Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2018-73**
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TO: Pharmacy Providers

RE: Medicare Part D Co-pays for Dual Eligible HUSKY Low Income Subsidy Clients

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The co-payment threshold for Low Income Subsidy/Full Benefit Dual Eligible individuals is changing for 2019. Currently, the co-pay for generic drugs is $3.35 and the co-pay for all other drugs is $8.35. **For dates of service January 1, 2019 and forward**, the co-pay for generic drugs will be $3.40 and for all other drugs the co-pay will be $8.50.

Clients covered under a HUSKY Benefit Plan will continue to be responsible for the first seventeen dollars ($17.00) per month of their Medicare Part D co-pays. For a pharmacy or compound claim billed with Other Coverage Code of 8 and a Carrier Code of MDD (Medicare D co-pay-only claim), a co-pay will be applied until $17.00 has been charged to the patient.

All Medicare Part D primary claims for clients who have Medicaid as a secondary payer must be submitted to DXC Technology for claims processing. This will allow the Department of Social Services (DSS) to track a client's $17.00 monthly co-pay responsibility. Submitting **all Medicare Part D** claims will allow the client's co-pays to systematically accrue to include prescriptions processed by another pharmacy or the reversal of a previously paid claim. The pharmacy should not try to tally the client's co-pays on their own or charge a client their Medicare Part D co-pay without submitting the claim to DXC Technology first, as either practice may cause the client to pay more than the maximum of $17.00 per calendar month.

Beginning January 1, 2019, Dual Eligible clients should never be billed a co-pay greater than $8.50 by their Medicare Part D Prescription Drug Plan (PDP) for a formulary drug.

In order to prevent the inappropriate use of the co-pay only transaction, a new edit is being implemented. This new edit will not allow a co-pay of greater than $8.50 to be billed to the Connecticut Medical Assistance Program (CMAP) on or after January 1, 2019. The claim will deny and return the following message back to the pharmacy: "**Co-pay only claim greater than $8.50 Not Allowed**". If a claim is returned from the PDP with a co-pay of greater than $8.50, **this issue must be resolved with the PDP**.