SDRC | State Data Resource Center

Medicare Modernization Act (MMA) File

Institutional Status Indicator, HCBS, and Part D Costs

Background

Most non-institutionalized dually eligible individuals pay small copayments for prescription drugs covered under Medicare Part D. However, section 1860D-14 (a)(1)(D)(i) of the Social Security Act eliminates Medicare Part D copayments for full-benefit dual eligible individuals who would be institutionalized if they were not receiving services under a home and community-based waiver authorized by a State under section 1115, or subsections (c) or (d) of section 1915, or under a State plan amendment under section 1915(i), or if such services are provided through enrollment in a Medicaid managed care organization with a contract under section 1903(m) or under section 1932. Since January 1, 2012, states have identified their full-benefit dually eligible beneficiaries (dual status codes 02, 04, 08) who are receiving certain home- and community-based services (HCBS) and coded these individuals "H" for HCBS in the Institutional Indicator field on the MMA file.

What is the Institutional Status Indicator?

The indicator represents a full-benefit dually eligible beneficiary that receives Medicaid-covered nursing facility, inpatient psychiatric hospital, or certain HCBS. This field, located at item 17 on the MMA Request File, establishes which full-benefit dually eligible beneficiaries (dual status codes 02, 04, 08) qualify for $0 Part D copayments.

The following fields on the Request File relate to Part D copayment status:

- Item 3 – Eligibility Status
- Item 14 – Beneficiary Dual Status Code
- Primary and Secondary Match Routine (section 6, MMA Request File). These values ensure a match for the beneficiary in the CMS Medicare Database.
    - Beneficiary Identifier (HICN, MBI)
    - Individual SSN
    - Date of Birth
    - Sex Code
    - First 6 characters of the individual last name
    - First character of the individual first name

Field values that trigger $0 copayment level:

Y – indicates that a full-benefit dually eligible beneficiary is enrolled in a Medicaid-paid institution for the full reporting month, or is projected by the state to be in the institution for the remainder of the month.

H (HCBS) – indicates that a full-benefit dually eligible beneficiary receives HCBS.

- The HCBS indicator is applicable for many, but not all types of HCBS programs. A state should populate the field with the H indicator for full-benefit dually eligible individuals receiving Medicaid-covered HCBS delivered under a section 1115(a) demonstration, under a 1915(c) or (d) waiver, under a state plan amendment under 1915(i), or through a Medicaid managed care

organization with a contract under section 1903(m) or under section 1932 of the Social Security Act. It does not include HCBS or personal care programs authorized under 1905(a), 1915(j) (self-directed personal care under a state plan), or 1915(k) (community first choice services).

Not all HCBS programs deem individuals eligible for the $0 copayment for Part D. Please see the CMS Information Bulletin linked at the end of this document for additional information.

States need to submit not only accurate current-month institutional status, but retroactive records reflecting institutional status changes in prior months. This is necessary to ensure that there is closure on the Part D Plan's responsibility for copayment amounts during the span of coverage.

CMS asks states that submit retroactive records in their files to cover any unreported past changes in institutional status. For example, if a state has reported a beneficiary for the first time as having institutional status in February, even though the first full month in the institution was January, a retroactive enrollment record is needed showing this update.

Resources

- CMS Informational Bulletin (CIB), 10/31/2011, Implementation of Section 3309 of the Affordable Care Act. Provides guidance to states to begin identifying full-benefit dually eligible individuals who are receiving HCBS. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/cib-10-31-11.pdf

- Medicare Advantage Prescription Drug (MAPD) State User Guide (SUG), provides technical information and file layouts for the MMA Request and Response files. https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/MAPD-State-User-Guide. Sections 4-7, MMA file and section 5.2.2., Retro DET records, specifically addresses how to submit changes on a record when a beneficiary was effective in a prior month.

Who Can I Contact with Questions?

- For technical assistance, please contact CMS' MAPD Help Desk at 800-927-8069 or mapdhelp@cms.hhs.gov

- For policy questions, please contact MMCO_MMA@cms.hhs.gov