DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Date: April 13, 2016
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Frequently Asked Questions on Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015 (FAQS #5)

Simplified Methodology

REGTAP 15451

Q1: When standard plans have separate deductibles for Medical and Prescription, but the annual Out-of-Pocket (OOP) maximums to Medical and Prescription is combined, how do you develop the separate parameters for Medical and Prescription? What subgroups should we use?

A1: For plans with separate medical and pharmaceutical deductibles but a combined annual limitation on cost sharing, issuers should develop separate effective cost sharing parameters for the medical and pharmaceutical claims. However, the total amount of cost sharing estimated under the standard plan for any policy must be limited to the combined annual limitation on cost sharing.

REGTAP 15452

Q2: When using the Simplified Actuarial Value (AV) method, should we pro-rate the annual limitation of cost sharing for members who are not active for the full plan year? For example, if a member is only active for 8 months should we multiply the out of pocket maximum by 8/12ths?

A2: Issuers must use the actual annual limitation on cost sharing for the plan in the equation for the AV methodology, regardless of whether a member is enrolled for less than the full benefit year.

Essential Health Benefits and Prescription Drugs

REGTAP 15453

Q3: In REGTAP FAQ 15117, CMS said taxes and administrative fees are not Cost-sharing Reductions (CSR) eligible. Does that include dispensing fees and sales taxes on prescription drugs? Those amounts are included in the allowed amount for the drugs and often are covered by member co-pay.

A3: Additional costs such as dispensing fees and sales taxes for prescription drugs are considered cost sharing for Essential Health Benefits (EHB) (and therefore CSR eligible) and part of total allowed costs if they are included in a plan's benefit design for the standard plan and the plan variations.

Claims that Cross Benefit Years

REGTAP 15454

Q4: If a member enrolled in a Cost-sharing Reduction (CSR) plan for the 2014 benefit year goes into the hospital in December 2014 but is not discharged until January 2015, in which benefit year reconciliation cycle should the issuer report the claim and CSR paid? Is this a CSR provided in 2014, or in 2015?

A4: For a hospital stay that crosses benefit years, the issuer should adjudicate CSRs based on the year for which accumulators for the CSRs applied, regardless of when the claim is presented for payment.

For example, if cost sharing (co-pays, deductibles, coinsurance) for part of the hospital stay was incurred in 2014, that cost sharing and associated cost-sharing reductions should be adjudicated against 2014 benefit year plan designs, re-adjudicated with other 2014 benefit year claims, and reported as part of CSR reconciliation data for the 2014 benefit year, regardless of whether further related services for the stay were provided in 2015. However, for example, if the enrollee's entire cost for hospital coinsurance related to the stay is not incurred until 2015, such claims and associated cost-sharing reductions should be adjudicated against 2015 benefit year plan designs, re-adjudicated with other 2015 benefit year claims, and reported as part of CSR reconciliation data for the 2015 benefit year. The issuer must apply accumulators consistently for all enrollees in the standard plan and plan variations.

The EDGE server data submission rules regarding discharge dates for claims that cross benefit years do not apply to the CSR reconciliation data submission.

REGTAP 15455

Q5: What if the subscriber does not renew coverage in the second year of a benefit that crosses plan years?

A5: Whether or not coverage is renewed for the second year, cost-sharing reductions should be calculated and reconciled based on the year for which the accumulators for the cost sharing would apply.

Claims for Services After an Expired Grace Period

REGTAP 15456

Q6: If a member in a Cost-sharing Reduction (CSR) plan is admitted to the hospital prior to a grace period, and is discharged after the 30-day grace period date, how should issuers handle these claims?

A6: The issuer should pay, adjudicate, and re-adjudicate the portion of claims with cost sharing incurred during the period the enrollee was covered, regardless of when the claim is presented for payment. The Centers for Medicare & Medicaid Services (CMS) will not reimburse issuers for cost-sharing reductions provided during the second and third months of a 90-day grace period after which the enrollee is retroactively terminated. See also REGTAP FAQ 15103.

Delayed Presentation of Claims

REGTAP 15457

Q7: If a service was provided in September 2015, but the claim is lost or not presented until June 2016, in which benefit year reconciliation cycle should the issuer report the Cost-sharing Reduction (CSR) provided? Is this a CSR provided in 2015, or in 2016?

A7: This is a CSR provided in 2015 but which could not be re-adjudicated and reconciled with other 2015 claims on the same policy because the issuer did not get the bill for service until after the data submission deadline. In such a case, the issuer would adjudicate and re-adjudicate all claims on the 2015 policy again, and restate 2015 CSRs for that policy during the 2016 reconciliation cycle (April 2017). The Centers for Medicare & Medicaid Services (CMS) intends to provide guidance on the CSR restatement process for previous year claims.

Re-adjudication of Claims

REGTAP 15458

Q8: For the standard methodology, the natural order of claims was described as temporal order (i.e., when claims are received). Which is it, the date of service or the date that the claim was processed/paid/presented?

A8: Claims for services provided in a particular benefit year must be re-adjudicated in the benefit year plan structure in which the cost sharing was incurred regardless of when they are presented for payment. Therefore, issuers should adjudicate and re-adjudicate claims in the order that best approximates their natural order, e. g, when cost sharing was incurred for a particular medical service. This may or may not coincide with the actual dates of service, for example, when coinsurance is assessed on a total bill rather than on a per-diem basis.

REGTAP 15459

Q9: If claims are pended during the plan year, should those claims be re-adjudicated in the original order they occurred during the plan year, or when resolved?

A9: Pended claims should be re-adjudicated in the order that best approximates the initial adjudication of the claims. Thus, if the issuer's practice is to adjudicate a pended claim upon resolution (and not to retroactively adjudicate the pended claim as if it had occurred when originally incurred), the pended cost-sharing reduction reconciliation should similarly be re-adjudicated based on date of resolution.

REGTAP 15460

Q10: For the standard methodology, natural order – for claims from different sources, specifically pharmacy and medical claims – is there an order to processing for those received on the same day, or for those received on different days, or can they all be re-adjudicated in the order received regardless of claim type/source?

A10: As discussed in November 2014 guidance from the Centers for Medicare & Medicaid Services (CMS) on re-adjudication of claims for the purpose of cost-sharing reduction reconciliation, all issuers must set all accumulators to zero and, if using a third party administrator (TPA), first re-process all medical claims in their natural order and then all pharmacy claims in their natural order. If not using a TPA, claims for any type of EHB service should be processed in the order received.
https://www.regtap.info/uploads/library/APTC_Claims_Readjudication_Guidance_110314_5CR_111714.pdf

REGTAP 15461

Q11: Can you provide clarification on whether understating the Cost-sharing Reductions (CSR) for a reported claim has any audit implications? We know that not reporting eligible claims doesn't have audit implications, but weren't sure about erring on the side of a conservative calculation.

A11: The Centers for Medicare & Medicaid Services (CMS) expects issuers to submit accurate data on cost-sharing reductions provided, and all amounts are subject to audit. However, in remedying any inaccuracies in a submission, CMS will consider the financial impact of the inaccuracy.

REGTAP 15462

Q12: If claims involving coordinated benefits cannot be properly handled before submission, is it acceptable to filter out Coordination of Benefits (COB) claims and not include them for Cost-sharing Reduction (CSR) reconciliation?

A12: Issuers may wait to re-adjudicate complex claims until the complete cost of the benefit has been accounted for; however, in such a case, the issuer must re-state claims for the entire policy, including the complete COB claim, reducing total allowed costs for EHB by the amount paid by another issuer, as applicable, in both the standard plan and the plan variation, to ensure correct re-adjudication of CSR provided for that policy. See also REGTAP FAQ 15101 and 15106.

Specifications

REGTAP 15463

Q13: I am an Federally-facilitated Marketplace (FFM) issuer who is receiving errors in my summary/error report for having reported invalid Exchange Assigned Subscriber IDs. Why might I be getting this error?

A13: For FFM plans, issuers need to report Exchange Assigned Subscriber IDs with any leading zeroes that the IDs originally had when generated by the FFM. Issuers will receive errors in their summary/error report if they report FFM generated Exchange Assigned Subscriber IDs without the leading zeroes.