

§ 423.2470

specified by CMS, the following information:

(1) *Fully credible and partially credible contracts.* For each contract under this part that has fully credible or partially credible experience, as determined in accordance with § 423.2440(d), the Part D sponsor must report to CMS the MLR for the contract and the amount of any remittance owed to CMS under § 423.2410.

(2) *Non-credible contracts.* For each contract under this part that has non-credible experience, as determined in accordance with § 423.2440(d), the Part D sponsor must report to CMS that the contract is non-credible.

(c) Total revenue included as part of the MLR calculation must be net of all projected reconciliations.

(d) Subject to paragraph (e) of this section, the MLR is reported once, and is not reopened as a result of any payment reconciliation processes.

(e) With respect to a Part D sponsor that has already submitted to CMS the MLR report or MLR data required under paragraph (a) or (b) of this section, respectively, for a contract for a contract year, paragraph (d) of this section does not prohibit resubmission of the MLR report or MLR data for the purpose of correcting the prior MLR report or data submission. Such resubmission must be authorized or directed by CMS, and upon receipt and acceptance by CMS, is regarded as the contract's MLR report or data submission for the contract year for purposes of this subpart.

[83 FR 16756, Apr. 16, 2018, as amended at 87 FR 27902, May 9, 2022]

§ 423.2470 Remittance to CMS if the applicable MLR requirement is not met.

(a) *General requirement.* For each contract year, a Part D sponsor must provide a remittance to CMS if the contract's MLR does not meet the minimum percentage required by § 423.2410(b).

(b) *Amount of remittance.* For each contract that does not meet MLR requirement for a contract year, the Part D sponsor must remit to CMS the amount by which the MLR requirement exceeds the contract's actual MLR multiplied by the total revenue of

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the contract, as provided in § 423.2420(c), for the contract year.

(c) *Timing of remittance.* CMS will deduct the remittance from plan payments in a timely manner after the MLR is reported, on a schedule determined by CMS.

(d) *Treatment of remittance.* Payment to CMS must not be included in the numerator or denominator of any year's MLR.

§ 423.2480 MLR review and non-compliance.

To ensure the accuracy of MLR reporting, CMS conducts selected review of data submitted under § 423.2460 to determine that the MLRs and remittance amounts under § 423.2410(b) and sanctions under § 423.2410(c) and (d), were accurately calculated, reported, and applied.

(a) The reviews will include a validation of amounts included in both the numerator and denominator of the MLR calculation reported to CMS.

(b) Part D sponsors are required to maintain evidence of the amounts reported to CMS and to validate all data necessary to calculate MLRs.

(c)(1) Documents and records must be maintained for 10 years from the date such calculations were reported to CMS with respect to a given contract year.

(2) Part D sponsors must require any third party vendor supplying drug cost contracting and claim adjudication services to the Part D sponsors to provide all underlying data associated with MLR reporting to that Part D sponsor in a timely manner, when requested by the Part D sponsor, regardless of current contractual limitations, in order to validate the accuracy of MLR reporting.

(d) Data submitted under § 423.2460, calculations, or any other MLR submission required by this subpart found to be materially incorrect or fraudulent—

(1) Are noted by CMS;

(2) Appropriate remittance amounts are recouped by CMS; and

(3) Sanctions may be imposed by CMS as provided in § 423.752.

[78 FR 31310, May 23, 2013, as amended at 83 FR 16756, Apr. 16, 2018]

§ 423.2490 Release of Part D MLR data.

(a) *Terminology.* Subject to the exclusions in paragraph (b) of this section, Part D MLR data consists of the information submitted under § 423.2460.

(b) *Exclusions from Part D MLR data.* For the purpose of this section, the following items are excluded from Part D MLR data:

(1) Narrative descriptions that Part D sponsors submit to support the information reported to CMS pursuant to the reporting requirements at § 423.2460, such as descriptions of expense allocation methods.

(2) Information that is reported at the plan level, such as the number of member months associated with each plan under a contract, including information submitted for a contract consisting of only one plan.

(3) Any information that could be used to identify Medicare beneficiaries or other individuals.

(4) MLR review correspondence.

(5) Any information for a contract for those contract years for which the contract is determined to be non-credible, as defined in accordance with § 423.2440(d).

(c) *Data release.* CMS releases to the public Part D MLR data, for each contract for each contract year, no earlier than 18 months after the end of the applicable contract year

[81 FR 80558, Nov. 15, 2016, as amended at 83 FR 16756, Apr. 16, 2018]

Subpart Y—Transitional Coverage and Retroactive Medicare Part D Coverage for Certain Low-Income Beneficiaries Through the Limited Income Newly Eligible Transition (LI NET) Program

SOURCE: 88 FR 22342, Apr. 12, 2023, unless otherwise noted.

§ 423.2500 Basis and scope.

(a) *Basis.* This subpart is based on section 1860D–14 of the Social Security Act.

(b) *Scope.* This subpart sets forth the requirements for the Limited Income Newly Eligible Transition (LI NET) program that begins no later than Jan-

uary 1, 2024. Under this program, eligible individuals are provided transitional coverage for Part D drugs.

§ 423.2504 LI NET eligibility and enrollment.

(a) *Eligibility.* An individual is eligible for LI NET coverage if they satisfy the criteria at paragraph (a)(1) or (2) of this section.

(1) *LIS-eligible.* The individual is a low-income subsidy eligible individual as defined at § 423.773 and—

(i) Has not yet enrolled in a prescription drug plan or an MA–PD plan; or

(ii) Has enrolled in a prescription drug plan or MA–PD plan but their coverage has not yet taken effect.

(2) *Immediate need individuals.* An individual who states their eligibility for LIS and immediate need for their prescription, but whose eligibility as defined at § 423.773 cannot be confirmed at the point-of-sale, will be granted immediate need LI NET coverage.

(3) *Documentation of LIS eligibility.* Individuals may provide documentation to the LI NET sponsor to demonstrate LIS eligibility. Documentation may include, but is not limited to:

(i) A copy of the beneficiary's Medicaid card that includes their name and the eligibility date;

(ii) A copy of a letter from the State or SSA showing LIS or “Extra Help” status;

(iii) The date that a verification call was made to the State Medicaid Agency, the name and telephone number of the State staff person who verified the Medicaid period, and the Medicaid eligibility dates confirmed on the call;

(iv) A copy of a State document that confirms active Medicaid status;

(v) A screen-print from the State's Medicaid systems showing Medicaid status; or

(vi) Evidence at point-of-sale of recent Medicaid billing and payment in the pharmacy's patient profile.

(4) *Confirmation of LIS eligibility.* CMS uses documentation submitted under paragraph (a)(3) of this section to confirm LIS eligibility.

(5) *Inability to confirmation of eligibility.* If CMS cannot confirm an immediate need individual's eligibility during the period of LI NET coverage, the individual will not be auto-enrolled