RDS Plan Year Reopening

A process to review retrospective RDS payments and validate maximum subsidy

Executive Summary:

RDS is a financially rewarding program to plan sponsors. However, RDS is a complex program and requires comprehensive administrative processes requiring technical expertise and data analytics to insure receiving the maximum subsidy. Furthermore, plan sponsor must coordinate with and rely on their third party managers, pharmacy benefit managers or health plans, to manage the overall RDS process. Due to the challenges facing the plan sponsor in regard to RDS participation and compliance, CMS will allow past plan years to be revaluated and corrected enabling the plan sponsor to capture maximum subsidy. Reopening a previously reconciled plan year can result in a significant amount of additional subsidy and every plan sponsor should consider the financial opportunity it can provide.

Introduction:

The Retiree Drug Subsidy Program (RDS) was created as part of the Medicare Modernization Act of 2003 and made available with the start of Medicare Part D prescription drug benefit on January 1, 2006. Many organizations have capitalized on the 28% subsidy over the years. Other than a change to the taxation stipulations of the program in 2013, RDS has remained operationally the same over the years. However, several years ago the Centers of Medicare and Medicaid Services announced that a plan sponsor could "re-open" a reconciled plan year if there was evidence that not all the RDS subsidy was captured. This presents a valuable opportunity for plan sponsors to validate their administrative processes performed in the past did in fact maximize their possible RDS reimbursement.

Since the implementation the RDS program, the administrative requirements have been a challenge for plan sponsors. RDS requires both a clear understanding of the RDS compliance requirements as well as technical knowledge to securely manage retiree eligibility and pharmacy cost data. In most situations, the plan sponsor is working with several external entities as well. The retiree eligibility information is often managed by a third party administrator (TPA) or benefit consulting firm, while the pharmacy claims data is provided to the plan sponsor by a pharmacy benefit manager or health plan. For those plan sponsors that perform the RDS administrative process themselves, they rarely feel comfortable with the time and expertise they have to support the overall RDS requirements.

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RDS Administrative Process:

To participate in the RDS program, the plan sponsor must offer "credible" drug coverage that is actuarially equivalent to, or better than, Medicare Part D coverage. The equivalence test is performed by an actuary and upon a positive determination, the plan sponsor can register with the RDS program and begin submitting retiree eligibility and cost report information to CMS.

There are many administrative actions in the overall RDS process and all of them must be completed successfully in order to receive RDS subsidy. Within the process, the identification and verification of retiree eligibility, the matching of retirees to claims, and comprehensive understanding of cost report calculations are critical to maximizing reimbursement. In both areas, data accuracy is critically important and if careful review is not performed, maximum RDS subsidy will not be attained and/or program compliance issues can occur.

RDS retiree eligibility processing requires careful focus on specific retiree information such as name, date of birth, social security number, and effective date. Aggregating this information, a data set can be created so a unique retiree can be identified and the beginning of the subsidy period can be determined. To validate the retiree is RDS subsidy eligible; the plan sponsor must submit the retiree information to CMS for verification. CMS validates the retiree's social security number is unique and the retiree is not participating in another Medicare Part D plan already. As part of the verification process, it is not uncommon that the plan sponsor is notified that the retiree's information is not correct via CMS rejection errors such as an incorrect social security number or date of birth. Therefore, the plan sponsor, or often times the plan sponsor's third party administrator, is responsible for researching and correcting the retiree data so the information can be resubmitted to CMS to validate retiree eligibility. This data verification and reiterative process is time consuming but must be performed to maximize plan sponsor reimbursement.

To determine the amount of RDS subsidy possible, the plan sponsor must also have access to all their retiree pharmacy claims. The pharmacy claim must contain specific information such as plan sponsor identifier, member subscriber number, payment amount, NDC code, quantities of medications dispensed. Due to the complexity of adjudicating pharmacy claims, most plan sponsors utilize a pharmacy benefit manager or health plan to manage claims payment. Most plan sponsors are not capable to receive and process claims files in accordance to RDS medication inclusion and exclusion requirements; therefore, most plan sponsors rely on their PBM or health plan to perform the RDS cost report calculations on their behalf.

An additional complication in generating the plan sponsor's cost report is in the situation where the PBM or health plan retains the active employees and retirees in one claims file. In this situation, the plan sponsor is responsible for providing the PBM or health plan with a retiree list from which they can match the claims. If the plan sponsor doesn't provide a full, error-free, retiree list for some reason, the PBM or health plan will processes the claims to generate an inaccurate cost report. Furthermore, if

there are issues matching all the claims to the retirees, the plan sponsor will not receive maximum subsidy. Often times, plan sponsors are unaware of the claims matching completeness because the PBM or health plan does not always analyze the matching process to ensure the complete use of all the data.

For plan sponsors doing the RDS steps themselves, they are faced with the challenge of matching all the retiree claims to RDS eligible retirees. In some cases there is a straight forward data link between the retiree eligibility information and the plan sponsor's claims; however that is not always the case. In these situations, a cross walk table must be created and used to be able to correctly identify and link the retiree and their claims. Plan sponsors usually do not have extensive matching skills or tools to insure all the provided claims match their retiree population. Without effective and comprehensive claims matching, maximum RDS subsidy will not be achieved due to claims costs not being incorporated into the total subsidy calculation.

RDS Reopen Process:

When a plan sponsor believes, or discovers, there may have been an error in a past plan year impacting their RDS reimbursement, CMS will allow a plan sponsor to re-open a previously reconciled plan year. This process can be done up to four years post reconciliation of a plan year. However, to re-open a plan year the plan sponsor must provide CMS with a written notice identifying their issue and the expected increase in reimbursement. CMS will review the plan sponsor request and reply to the plan sponsor with a determination in approximately 30 days.

As a requirement of the CMS reopen request, the plan sponsor must provide an estimated amount of additional subsidy. To determine the "new" subsidy total, the plan sponsor must reevaluate their past data and their RDS process to identify what could have potentially caused their subsidy shortfall. The review process is time consuming, complicated, and not something most plan sponsors are able to do. To clearly identify issues impacting their subsidy calculation, the plan sponsor would need analytical tools and expertise to identify the specific data or processing issues causing the subsidy shortfall.

Over the years, the RDS subsidy has averaged approximately $550 per retiree per year. It is in the plan sponsor's financial interest to capture subsidy for every eligible retiree, spouse, and dependent in the plan. However, in audits performed over the years, it has been identified that plan sponsors have an average of 5-10% of their retiree population rejection from CMS' eligibility verification process. If the plan sponsor does not have a process to correct eligibility rejections and resend the corrected retiree information to CMS, the plan sponsor did not capture the maximum subsidy for that plan year. As part of the reopen process, CMS allows past plan year retiree eligibility information to be resent and validated which enables the plan to correct past eligibility rejection issues which leads to additional subsidy to the plan sponsor.

In addition to verifying all retiree's eligibility in the plan, analysis of the claims file and claims processing should be thoroughly reviewed for anomalies. An important metric is confirming an appropriate number of claims were received from the PBM to generate an appropriate gross cost. Another important audit step is confirming that all claims match with the retirees on the covered retiree list. It is valuable to review the utilization of costs per retiree to determine if the overall member utilization is high or low. Furthermore, an important adjustment to the total allowable cost is the rebate percentage which is deducted from the allowable total charges. Rebate percentages can vary widely and need verification either by requesting the PBM or health plan to provide it again, or by recalculating the claims and rebate data to validate the percentage used in the past was correct.

Following all the retiree and data verification steps, the entire plan year should be reprocessed and a "new" cost report created. If there is additional subsidy identified, the plan sponsor can submit a specific CMS request letter that outlines their application information, plan year, and additional subsidy requested. CMS will usually respond to the plan sponsor's request with a determination in 30 days or less.

If CMS responds with a favorable determination and the reopen request is approved, the plan sponsor is notified it has ninety days to resubmit the appropriate information and request payment. This process follows the same process as an annual reconciliation and upon completion CMS will electronically pay plan sponsor in thirty days or less.