

Information for Advocates:

No Part D Copayments for Dual Eligibles Receiving Medicaid HCBS Services

The change. The Affordable Care Act provides that full-benefit dual eligibles (those who qualify for both Medicare and full Medicaid benefits) who are receiving Medicaid home and community based services (HCBS) are eligible for a full waiver of copayment requirements for their Medicare Part D prescription drugs. The provision is designed to put people who are receiving HCBS in the community on equal footing with those who are institutionalized. Full duals who reside in skilled nursing facilities already have no copayment liability.

Who qualifies. Individuals who qualify for both Medicare and full-scope Medicaid (full-benefit dual eligibles) and who receive HCBS services under a state plan, a Section 1115 waiver, a Section 1915 (c) or (d) waiver, or through a Medicaid managed care plan qualify. Since this list is broad and CMS, by regulation, has taken an inclusive approach (see “Regulatory background” below), we suggest that advocates assume that enrollment in any Medicaid HCBS program meet the criteria.

Timing. CMS is implementing the provision as of January 1, 2012, the earliest date permitted by the statute. Starting January 1, states are required to include HCBS status in their submissions to CMS. CMS urged, but did not require, states to send a special submission in December so that HCBS status could be on CMS and plan records by January 1. It is not clear how many states made a special December submission.

Length of qualification. As with other Low-Income Subsidy categories, individuals who are on the state files as qualifying in any month will be deemed qualified for the entire plan year. If an individual qualifies in July or any subsequent month, their qualification will be deemed for the rest of that year and for the entire subsequent year. Note, however, that the benefit cannot start prior to January 1, 2012.

Expected challenges. Some states only submit Medicaid status to CMS once a month, sometimes mid-month. If your state is in that category and did not make a December submission, there will be a lag in recognition of HCBS status until the state’s January submission is processed. Further, because implementation requires modifications to state reporting, it is possible that problems will emerge if a state’s data systems have not been appropriately adjusted to conform to the new reporting requirements.

Best Available Evidence (BAE) policy. If a full dual receiving HCBS does not show as eligible for zero copays, the individual may present evidence to her Part D plan showing HCBS status, including:

- a) A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;
- b) A copy of a State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
- c) A copy of a State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
- d) Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or
- e) A copy of a State-issued document confirming Medicaid payment for dates of HCBS service on or after January 1, 2012, such as Remittance Advice, including the beneficiary's name and dates of HCBS.

For any other State-issued document to be acceptable as BAE, it must include at least these elements:

- a) Beneficiary's name;
- b) HCBS eligibility date.

Notice: CMS will not be sending notices to individuals about their change to zero copay status. Plans, however, will be sending updated LIS riders showing the beneficiary's new copay status. To our knowledge, the outreach to pharmacies has been limited so pharmacists may not understand the changes.

What advocates can do:

1. Identify individuals who qualify for zero copays and assist them in submitting BAE showing HCBS eligibility. CMS issued a recent notice to plans about their obligation to accept BAE (attached), which should be useful to show if a plan representative is unfamiliar with plan obligations.
2. Tell qualifying individuals to ask for refunds. If recognition of HCBS status is delayed, individuals who incorrectly were required to make copays after January 1 are entitled to a refund of overpayments. CMS has not issued any special instructions to plans about refunds, which are likely to be relatively small, but numerous.

3. Look for systemic issues. If your state routinely submits Medicaid eligibility data on, for example, January 10, and did not submit a special December report, it is likely that there will be delays in recognition for all eligible individuals in the state. Little can be done about this other than helping individuals with BAE and refunds. If, however, you see problems such as the state not submitting HCBS data at all, or particular plans not accepting BAE or 1-800-MEDICARE giving out erroneous information on BAE for HCBS, please let us know so we can alert CMS. Note particularly that individuals receiving HCBS through Medicaid managed care qualify for the zero copay. Issues may arise around whether plans have systems in place to report to the states so the states can report to CMS.
4. Urge your state to make daily submissions to CMS of Medicaid eligibility data (MMA files), including HCBS, or at least to submit data more frequently than once a month. Advocates in states that have moved to more frequent reporting have seen a very significant reduction in problems around auto-enrollment and retroactive LIS coverage and can expect fewer problems with HCBS recognition as well.

Regulatory background. The Affordable Care Act provision extending zero copays to individuals receiving HCBS is found at Section 1860D-14 of the Social Security Act, 42 U.S.C. 1395w-114 (a)(1)(D):

Reduction in cost-sharing below out-of-pocket threshold.—

(i) Institutionalized individuals.—In the case of an individual who is a full-benefit dual eligible individual and who is an institutionalized individual or couple (as defined in section [1902\(q\)\(1\)\(B\)](#)) or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section [1115](#) or subsection (c) or (d) of section [1915](#) or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a Medicaid managed care organization with a contract under section [1903\(m\)](#) or under section [1932^{\[516\]}](#), the elimination of any beneficiary coinsurance described in section [1860D-2\(b\)\(2\)](#) (for all amounts through the total amount of expenditures at which benefits are available under section [1860D-2\(b\)\(4\)](#)).

The CMS implementing regulation, 42 CFR 423.782(a)(2)(ii), is significantly simpler:

Full-benefit dual-eligible individuals who are institutionalized or who are receiving home and community-based services have no cost-sharing for Part D drugs covered under their PDP or MA-PD plans.

In adopting its regulation, CMS recognized that, although some of the HCBS programs listed in the statute do not require a specific assessment that someone found eligible for HCBS would be an institutionalized individual but for the provision of HCBS, all the listed programs are designed to prevent unnecessary or premature institutionalization.

Advocates should assume that a full benefit dual eligible receiving HCBS under Medicaid in any context is eligible for the zero copay. Please let us know if you are seeing any exceptions.

The guidance for plans about BAE and implementation of the zero copay is found in the Prescription Drug Benefit Manual, Ch. 13 At 60.2, 60.2.2, and 70.5.2, www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter13.pdf.

For further information, contact Georgia Burke, gburke@nsclc.org.

