LIS Incorrect Cost-Sharing - Making the Beneficiary Whole

Q: If a plan determines that a LIS-eligible enrollee was assessed a higher level of cost-sharing than CMS confirms he or she qualified for (e.g., $2/$5 rather than $1/$3), how can it make the enrollee whole? If the amount owed by the plan is minimal, is the plan still obligated to make the enrollee whole?

A: Given the vulnerability of this population, as well as our rules in 42 CFR 423.800(c), we believe the plan must make the enrollee whole by refunding any improperly collected cost-sharing. In general, a plan should send the enrollee a check for any amounts owed by the plan to the beneficiary.

A plan may also identify a minimal cut-off amount whereby, if the amount owed by the plan is less than that amount, it would reimburse the beneficiary through an offset of future cost-sharing rather than a check. In other words, rather than send a check, the plan would choose to reimburse a beneficiary who is owed less than the cut-off amount via an offset. However, an enrollee should always have the opportunity to request and receive reimbursement via check.

CMS regulations at 42 CRF 423.800(c) direct the plan to reimburse subsidy-eligible individuals, and any organizations paying cost sharing on behalf of such individuals, any excess premiums or cost sharing paid by such individual or organization. The intent of this provision is to direct the plan to make reasonable efforts to determine the party that should be reimbursed for excess cost sharing before making reimbursement. Therefore, CMS expects that plans will develop standard operating procedures (SOPs) to address the research and determinations of liability for cost sharing reimbursements, and will not adopt a “one size fits all” approach, such as always cutting checks to the beneficiary. Plans should consider such variables as institutionalized status or the presence of secondary payers reported on the COB files in their SOPs. Moreover, any direct request for reimbursement with appropriate evidence of payment should be handled expeditiously.

Per previous guidance, when implementing retroactive subsidy level changes for a full-benefit dual eligible who meets the definition of an institutionalized individual but is incorrectly charged cost-sharing, plans should not automatically reimburse beneficiaries residing in long-term care (LTC) facilities. In such situations, it is unlikely that LTC pharmacies have collected the applicable cost-sharing from beneficiaries due to the expectation that the plan eventually would reimburse the pharmacy retroactively for such amounts. This may also be the case in non-LTC pharmacies, though probably not to the same degree as it has been the case in the LTC setting, where the LTC pharmacy is more likely to hold a receivable balance on its books, or may have recourse to the LTC facility for uncollected amounts.

Plans should work with their network pharmacies to provide them with direct reimbursement for any cost-sharing amounts not collected from LIS-eligible enrollees. Before reimbursement is made, plans should ensure that the pharmacies in question have

not collected cost-sharing amounts, otherwise waived the cost-sharing charges, and, in fact, are carrying a debt for the amounts incorrectly charged to the beneficiary. For auditing purposes, plans should ensure that pharmacies certify that the amounts reimbursed are appropriate, owed, and payable. Providing direct reimbursement to pharmacies for excess cost-sharing charges that have not been paid by Part D enrollees or that have been waived by the pharmacy does not conflict with the requirement in 42 CFR 423.800(c) that beneficiaries be made whole, since such amounts were never paid by either the enrollee or others on his or her behalf.

In addition, the plan should ensure that once it refunds any cost-sharing, the PDE is adjusted. Although both LICS and Patient Pay amounts are TrOOP-eligible amounts, the LICS amount must be correct because LICS is a cost-based payment mechanism and CMS uses the LICS Amount field to calculate the Part D Payment Reconciliation for LICS. The adjustment PDE shows that LICS increases and Patient Pay decreases by the same amount (provided the beneficiary receives no assistance from a TrOOP-eligible other payer like an SPAP). Plans must use the "Report-As-Adjusted" method to show changes in every affected PDE, and not the "Report-As-Administered" method, anytime a change in LICS amounts is involved.