than
<Insert applicable amount>*	\$0	\$<insert level>	\$<insert level>

[Sponsors: Insert this statement for affected LIS members: Changes to your prescription drug costs began as of <effective date at the top of this letter>. If you have filled prescriptions since this date, you may have been charged more than you should have paid as a member of our plan.

If we owe you money, we will send you a separate letter later to let you know how much and include the refund. You may get similar letters from other prescription drug plans in which you were enrolled in the past. **Refunds you get will not have any impact on your MassHealth eligibility, and you do not need to report the amount to your MassHealth caseworker.**

If you disagree with our decision on the amount of the refund, you can make an appeal. You can make your appeal by sending a written request to us at <address>. *[If applicable, add: You may also call us at <insert Toll-free number> to submit an appeal by phone.]*

Medicare or Social Security will periodically review your eligibility to make sure that you still qualify for extra help with your Medicare prescription drug plan costs. Your eligibility for extra help might change if there is a change in your income or resources, if you get married or become single, or if you lose MassHealth.

If you have any questions about this notice, contact *[optional <us>]* <Plan Name>, *[optional <Member Services>]* at <Toll-free Number>, <Toll-free TTY Number>, <Days/Hours of Operation>, or at <web address>.

If you have general questions, you can also contact 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) or SHINE at 1-800-243-4636.

[Insert appropriate language, including disclaimers as outlined in Appendix 2 of the Medicare Communications and Marketing Guidelines or State-specific MMP Marketing Guidance.]

[Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to <https://www.hhs.gov/civil-rights/for-individuals/section-1557>.]

You can also get this notice for free in other languages and formats, like large print, braille, or audio. Call *[insert Member Services toll-free phone and TTY numbers and days and hours of operation]*. The call is free.

Attachment 2 – Model Cover Letter for Refund

<date>

<member name>

<address 1>

<city, state zip>

[Plan Name] Medicare Plan Refund of Copays

Dear <name>,

[Sponsors: In first sentence populate dates for which refund is being provided: You <were> <have been> enrolled in <Plan Name> from <Date 1> through <Date 2>.] We recently learned that the government had inaccurate information that caused you to be charged and pay copays in error for Part D covered drugs while enrolled in our plan. As a result, we owe you <refund total>. To figure out how much we owed you, we looked at our records and added all the copayments we charged you in error during this period. This error has been fixed for these dates, and we have included a refund for the total amount. **This refund will not have any impact on your MassHealth eligibility, and you do not need to report the amount to your MassHealth caseworker.**

You may get similar letters with refunds from other prescription drug plans you were enrolled in in the past.

If you disagree with our decision on the amount of this refund, you can make an appeal. You can make your appeal by sending a written request to us at <address>. *[If applicable, add: You may also call us at <insert toll-free number> to make an appeal by phone.]*

We are sorry for any problems this may have caused. We are happy to answer any of your questions and make sure you don't have any problems as a result of this error. Please contact <Plan Name> at Member Services by phone at <toll-free telephone number (toll-free TTY telephone number), call center hours/days> with your questions. When you call, tell Member Services that you are calling about "Medicare Plan Refund of Copays."

If you have general questions about why you are getting this refund, you can also contact 1-800- MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) or HICAP at 1-800-434-0222.

Thank you for your patience and understanding.
Sincerely,

<Signature>

<Name>

President, <Plan Name>

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