

Resource Series provides MCOs with best practices, guidance and/or reference materials. This series does not include directions on contract requirements or directives from the Department.

ON JANUARY 1, 2012, DUAL ELIGIBLES RECEIVING HCBS WILL HAVE \$0 CO-PAY RESPONSIBILITY ON MEDICARE PART D DRUGS

The Affordable Care Act eliminates Part D drug co-pays for dual eligibles (those with Medicare and Medicaid) receiving home and community based waiver services (HCBS). This was effective on January 1, 2012. The intent behind this change is to treat individuals at a nursing home level of care receiving home-and-community based services and supports in the same manner as those who are institutionalized.

HCBS PROGRAMS IN WISCONSIN

- Family Care
- Family Care – Partnership
- PACE
- IRIS
- All Legacy Waivers (COP, CIP, BIW.)
- Children’s Long Term Support Waiver

IMPLEMENTATION TIMELINE

The Wisconsin Department of Health Services plans to begin sending information to Medicare about who receives HCBS on January 19, 2012. This data will indicate that these individuals received HCBS as of January 1, 2012. We do not at this time have information about when that information will be provided to Part D plans.

Since Medicare and pharmacies will not have information about individuals receiving HCBS in Wisconsin on January 1, HCBS participants will still be charged a co-pay at the pharmacy counter for several weeks in January until the HCBS data reaches the Medicare Part D plans (sometime after January 19). All of these individuals should already be receiving low co-pays by virtue of having both Medicare and Medicaid; they just won’t have \$0 co-pays right away.

RETROACTIVE REIMBURSEMENTS

Once the Medicare Part D plans receive the information about which of their members receive HCBS, they will be required to adjust members’ status retroactive to January 1. Medicare Part D plans are then required to automatically reimburse members for overpaid, out-of-pocket costs incurred since January 1. This adjustment should occur without any specific request from the member. This reimbursement must be made within 45 days from when the Medicare Part D plan receives the information about the change in co-pay status. If HCBS beneficiaries have not received reimbursement by March 16, 2012 for out of pocket Medicare Part D co-pays incurred after January 1, 2012, they should contact the Med D plan to specifically ask for a reimbursement.

BEST AVAILABLE EVIDENCE

Beneficiaries can also utilize CMS's "Best Available Evidence" (BAE) policy to ask for the \$0 co-pays even before the Med D plan knows that a member receives HCBS. The BAE policy allows beneficiaries who are not receiving correct cost-sharing benefits to prove to the Medicare Part D plan their eligibility for lower cost sharing. Part D plans must accept the following as Best Available Evidence:

- A state-issued notice of action, notice of determination, or notice of enrollment including the beneficiary's name and HCBS eligibility date during any month after January 1, 2012;
- A state document that confirms HCBS status as of January 1, 2012;
- A printout from the State's electronic enrollment file or a screen print from the State's Medicaid system showing the HCBS status as of January 1, 2012;
- Any other documentation from the State showing the HCBS status as of January 1, 2012 that includes the beneficiary's name and shows HCBS eligibility;
- A remittance notice from the HCBS entity showing the HCBS status as of January 1 2012;
- A state issued HCBS Service plan that includes the beneficiary's name and showing an effective date any time after January 1, 2012;
- The person may also verbally inform the Part D plan of the HCBS Status. The Med D plan can contact the State Medicaid Agency and if the State Medicaid Agency confirms the HCBS eligibility as of January 1, 2012, the Part D plan can prepare a report of contact which is sufficient BAE documentation.

Whenever it says "state" in most bullets above, you may be able to substitute "IM unit" or, depending on the context, "MCO", since both these are agents of the state in administering the HCBS program. In that case, MCO issued notices of action, or IM documentation of HCBS enrollment, would be sufficient.

The pharmacist (if the pharmacist can obtain this verification), the beneficiary, or another individual, such as a care manager acting on behalf of the beneficiary, may fax this information to the Medicare Part D plan along with a beneficiary request for an adjusted co-pay. As soon as the plan receives this documentation, it must provide the \$0 cost-sharing and update its systems to reflect this. The Medicare Part D plan should be able to provide you with the correct fax information. If you have problems, you can look up the plan contact information here:

http://www.cms.gov/PrescriptionDrugCovContra/17_Best_Available_Evidence_Policy.asp

Please note that the Medicare Part D plan must receive the BAE documentation to make the change to \$0 co-pays. Simply informing the pharmacist of the HCBS status is not enough. The pharmacist can help the beneficiary get the information to the plan if s/he so chooses, but the pharmacist is not able to make the change him/herself (this process is not the same as the point of sale facilitated enrollment). A pharmacist may also choose not to collect a co-pay from an individual who owes one.

A Medicare Part D plan must take action when it receives information indicating that one of its members receives HCBS, even if this is a verbal notification without documentation. A request without documentation will trigger an investigation by the plan to determine if the person

receives HCBS, but in the absence of documentation, the reduced cost-sharing will not be implemented until the conclusion of that process.

Since it may not be feasible to for every HCBS recipient to use the BAE policy in January, MCOs may want to focus assistance on those persons with the highest drug co-payment burden due to low income, a large number of prescriptions, or a combination of both.