

Low Income Subsidy (“Extra Help”) for Dual Eligibles Receiving Home and Community-Based Services

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What is the cost-sharing rule for dual eligibles receiving Medicaid Home and Community Based Services?

The Affordable Care Act provides that full-benefit dual eligibles—people who qualify for both Medicare and full Medicaid benefits—who receive certain Medicaid home- and community-based services (HCBS) are eligible for the institutional cost-sharing level on Medicare Part D prescription drugs. The institutional cost-sharing level is \$0 co-payments for all covered Part D drugs. The provision is designed to put people who receive HCBS in the community on equal footing with those who are institutionalized.

Whom does the cost-sharing rule apply to?

The \$0 cost-sharing level is available to individuals who

- (a) qualify for both Medicare and full-scope Medicaid benefits, also known as full-benefit dual eligibles, and
- (b) also receive HCBS under a state Medicaid plan, a Section 1115 waiver, a Section 1915(c) or Section 1915 (d) waiver, or through a Medicaid managed care organization.

When did the cost-sharing rule take effect?

The effective date of this change was January 1, 2012.

How long is an individual eligible for the institutional cost-sharing level?

The dual eligible should continue in \$0 co-pay status for as long as they maintain their dual eligibility and remain enrolled in the HCBS program, and perhaps even longer. As with other Low-Income Subsidy categories, individuals who are on the state files as qualifying for the HCBS \$0 co-pay

category 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 extend to the rest of that year and for the entire subsequent year.

What if my dual eligible HCBS-enrolled client is asked for a co-pay at the pharmacy?

Dual eligibles receiving Medicaid HCBS services are entitled to \$0 co-pays for their Part D prescription drugs; however, due to technical errors, these individuals may be wrongly asked to pay for their drugs at the pharmacy. Under the Best Available Evidence (BAE) policy, a dual eligible who receives Medicaid HCBS can dispute the incorrect charge at the pharmacy. If the individual provides BAE, the pharmacist often can immediately contact the Part D plan and change the cost sharing level. The plan is then responsible to ensure that the cost-sharing change is permanently entered so that the change is permanent within 48 to 72 hours, meaning the beneficiary will not have to resubmit BAE each time they go to the pharmacy.

To provide BAE, full dual eligibles who receive Medicaid HCBS (or their representative) must present the pharmacy with one of these documents:

- » A copy of a state-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and the HCBS eligibility date. A copy of the state-approved HCBS service plan that includes the beneficiary's name and effective date;
- » A copy of the state-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date;
- » Other documentation provided by the state showing HCBS eligibility status; or
- » A state-issued document (e.g. remittance advice) confirming payment for HCBS that includes the beneficiary's name and the dates of HCBS.

What if my client is owed a refund?

Part D plans have a responsibility to make sure a dual eligible who is assessed a higher cost-sharing level is made whole. In general, a Part D plan must send the member a check for any amounts owed. Plans also have discretion to identify a minimal cut-off and if the reimbursement owed is less than the cut-off, a plan can reimburse the member by offsetting future cost-sharing.

What can advocates do?

1. Ask your clients receiving HCBS if they are charged any co-pays for their Part D drugs. If they think they are being charged or aren't sure, ask them to bring in their Explanation of Benefits (EOB), which will show co-pay amounts.
2. If the client appears to be eligible for HCBS \$0 co-pay status and not properly coded, help your

client to contact the Part D plan and provide evidence of HCBS status. Tell the client to use the term "Best Available Evidence," which should help to ensure that the call is handled properly.

3. Look for systemic issues. If you notice two or three dual eligible individuals in the same HCBS program being charged co-pays, it is possible that many others may be as well. Note particularly that individuals receiving HCBS through Medicaid managed care still qualify for the zero copay. How an individual receives the Medicaid HCBS program – managed care or fee-for-service – does not change the cost-sharing rule, but issues may arise around whether plans have systems in place to report to the states so the states can report to CMS, particularly as a state transitions part or all of its Medicaid program to managed care. Tell Justice in Aging if you think there might be a systemic issue.

Authorities:

Statute: 42 U.S.C. 1395w-114(a)(1)(D)

Regulation: 42 C.F.R. 423.782(a)

For further information, contact info@justiceinaging.org.