

ON JANUARY 1, 2012, DUAL ELIGIBLES RECEIVING HCBS WILL HAVE \$0 COPAYS ON MED D DRUGS

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

HCBS PROGRAMS IN WISCONSIN

Family Care

IRIS

All Legacy Waivers (COP, CIP, BIW.)

Children's Long Term Support Waiver

Partnership

IMPLEMENTATION TIMELINE

Unfortunately, the Medicare Part D plans won't know who is receiving HCBS on January 1. This is because the Medicare Part D plans rely on data from Wisconsin to determine who is receiving HCBS. The first time Wisconsin will tell Medicare know who receives HCBS is January 19. This data will indicate that these individuals received HCBS as of January 1.

Further, January is the first month in which HCBS recipients nationwide will be afforded the reduced co-pays. Therefore, we won't know until after January 19 if there are problems with any of the systems involved.

This means that individuals receiving HCBS in Wisconsin, although eligible for \$0 copays, will still be charged a co-pay at the pharmacy counter for several weeks in January until the Wisconsin HCBS data reaches the Medicare Part D plans sometime after January 19. All of these individuals should be receiving low co-pays by virtue of having both Medicare and Medicaid, they just won't have \$0 copays 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 their 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 1st. 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 copays 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 the best available evidence (BAE) policy to ask for the \$0 copays 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 to the Med D plan.

Part D plans must accept the following as Best Available Evidence:

- 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 showing HCBS eligibility.
- a remittance notice from the HCBS entity showing the HCBS status as of January 1, 2012.
- 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 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.

The pharmacist (if the pharmacist can obtain this verification), the beneficiary, or another individual acting on behalf of the beneficiary may fax this information to the Medicare Part D plan along with a beneficiary request for an adjusted copay. 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 to make the change to \$0 copays. 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.) Of course, a pharmacist can always 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 won't be implemented until the conclusion of that process.

We know that it is not feasible to use the BAE policy for every HCBS recipient in January. However, for some individuals, even one month of co-pays is a great hardship and we hope to help as many of these individuals as possible.