Part D Co-Pays and California Duals on HCBS

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February 25, 2020
Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Since 1972 we’ve focused our efforts primarily on fighting for people who have been marginalized and excluded from justice, such as women, people of color, LGBTQ individuals, and people with limited English proficiency.
Housekeeping

• All on mute. Use Questions function for substantive questions and for technical concerns.
• Problems with getting on to the webinar? Send an e-mail to training@justiceinaging.org.
• Slides and a recording are available at Justice in Aging – Advocates Resources – Trainings: justiceinaging.org/resources-for-advocates/webinars. See also the chat box for this web address.
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Go to justiceinaging.org and hit “Subscribe.”

Send an email to info@justiceinaging.org.

Open a text and text the message “4justice” to the number 51555.
To achieve Justice in Aging, we must:

- Acknowledge systemic racism and discrimination
- Address the enduring negative effects of racism and differential treatment
- Promote access and equity in economic security, health care, and the courts for our nation’s low-income older adults
- Recruit, support, and retain a diverse staff and board, including race, ethnicity, gender, gender identity and presentation, sexual orientation, disability, age, economic class
Roadmap

- Glossary and Overview of LIS Rules
- Populations Impacted
- Summary of Co-Pay and Refund Processes
- Timelines and Template Notices
- Tips for Advocates
Glossary

• Part D Extra Help
• Full benefit dual eligible
• Home and community based services (HCBS)
• Institutional/HCBS cost-sharing
Federal Law Requires Zero Dollar Co-Pays

• The Affordable Care Act requires that full benefit HCBS dual eligibles are charged zero dollar co-pays for Part D covered drugs.
• Change brought these dual eligibles to the same cost-sharing level as institutional dual eligibles.
• Became effective January 2012.

42 U.S.C. 1395w-114(a)(1)(D); 42 C.F.R. 423.782(a)
HCBS Programs

• HCBS under a state Medicaid plan,
• Authorized under a Section 1115 waiver,
• Authorized under a Section 1915(c) or Section 1915 (d) waiver, or
• Delivered through a Medicaid managed care organization
How the Zero Dollar Co-Pay Works

• State Medicaid agency (DHCS) reports which duals are eligible for the co-pay to CMS.

• CMS runs quality control on the lists and sends the information to the plans responsible for the Part D benefit.

• The dual eligible is properly assessed no co-pay at the pharmacy.
Issue in California

• Due to reporting issues at DHCS, some dual eligibles have not been properly identified as part of the zero-dollar co-pay population.

• Impacted populations include dual eligibles in the Community Based Adult Services (CBAS) program and in San Mateo’s Multipurpose Senior Services Program (MSSP).
Numbers and Dates

• DHCS estimates around 30,000 full benefit dual eligibles were affected and therefore erroneously charged co-pays.
• Co-pays were incurred from January 2012 to December 2019.
Refund Processes

- Wave 1: Co-Pays from February 2017 to December 2020
- Wave 2: Prospective/present day co-pays
- Wave 3: January 2012 to January 2017

Refunds are issued from the plan the dual eligible was enrolled in when the improper co-pay was collected.
Wave 1: More Info

- Refund process generates two notices.
- 1st Notice: LIS Eligibility Notice, also known as the LIS “Rider”
- 2nd Notice: Reimbursement with Check
- Notices have requirements re: timing of mailing.
  - 1st Notice: late February 2020
  - 2nd Notice: mid-March 2020
LIS “Rider” Notice

Attachment 1 – Revised Model LIS Rider for Corrections for Certain California Enrollees with HCBS

[Legend for Model LIS Rider:
  o Variable Placeholders are located within < >.
  o Language that a sponsor may include or remove in its entirety, based on benefit design, is located within { }.
  o Language in italics is instructions to sponsors.
  o SNPs that provide prescription drug benefits exclusively to people dually eligible for Medicare and Medicaid and do not charge any cost sharing in excess of the LIS cost-sharing levels must reflect their plan amounts in the LIS Rider.

In all instances throughout this document in which dollar or percentage values appear (for instance, deductibles or copays), sponsors must provide the one (not multiple) value that applies to the enrollee who will receive this copy of the LIS Rider.]

Effective Date: [Insert Date as Month Day, Calendar Year or Date Range]

Evidence of Coverage Rider
for People Who Get Extra Help Paying for Prescription Drugs
(also called a Low-Income Subsidy Rider or LIS Rider)

[OPTIONAL: Sponsors may insert member’s Rx BIN/PCN]

Keep this notice - it is part of <Plan Name>’s Evidence of Coverage <MMP: use Member Handbook>.

We have new information that shows that you qualify for extra help paying for your prescription drug coverage. This means that you will get help paying your monthly premium, yearly deductible, and prescription drug cost sharing. Your prescription drug coverage will not change.

See the chart below for a description of your prescription drug coverage:

<table>
<thead>
<tr>
<th>Your monthly plan premium is</th>
<th>Your yearly deductible is</th>
<th>Your cost-sharing amount for generic/preferred multi-source drugs is no more than</th>
<th>Your cost-sharing amount for all other drugs is no more than</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;Insert applicable amount&gt;*</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

[Sponsors: Insert this statement for affected LIS members: Changes to your prescription drug costs began as of <effective date at the top of this letter>. If you have filled prescriptions since this date, you may have been charged more than you should have paid as a member of our plan.

If we owe you money, we will send you a separate letter later to let you know how much and include the refund. You may get similar letters from other prescription drug plans you were enrolled in in the past. Refunds you get will not have any impact on your Medi-Cal eligibility, and you do not need to report the amount to your Medi-Cal caseworker.]

If you disagree with our decision on the amount of the refund, you can make an appeal. You can make your appeal by sending a written request to us at <address>. [If applicable, add: You may also call us at <insert Toll-free number> to submit an appeal by phone.]

Medicare or Social Security will periodically review your eligibility to make sure that you still qualify for extra help with your Medicare prescription drug plan costs. Your eligibility for extra help might change if there is a change in your income or resources, if you get married or become single, or if you lose Medicaid.

If you have any questions about this notice, contact [optional <us>] / <Plan Name>, [optional <Member Services>] at <Toll-free Number>, <Toll-free TTY Number>, <Days/Hours of Operation>, or at <web address>.

If you have general questions, you can also contact 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) or HICAP at 1-800-434-0222.

[Insert appropriate language, including disclaimers as outlined in Appendix 2 of the Medicare Communications and Marketing Guidelines or State-specific MMP Marketing Guidance.]

[Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]

You can also get this notice for free in other languages and formats, like large print, braille, or audio. Call [insert Member Services toll-free phone and TTY numbers and days and hours of operation]. The call is free.

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Reimbursement Notice

Attachment 2 – Model Cover Letter for Refund

<date>

<member name>
<address 1>
<city, state zip>

[Plan Name] Medicare Plan Refund of Copays

Dear <name>,

[Sponsors: In first sentence populate dates for which refund is being provided: You <were> <have been> enrolled in <Plan Name> from <Date 1> through <Date 2>.] We recently learned that the government had inaccurate information that caused you to be charged and pay copays in error for Part D covered drugs while enrolled in our plan. As a result, we owe you <refund total>. To figure out how much we owed you, we looked at our records and added all the copayments we charged you in error during this period. This error has been fixed for these dates, and we have included a refund for the total amount. **This refund will not have any impact on your Medi-Cal eligibility, and you do not need to report the amount to your Medi-Cal caseworker.**

You may get similar letters with refunds from other prescription drug plans you were enrolled in in the past.

If you disagree with our decision on the amount of this refund, you can make an appeal. You can make your appeal by sending a written request to us at <address>. **[If applicable, add: You may also call us at <insert toll-free number> to make an appeal by phone.]**

We are sorry for any problems this may have caused. We are happy to answer any of your questions and make sure you don’t have any problems as a result of this error. Please contact <Plan Name> at Member Services by phone at <toll-free telephone number (toll-free TTY telephone number), call center hours/days> with your questions. When you call, tell Member Services that you are calling about “Medicare Plan Refund of Copays.”

If you have general questions about why you are getting this refund, you can also contact 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) or HICAP at 1-800-434-0222.

Thank you for your patience and understanding.

Sincerely,

<Signature>
Waves 2 and 3: More Info

• DHCS working on wave 2 by April 2020.
  • LIS deeming rules allow duals to be eligible for cost-sharing through end of 2020.
  • Very few should be reporting co-pays as a result.

• CMS and DHCS working on a process to capture wave 3 data. Timeline TBD.
Case Example: Maria

- Full benefit dual eligible enrolled in CBAS starting in 2016
- Lives in Ventura County, enrolled in Healthy Me PDP from 2016 to March 2018, then joined Fit Choice MA in April 2018.
- In Wave 1, will receive separate notices and reimbursements from Healthy Me (Feb. 2017 to April 2018) and Fit Choice (April 2018 to Dec. 2019).
- Period from 2016 to Jan. 2017 will be reimbursed as part of Wave 3.
Tips for Advocates

• Pay attention to mail in the next few weeks.
• Refunds do not affect Medi-Cal eligibility.
• Do not throw out letters from a previous plan thinking it is potentially marketing material.
• Refund decisions and amounts are appealable.
The Best Available Evidence Rule

• What if a dual eligible continues to be charged co-pays despite HCBS enrollment?

• Use Best Available Evidence Rule to establish HCBS enrollment at point of sale.

• DHCS/CMS working on outreach and education to pharmacies.
Additional Resources

• Justice in Aging General FAQ on LIS and HCBS
• Justice in Aging FAQ on California Refunds
• HPMS Memo

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Questions?

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