Department of Health & Human Services
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

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TO: All Prescription Drug Plans, Medicare Advantage-Prescription Drug Plan Sponsors, and Cost Plans with optional supplemental Part D benefits

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SUBJECT: Implementing the Waiver of Part D Cost-Sharing for Full Benefit Dual-Eligible Beneficiaries Receiving Home and Community-Based Services

Background

The Medicare Modernization Act of 2003 provided that full benefit dual-eligible beneficiaries who are institutionalized would not have any Part D cost sharing. Section 3309 of the Affordable Care Act (ACA) extended the waiver of Part D cost sharing to full benefit dual-eligible individuals who would be institutionalized if they were not receiving home and community-based services (HCBS) through one of the authorities listed in section 3309.

Prior Guidance

The purpose of this memorandum is to provide Part D plan sponsors with additional information about implementing the waiver of Part D cost-sharing for full benefit dual-eligibles who are receiving HCBS. On September 14, 2011, CMS issued an HPMS memo to plans describing the requirement to use co-payment level 3 ($0) for individuals identified as eligible to receive the waiver. We also issued guidance to States, via the October 31, 2011, State Bulletin regarding the best available evidence (BAE) policy associated with the waiver. In the State Bulletin, we indicated that States must report full benefit dual-eligible individuals who are eligible to receive HCBS to help CMS identify individuals who are eligible to receive the waiver of Part D cost-sharing. All States and the District of Columbia have confirmed that they have at least one HCBS program covered under section 3309 of the Affordable Care Act. Consistent with the regulations at 42 CFR §423.800, beginning on January 1, 2012, plans must adjust their systems to reduce to zero, the copayments of full dual individuals who are identified by CMS as eligible to receive HCBS. In cases where CMS' systems do not reflect a beneficiary's correct LIS status (e.g., because of episodic reporting by the States and SSA), plans must apply the BAE policy.

HCBS Best Available Evidence (BAE) Policy

In situations where CMS data systems do not reflect State data verifying HCBS status, individuals may provide their plan sponsor with certain State documents to verify their status as

a full dual beneficiary receiving HCBS. These documents would constitute BAE and serve as proof that the full dual beneficiary is receiving HCBS. The beneficiary will present the BAE document to his/her plan sponsor, and the plan sponsor must forward the document to CMS' agent for a correction of CMS data. Plan sponsors must also correct these individuals' cost-sharing levels in their data systems, assigning copayment level 3 ($0) to full dual individuals receiving HCBS.

Included below is a list of the types of State documents that plan sponsors should accept as proof that a full dual beneficiary is receiving HCBS and qualifies for zero ($0) cost-sharing:

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.

Please note that individuals who do not appear in CMS systems as Medicaid-eligible must also provide best available evidence of their Medicaid status. A list of acceptable documents verifying Medicaid eligibility can be found in section 70.5.2 of Chapter 13 of the Medicare Prescription Drug Benefit Manual. Chapter 13 can be found at http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp.

If you have questions, please contact Kay Pokrzywa at katherine.pokrzywa@cms.hhs.gov or 410-786-5530.