

Medicare Part D Essentials For Long Term Care Facilities

November 2005
(Updated November 11, 2005)

The American Health Care Association

This paper is an informal guide for Long Term Care Administrators and Staff prepared by AHCA staff. The information is derived from statute, regulation, and CMS guidance and, as such, is subject to change. This guide will be reviewed every month by AHCA staff and updated accordingly. For further information, contact Elise Smith at esmith@ahca.org.

Executive Summary

On January 1, 2006, *all* Medicare beneficiaries will be eligible for a federal Medicare drug benefit called Part D. This long term care (LTC) primer provides:

- a) A description of the MMA impact on LTC populations;
- b) An overview of LTC specific MMA regulations;
- c) A summary of Part D regulations and sub-regulatory guidance for long term care facilities; and
- d) A compilation of web-based resources and tools on Part D. A “phase two” AHCA Part D publication will provide more detailed information on changing daily operations under Part D.

Eligibility and Cost Sharing: All individuals eligible for either Medicare Part A or Part B are also eligible for the Part D drug benefit. Some individuals may be eligible for drug cost assistance through a “low-income subsidy” based on financial tests. Dually eligible individuals previously receiving Medicaid-financed drug coverage will begin receiving coverage under Medicare Part D. Medicare-only beneficiaries who elect to participate in Part D may receive “wrapping” coverage through their employer or state general fund drug coverage, such as from a State Pharmaceutical Assistance Program (SPAP). In essence, there will be a fundamental shift from Medicaid as the primary financer of drugs in nursing homes to Medicare drug plans.

Full dually eligible participants residing in LTC facilities will have no cost-sharing responsibilities under Part D. However, other Part D participants will have cost-sharing responsibilities, unless they are determined eligible for a “low-income subsidy” (LIS). Eligibility for LIS is determined by beneficiaries’ income and assets; determinations for LIS may be made by either state Medicaid agencies or the Social Security Administration (SSA). A complete table of LIS categories developed by CMS can be found in Attachment B.

Part D Administration and Enrollment: The Part D drug benefit will be delivered through a network of private prescription drug plans (PDPs) or through a Medicare Advantage managed health care plan that also includes the Part D benefit (MA-PD). The number of plans announced by CMS in September has far exceeded CMS expectations; within the CMS defined 34 PDP-only regions and 26 MA-PDP regions, there are at least ten plans (and some regions have as many as 40).

Part D beneficiaries will have a choice of Part D drug plans and multiple PDPs and MA-PDPs, each with their own formularies and contracted LTC pharmacy providers. However, dually eligible beneficiaries, for whom the benefit is mandatory, will be assigned to a Part D plan beginning October 15 through a process called “auto-enrollment.” Notification of auto-enrollment will be sent to dually eligible individuals and to plans; CMS has stated it will not inform facilities of residents’ plan status. Dually eligible LTC facility residents have access to an ongoing Special Enrollment Period (SEP) that allows them to change drug plans from month to month. SEP also is available to dually eligible individuals living in the community and in assisted living facilities.

Other LTC facility residents will also have access to a SEP, but CMS has yet to provide exact details on the frequency. Medicare-only beneficiaries must follow an initial enrollment period running from November 15, 2005 through May 15, 2006 and a subsequent annual enrollment period running from November 15 through December 31.

LTC facility residents are guaranteed continued access to specialized pharmacy services through LTC pharmacies including twenty-four/seven delivery and special packaging. Part D plans must accept any LTC pharmacy into their networks willing to accept contractual terms and LTC pharmacy providers may participate with several Part D drug plans. LTC pharmacies' revenues will shift from predominantly Medicaid to the Part D plans. However, nursing facilities will remain financially responsible for medications provided during a Part A stay.

Part D plans will be required to offer a contract to any pharmacy willing to participate in its LTC pharmacy network. The pharmacy must be capable of meeting certain minimum performance and service criteria (and relevant state laws governing the practice of pharmacy in the LTC setting) and any other standard terms and conditions established by the plan for its network pharmacies. Part D plans must demonstrate that they have a network of participating LTC pharmacies that provide convenient access to LTC pharmacies for LTC residents who are Part D enrollees.

Outreach and Education: LTC facilities are expected to provide education and outreach materials and information to residents and their families on Part D but may not take any steps that could influence beneficiary decisions regarding plan selection. CMS has stated that the beneficiary, legal guardians or other persons with durable power of attorney may complete the application or request a plan change.

Coverage and Exceptions/Appeals: All Part D drug plans must provide coverage within CMS defined guidelines and have a pharmaceutical and therapeutics (P&T) committee that includes practicing physicians and pharmacists. At least one doctor and one pharmacist must have expertise in care for persons with disabilities and individuals of advanced age. Plans must: a) offer at least two medications in each of the 146 drug classes and categories; and b) offer coverage free of tiering or other restrictions to vulnerable groups such as persons with HIV/AIDS, persons with mental illness, and persons with cognitive impairments. Part D will not cover over-the-counter medications (OTC), weight-related medications, vitamins, barbiturates, and benzodiazepines. State Medicaid agencies may cover MMA-excluded medications for individuals who are dually eligible. Plans may offer these drugs through buy-up plans which include higher cost-sharing responsibilities.

Non-formulary medications can be covered by two means – either through the exceptions and appeals process or through the initial transition process. Through the exceptions and appeals process, plans must allow beneficiaries and their physicians to argue for payment of non-formulary medications. The process may follow either a routine course or may be expedited if the non-formulary request is urgent. CMS recommends that plans cover an emergency fill while processing an exception or appeal request for non-formulary drugs.

It is unclear at this time whether this recommendation would cover the entire appeals process or whether it implies coverage through the initial appeal (i.e. through an initial 24 or 72 hours). In addition, transitioning -- moving from a beneficiary's current medication to one that is covered under the plan -- will be important because many LTC facility residents will need to change medications. CMS has recommended a transition period of 90 to 180 days for facility residents.

The MMA contains specific Part D coverage and enrollment provisions for "LTC facilities" -- nursing facilities, intermediate care facilities for persons with mental retardation (ICFs/MR), and inpatient psychiatric hospitals -- and their residents.

Table ES-2. Summary of Long Term Care Facility-Specific Part D Impacts

Stakeholder Group	Impact
<i>LTC Residents</i>	<ul style="list-style-type: none"> • Auto-enrollment for full dually eligibles • Special Enrollment Period • No cost-sharing for duals • Access to in-network pharmacies • Longer Transitioning Period • One-time refill for exceptions and appeals
<i>Long Term Care Facilities</i>	<ul style="list-style-type: none"> • Transition residents from non-covered medications to those on the drug plan formulary • Potentially coordinate multiple drug plan coverage with long term care pharmacy • Provide residents, legal guardians, and family members with education and assistance (as appropriate) on Part D including auto-enrollment, SEP, off-formulary requests

Additionally, plans are required to provide Medication Therapy Management Services (MTMS) to individuals with multiple chronic conditions, "multiple prescriptions" and/or who incur significant drug spending (i.e., \$4,000 or more per year). Any network participant, including a LTC pharmacy, could provide MTMS for the drug plan.

MTMS includes:

- a) Education and counseling to promote the appropriate use of medications and reduce risks of potentially adverse medication events;
 - b) Strategies to increase participant adherence to appropriate medication regimens including refill reminders, special packaging, and compliance programs; and
 - c) Processes to ensure dispensing of appropriate medications with no counter indications.
- MTMS is similar to services offered by long term care pharmacies; CMS has not clarified how MTMS will interface with LTC pharmacies that are not a plan's MTMS provider.

Conclusion: The combination of Part D plan options, LIS eligibility and determination, and variance in plan formularies and related exception/appeals, and transition processes -- each specific to each plan -- will increase the administrative responsibilities for LTC facilities. In the coming weeks, AHCA will develop a Part D operations guidance document for long term care facilities.

**Medicare Part D Essentials
For Long Term Care Facilities**

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Medicare Part D Essentials for Long Term Care Facilities

I. Overview and Implementation Timeline

The new Medicare Part D drug benefit starts on January 1, 2006.¹ The Medicare Part D benefit will provide prescription drug coverage through private plans called Prescription Drug Plan (PDP), known also as a Part D plan, or through a Medicare Advantage managed care program that includes the new Medicare prescription drug coverage (MA-PD). CMS has established 34 PDP and 26 MA-PD regions; as of October 2005, each region had at least ten plans.

The benefit is voluntary for all Medicare beneficiaries except those who receive both Medicare and Medicaid benefits (dual eligibles). Dually eligible beneficiaries will receive covered prescription drugs through Medicare Part D instead of their state Medicaid programs. Beginning in January 2006, states may no longer draw federal Medicaid matching funds for Part D covered drugs provided to dually eligible beneficiaries.

Under Part D, CMS defines a long term care (LTC) facility as a nursing facility, an intermediate care facility for people with mental retardation and developmental disabilities (ICFs/MR/DD) or an inpatient psychiatric hospital. Full benefit dual eligibles who reside in a LTC facility have certain benefits under Medicare Part D not accorded to other dual eligibles. For example, they pay no cost sharing at all, and they are assured access to the services of LTC pharmacies. In addition, all LTC facility residents are assured access to LTC pharmacy services and have additional special enrollment periods which enable them to change Part D plans upon admission or discharge from a LTC facility. Full dually eligible individuals residing in home and community-based settings, including assisted living facilities, will not have access to such provisions.

For LTC facility administrators, key Part D events include:

- *Auto-enrollment for full dually eligible individual:* Full dually eligible individuals will be automatically enrolled in a Part D plan by CMS starting on October 15, 2005.
- *Special Enrollment period begins:* Beginning on November 15, 2005, full dually eligible individuals may change Part D plans at any time.

For a detailed overview of Part D implementation steps, see chart below:

¹ On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L.108-173) (“MMA”) which provided the new Part D benefit.

July 15, 2005	Part D plans attest to having adequate pharmacy coverage
September 1, 2005	PDP contracts awarded
September 5, 2005	CMS announced approved Part D sponsors
September 5, 2005	Part D Plans required to publish formularies
October 1, 2005	Part D plan marketing begins
October 15, 2005	CMS starts notification to dual eligibles of automatic enrollment in PDPs
November 15, 2005	Open enrollment begins; dual eligibles may switch plans
December 31, 2005	Last day for Medicaid to provide prescription drugs
January 1, 2006	Medicare Part D benefit coverage begins
May 15, 2006	Open enrollment ends; Penalty for late enrollment applies

II. Prescription Drug Plans and LTC Pharmacies

Part D plans will be required to offer a contract to any pharmacy willing to participate in its LTC pharmacy network. The pharmacy must be capable of meeting certain minimum performance and service criteria (and relevant state laws governing the practice of pharmacy in the LTC setting) and any other standard terms and conditions established by the plan for its network pharmacies. CMS has developed the following minimum performance and service criteria for LTC pharmacies that contract with PDPs:

- *Comprehensive Inventory and Inventory*
- *Pharmacy Operations and Prescription Orders*
- *Special Packaging*
- *IV Medications*
- *Compounding /Alternative Forms of Drug Composition*
- *Pharmacist On-call Service*
- *Delivery Service*
- *Emergency Boxes*
- *Emergency Log Books*
- *Miscellaneous Reports, Forms and Prescription Ordering.*

Most of the services that are usually provided by LTC pharmacies are included in the definition with the exceptions of drug carts, Pyxis machines, and fax machines. Part D cannot cover these devices and must be paid for by another source, possibly the LTC facility. Facilities could pay for these services through their Part A contracts with LTC pharmacies or through a fair-market lease arrangement.

While payment terms for LTC pharmaceutical and dispensing services are subject to negotiations between the plan and its network LTC pharmacies, CMS states that payment to LTC pharmacies under Part D may only cover drug costs and dispensing fees. However, CMS makes clear that the elements above, not including the cost of drugs, would all be legitimate costs to reflect in the dispensing fee.

Once a Part D plan has negotiated an agreement with an LTC pharmacy, the LTC pharmacy becomes a network provider and is eligible to serve the plan's enrollees who reside in LTC facilities. CMS expects that each LTC facility will select one or more eligible LTC pharmacy to provide Medicare drug benefits to its residents. CMS confirms that a LTC facility can continue to contract with only one LTC pharmacy. However, CMS believes that competition will likely give each facility access to a broader range of potential LTC pharmacies than is the case today. Part D plans must demonstrate that they have a network of participating LTC pharmacies that provide convenient access to LTC pharmacies for LTC residents who are Part D enrollees.

III. Eligibility and Cost-Sharing

A person is eligible for Part D if eligible for either Medicare Part A or Part B. If Medicare Part A or B eligibility is retroactively determined, then Part D eligibility begins the month that the beneficiary received the Medicare eligibility notice. Full dually eligibles will be automatically enrolled by CMS in Part D plans with premiums that do not exceed the low income benchmark premium amount or the lowest Part D plan premium for basic coverage in the given region.

Personal income and assets have implications for whether or not an individual has cost sharing responsibilities and, if they have such responsibilities, how much. Individuals whose income is greater than 150% of the Federal Poverty Limit approximately \$1,196 per month, are subject to a number of cost sharing requirements:

- An initial deductible of \$250, after which Medicare pays 75% of the drug cost up to a total drug cost of \$2,250 (equivalent to \$750 in out-of-pocket spending). However, PDPs may adjust this benefit so long as it is actuarially equivalent.
- When a beneficiary reaches a total cost of \$2,250 there will be a coverage gap, often referred to as the "doughnut hole," during which the beneficiary must pay 100% of the drug cost, up to a total drug cost of \$5,100 (equivalent to \$3,600 in out-of-pocket spending).
- After this, catastrophic coverage kicks in, and Medicare pays 95% of all drug costs thereafter.

IV. Low Income Subsidy Benefits and Full Dually Eligible Benefits

Individuals with incomes below 150% federal poverty level (FPL), low-income Medicare beneficiaries, will receive what CMS terms full or partial subsidies of premiums and

reductions in cost sharing for the Medicare prescription drug benefit. The extent of the subsidy is determined by income and assets. There are numerous categories of subsidy recipients driven by income level; low-income subsidy (LIS) beneficiaries also may not have assets in excess of \$10,000 for an individual or \$20,000 for a couple. Beneficiaries in LTC facilities who are full dually eligibles receive the most comprehensive full subsidy. They will incur no cost for Part D coverage. In short, fully dual eligibles will have:

- No premium
- No deductibles
- No co-payments
- No gap in coverage (out-of-pocket expenditures before catastrophic coverage)

However, LTC facilities may have other beneficiaries who will be receiving a lesser full subsidy or a partial subsidy of premiums and reductions in cost sharing for the Medicare prescription drug benefit. It is thus important that facilities have an understanding of the spectrum of subsidy beneficiaries that may reside in the facilities. Below, in Table 1, the two key subsidy categories and related features are provided.

Table 1. Subsidy Categories

Full Subsidy	<ul style="list-style-type: none"> • Medicare beneficiaries with limited savings and income below 135 percent of the federal poverty level can enroll in a plan that has: <ul style="list-style-type: none"> ○ A \$0 deductible. ○ A \$0 premium. ○ Continuation of coverage beyond the initial coverage limit. ○ Co-pays of not more than \$2 for generics and preferred multiple source drugs and not more than \$5 for other drugs up to the out-of-pocket limit. ○ No co-pays for prescriptions beyond the out-of-pocket limit. ○ Medicare beneficiaries who are full-benefit dual eligibles with income at or below 100% of poverty will have co-pays reduced to \$1 for generics and preferred multiple source drugs and \$3 for other drugs up to the out-of-pocket limit. No co-pays for prescriptions beyond the out-of-pocket limit. • <i>Beneficiaries who are full benefit dual eligibles and reside in an institution will have no co-payments.</i>
Partial Subsidy	<ul style="list-style-type: none"> • Beneficiaries with limited savings and income below 150 percent of the federal poverty level but at or above 135 percent of the federal poverty level can enroll in a plan that has as a general matter: <ul style="list-style-type: none"> ○ A sliding scale monthly premium that is between \$0 and \$27.29 or up to 75% of the highest regional benchmark. * ○ A \$50 deductible.* ○ Continuation of coverage beyond the initial coverage limit. ○ Coinsurance of 15 percent up to the out-of-pocket limit.* ○ Co-pays of no more than \$2 for generics and preferred multiple source drugs and no more than \$5 for other drugs up to the out-of-pocket limit. <p>(*NOTE: The benefit structure for plans may vary.)</p>

A complete table of LIS categories developed by CMS can be found in **Attachment B**.

Certain groups of Medicare beneficiaries will automatically qualify for the low-income subsidy program. These beneficiaries include full-benefit dual eligible individuals, Medicare beneficiaries who are recipients of Supplemental Security Income benefits, and participants in Medicare Savings Programs (Qualified Medicare Beneficiaries (QMBs), Specific Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs).

Beneficiaries with low incomes and limited resources who do not fall into one of the automatic subsidy eligibility groups must apply for a low-income subsidy. Their eligibility for subsidy assistance will be determined by either the Social Security Administration (SSA) or the state Medicaid office. For beneficiaries that apply for the subsidy, the type of income to be counted will be based on the rules of the Supplemental Security Income program.

CMS has worked with SSA to develop a model, simplified application form and process that SSA will use for the determination and verification of an eligible beneficiary's income and resources. The application form consists of an attestation under penalty of perjury regarding a beneficiary's level of assets or resources and their valuation. While some documentation may be required, beneficiaries won't have to bring volumes of files with them when they apply. States can assist individuals who present themselves at state Medicaid offices in completing an SSA application, with the state sending the completed SSA applications to SSA for processing.

V. Enrollment Periods

There are three major enrollment periods. There is an initial enrollment period; an annual enrollment period; and special enrollment periods.

- **The initial enrollment period:** Runs from November 15, 2005 through May 15, 2006. After May 15, 2006, penalties may be incurred.
- **The annual enrollment period:** Runs from November 15 through December 31 of every year and coverage beginning on January 1 of the following year.
- **Special election periods (SEPs):** These allow a beneficiary to disenroll from one Part D plan and enroll in another without regard to the initial or annual periods.

SEPs are extremely important for all beneficiaries in a LTC facility, including full dual eligibles. All full benefit dual eligibles may disenroll from a Part D plan and enroll in another Part D plan. A beneficiary in a LTC may disenroll from his or her current Part D plan and enroll in another. An individual may change plans when he or she moves into, resides in, or moves out of a:²

² CMS PDP Guidance, Eligibility, Enrollment and Disenrollment, August, 2005.

- Skilled nursing facility (SNF);
- Nursing facility (NF);
- Intermediate care facility for persons with mental retardation (ICF/MR);
- Psychiatric hospital or unit;
- Rehabilitation hospital or unit;
- LTC hospital; or a
- Swing-bed hospital.

In addition, for individuals who move out of one of the facilities listed above, the individual will have an SEP for up to 2 months after he/she moves out of the facility. The effective date is the first of the month following the month in which the enrollment/disenrollment request is received, but not prior to the month residency begins.

VI. Part D Application Completion

A Medicare beneficiary is generally the only individual who may execute a valid enrollment or disenrollment request from a Part D plan. However, another individual could be the legal representative or appropriate party to execute an enrollment or disenrollment request as the law of the state in which the beneficiary resides may allow. CMS will recognize state laws that authorize persons to affect a Part D enrollment or disenrollment request for Medicare beneficiaries. For example, persons authorized under State law may be court-appointed legal guardians or persons having durable power of attorney for health care decisions, provided they have authority to act for the beneficiary in this capacity.

If a Medicare beneficiary is unable to sign an enrollment form or disenrollment request due to reasons such as physical limitations or illiteracy, state law governs whether another individual may execute the request on behalf of the beneficiary. Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, check state laws regarding the authority of persons to sign for and make health care treatment decisions for other persons. When someone other than the Medicare beneficiary completes an enrollment request, he or she must:

- Attest that he or she has the authority under state law to make the enrollment request on behalf of the individual;
- Attest that a copy of the proof of other authorization required by state law that empowers the individual to affect an enrollment request on behalf of the applicant is available upon request by the Part D plan or CMS. Acceptable documentation may include items such as court-appointed legal guardianship or durable power of attorney; and
- Provide contact information.

Representative payee status (as designated by SSA) is not necessarily sufficient to enroll or disenroll a Medicare beneficiary. Where Part D plans are aware that an individual has

a representative payee designated by SSA to handle the individual's finances, Part D plans should contact the representative payee to determine his/her legal relationship to the individual, and to ascertain whether he/she is the appropriate person, under state law, to execute the enrollment or disenrollment request.

VII. Assistance with PDP Selection and Marketing Guidelines

AHCA has requested clarification regarding when a LTC facility may assist a resident of a LTC facility in making decisions about enrollment in a PDP plan. However, CMS prohibits providers from steering, or attempting to steer an undecided potential enrollee toward a plan, or limited number of plans, offered either by the particular Part D plan or another plan, based on the financial interest of the provider or agent, (or their subcontractors). CMS indicates that it is concerned with provider activities for the following reasons:

- Providers may not be fully aware of all Plan benefits and costs;
- Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the Plan vs. acting as the beneficiary's provider; and
- The potential for financial gain by the provider steering a beneficiary's selection of a plan could result in recommendations that do not address all of the concerns or needs of a potential plan enrollee.

The CMS marketing guidelines released August 15, 2005 provide some indication of what actions nursing facilities can undertake in order to ensure patient access to drugs under Part D through education about the benefit and aide in enrolling in Part D plans. Below is a list of broad activities nursing facilities can and cannot undertake relative to Part D. Facilities might use this list as a framework for developing Part D outreach and enrollment action plans.

Nursing Facilities can:

- Distribute marketing materials prepared by PDPs, MA-PDs, or their own facility or management;
- Invite a representative of State Health Insurance Assistance program (SHIP) representative from a local Area Agency on Aging (AAA) or the local SSA office come in to explain Part D to residents;
- Assist residents with the completion of their applications;
- Discuss characteristics of plans and their formulary with residents; and
- Encourage residents to investigate and consider Part D coverage.

Nursing Facilities cannot:

- Accept compensation from a PDP, MA-PD, or LTCP to enroll residents into a particular plan or set of plans; and
- State directly that residents choose one plan, or from a set of plans.

See *Attachment C* for a side-by-side comparison of steps providers may and may not take according to CMS when assisting potential Part D enrollees with applications and plan decisions.

VIII. Coverage and Formularies

Part D will cover certain drugs that are available only by prescription, approved by the FDA, used and sold in the United States and prescribed for a medically accepted indication. This includes prescription drugs, biological products, insulin, and certain vaccines. It also includes medical supplies associated with the injection of insulin (i.e., syringes, needles, alcohol swabs, and gauze associated with the injection of insulin). There is no guarantee of coverage of every drug under every Part D plan formulary.

Certain categories of drugs, listed below, are expressly excluded from basic Part D coverage. However, plans can offer these drugs through enhanced plans at premiums greater than the basic premium. Since full dually eligibles will be automatically enrolled by CMS only in Part D plans with premiums that do not exceed the low income benchmark premium amount or the lowest Part D plan premium for basic coverage in the given region, these beneficiaries will probably not have access to the excluded drugs unless they or their families are able to enroll them in a plan that will cover these drugs at greater cost. The excluded drug categories that are of direct importance to LTC facility residents are the following:

- *Benzodiazepines*
- *Barbiturates*
- *Drugs for anorexia, weight loss or weight gain*
- *Nonprescription drugs*³

Since the drugs in question are excluded from basic Part D coverage, states are permitted to continue to provide these drugs through the Medicaid program. The states will get federal financial participation (FFP) for the cost of the drugs. To date, 33 states have announced that they will continue to cover Part D excluded classes to the extent that they are currently covered in their Medicaid programs. Two other states have indicated that are likely to continue such coverage. Finally, 15 states have not yet determined whether they will maintain Medicaid coverage for excluded classes. No states have yet announced that they will not continue to cover these drugs. The following chart summarizes state decisions about coverage of excluded classes.

³ Additional exclusions include:

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or hair growth
- Drugs used for symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs from which the manufacturer seeks to require that associated tests or monitoring devices be purchased exclusively from the manufacturer as a condition of sale

Table 2. State Medicaid Coverage Decisions for Part D Excluded Classes

Covering Excluded Classes		Likely to Cover Excluded Classes	No Coverage Decision Announced
Alaska	Nevada	Vermont	Alabama
Arkansas	New Jersey	South Carolina	Arizona
California	New Mexico		Colorado
Connecticut	North Carolina		Delaware
District of Columbia	North Dakota		Hawaii
Florida	Ohio		Louisiana
Georgia	Oklahoma		Maryland
Idaho	Oregon		Massachusetts
Illinois	Rhode Island		Michigan
Indiana	South Dakota		Mississippi
Iowa	Texas		Missouri
Kansas	Utah		New Hampshire
Kentucky	Virginia		New York
Maine	Washington		Pennsylvania
Minnesota	West Virginia		Tennessee
Montana	Wyoming		Wisconsin
Nebraska			

Source: Avalere Health, LLC

In 2004, United States Pharmacopeia (USP), under a CMS contract issued model Part D formulary guidelines, which list 146 unique therapeutic categories and pharmacologic classes. While Part D drug plan sponsors are not required to use the model guidelines, conformance with the USP guidelines would: a) protect a plan from charges that its *formulary classifications* violate the MMA by discouraging enrollment of certain individuals; b) increase the likelihood of bid approval since the guidelines are one of the components that CMS considers during its Part D drug review process. CMS also will look into other plan benefit designs, including tiered cost-sharing formulary structures, P&T committee utilization and structure, utilization management policies and processes, and exceptions and appeals processes, to ensure that the other plan benefit design features do not discourage enrollment by certain classes of Part D eligible individuals.

Part D plan formularies are generally required to include at least two Part D drugs within each therapeutic category and class of Part D drugs that are not therapeutically equivalent and bioequivalent, with different strengths and dosage forms available for each of those drugs. Plans also are required to provide adequate coverage of the types of drugs most commonly needed by Part D enrollees, as recognized in national treatment guidelines. For instance, plans will be expected to offer “complete treatment options for a variety of medical conditions,” such as asthma, diabetes, depression, lipid disorders, hypertension, and HIV. While a plan will not be required to include every Part D drug on its formulary, the agency has the discretion to find that failure to include a specific drug would substantially discourage enrollment by beneficiaries with a condition that may only be treated by that drug.

Formularies must include “all or substantially all” of the drugs in the antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant and HIV/AIDS categories. CMS formulary guidance explicitly stated that its requirements for these six categories of drugs are consistent with its review of commonly-used formularies. In addition, many state Medicaid programs allow direct access to drugs within these six categories, even where the drugs are not included on the state’s preferred drug list (PDL).

IX. Exceptions/Appeals

Beneficiaries or their designated representatives can appeal the results of the coverage determination (exceptions) process. All drug plans are required to have a timely coverage determination process, and CMS will review each plan’s coverage determination process to ensure that it provides a timely and fair opportunity to review coverage decisions. The timeframe for making coverage determinations is no later less than 72 hours for standard requests or 24 hours for expedited requests.

If a drug is not covered or is covered at a more expensive cost sharing tier level, an appeal referred to as an “exception” can be filed. If the plan does not make a coverage determination within 72 hours or within 24 hours for expedited requests, the request is automatically forwarded to the Independent Review Entity (IRE) level which is a CMS contractor that reviews determinations made by a plan. If the IRE’s reconsideration is unfavorable, an enrollee may request a hearing with an Administrative Law Judge (ALJ) if the amount in controversy requirement is satisfied. If the ALJ’s decision is unfavorable, the enrollee may appeal to the Medicare Appeals Council (MAC), an entity within the Department of Health and Human Services that reviews ALJ’s decisions. If the MAC’s decision is unfavorable, the enrollee may appeal to a federal district court, if the amount in controversy requirement is satisfied.

CMS released guidance specific to individuals residing in nursing facilities that states that plans must cover an emergency supply of medications. CMS provided for protection of nursing facilities, which must comply with state and Federal regulations for emergency fill of prescriptions. CMS recommends that plans cover an emergency fill while processing an exception or appeal request for non-formulary drugs. It is unclear at this time whether this recommendation would cover the entire appeals process or whether it implies coverage through the initial appeal (i.e. through an initial 24 or 72 hours).

X. Coverage During Transition Processes

In addition to mandating that all Part D plans must cover a temporary supply of non-formulary part D drugs while an exception is being adjudicated, CMS has required Part D plans to establish an appropriate transition process for new enrollees who are transitioning to Part D from other prescription drug coverage, and whose current drug therapies may not be included in their Part D plan’s formulary. CMS will review the plan’s transition process as part of the formulary and plan benefit design review. CMS indicates that the issue of transition is important both with respect to initiating and changing enrollment in plans and transitioning from one level of care to another.

A. Part D Plan Transitions:

- The initial transition of beneficiaries to the Medicare prescription drug benefit on January 1, 2006;
- The transition of new enrollees after the initial implementation of the program; and
- The transition of individuals who switch from one plan to another after implementation of the benefit.

CMS states that the process for handling these transitions should address situations where an individual first presents at a participating pharmacy with a prescription for a drug that is not on the formulary, unaware of what is covered by the plan or what is included in the plan's exception process to provide access to Part D drugs that are not covered. CMS expects that plan sponsors would consider processes such as the filling of a temporary one-time transition supply, referred to as a "first fill" in order to accommodate the immediate need of the beneficiary and to allow the plan and/or the enrollee time to work out with the prescriber an appropriate switch to another medication or the completion of an exception request to maintain coverage of an existing drug based on reasons of medical necessity.

- "First fill" supply of 30 days for non-LTC facility beneficiaries: CMS states that a temporary "first fill" supply of 30 days may be reasonable for new enrollees who first present at a pharmacy with a prescription for a drug not on the formulary so that the plan and/or enrollees may contact the provider to work out appropriate therapeutic substitutions or to allow the enrollee and the provider time to request exceptions for continued access to Part D drugs not on the plan's formulary.
- "First fill" supply of 90 to 180 days for LTC facility beneficiaries: CMS states a longer "first fill" period for LTC residents: CMS recommends that a transition period of 90 to 180 days might be appropriate for residents of LTC facilities on multiple medications who require some changes to their medication regimen in order to accommodate plan formularies.

B. Level of Care Change Transitions:

CMS refers to these transitions as unplanned and indicates that these circumstances usually involve level of care changes in which a beneficiary is changing from one treatment setting to another. CMS provides examples such as beneficiaries who enter LTC facilities from hospitals and are sometimes accompanied by a discharge list of medications from the hospital formulary, with very short term planning taken into account (often under 8 hrs). Similar situations may exist for beneficiaries who are discharged from a hospital to a home; for beneficiaries who end their LTC facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert back to their Part D plan formulary; for beneficiaries who give up hospice status to

revert back to standard Medicare Part A and B benefits; and for beneficiaries who are discharged from chronic psychiatric hospitals with medication regimens that are highly individualized.

CMS acknowledges that for these unplanned transitions, beneficiaries and providers need to utilize the plan's exceptions and appeals processes.

- Non-LTC Facility Beneficiaries: CMS encourages plans to adopt a one-time temporary or emergency supply process as a method for ensuring that enrollees do not have a coverage gap while proceeding through the plan's exceptions process.
- LTC Facility Beneficiaries: As indicated above, in the section on appeals, CMS in guidance has provided that all Part D plans must cover a temporary supply of non-formulary part D drugs while an exception is being adjudicated. However, CMS has not clarified whether the temporary supply is to be provided through the full course of an appeal that goes up to a federal district court.

XI. Conclusion.

The combination of Part D plan options, LIS eligibility and determination, and variance in plan formularies and related exception/appeals and transition processes – each specific to each plan -- will increase the administrative responsibilities for LTC facilities. In the coming weeks, AHCA will develop a Part D operations guidance document for LTC facilities that will provide explicit guidance for facilities on how to change admissions and daily operations changes in order to prepare for the new Medicare prescription drug benefit.

Attachment A
Part D Web Resources by Category
Prepared by Avalere Health, LLC

Current News

Centers for Medicare & Medicaid Services (CMS) Partner Center News:

<http://www.cms.hhs.gov/partnerships/news/default.asp>

CMS Pharmacy MMA Information page at:

<http://www.cms.hhs.gov/medicarerreform/pharmacy/>.

CMS SPAP Contact List: Programs Coordinating Benefits with Part D Plans. It contains contact info for SPAPs by state. The document is available at:

<http://www.cms.hhs.gov/pdps/SPAPContactList.pdf>

CMS “Press Kit” dealing with the low-income subsidy. It includes a link to the SSA application, a calendar, and a document that discusses the basics of drug coverage. :

<http://www.cms.hhs.gov/medicarerreform/presskit.asp>.

CMS LIS fact sheet page: <http://www.cms.hhs.gov/medicarerreform/factsheets.asp>.

Medicare Updates: <http://www.aoa.gov/medicare/index.asp>. (Administration on Aging)

Medicare Rx Education Network Media Center:

<http://www.medicarerxeducation.org/media-center.htm> (Medicare Rx Education Network)

Medicare News and Press Center:

http://my.webmd.com/content/pages/16/98840.html?z=4241_00001_1502_00_06
(WebMD)

MedlinePlus Latest News: <http://www.nlm.nih.gov/medlineplus/medicare.html> (National Institutes of Health)

Brochures and Fact Sheets

CMS Part D Plan List Page

<http://www.cms.hhs.gov/map/charts/nationalprescriptiondrugplanorganizations.pdf>.

Part D Plans and ICF/MR Contracting

<http://www.cms.hhs.gov/pdps/Intrstd3rdPrtyInfo.asp>

Voice of the Retarded Part D Webpage

<http://www.vor.net/Medicare%20Part%20D%20Dual%20Eligibles.htm>

Medicare Current Publications List:

<http://www.medicare.gov/Publications/Search/Results.asp?PubName=prescription+drugs&PubCat=All%7CAI+Publications&Type=NameCat&Language=English&pagelist=Home&dest=NAV%7CHome%7CSearch%7CResults%7CSearchCriteria&comingFrom=13&version=default&browser=IE%7C6%7CWinXP> (CMS)

CMS Prescription Drug Coverage for Nursing Home Residents and Other Long Term Care Facilities: <http://www.medicare.gov/Publications/Pubs/pdf/11121.pdf>

CMS What Medicare Prescription Drug Coverage Means to You: A Guide to Getting Started: http://www.cms.hhs.gov/medicarerereform/91007_MedicareBrochure.pdf

CMS “Medicare Covers America” tri-fold brochure in English:

<http://www.cms.hhs.gov/medicarerereform/DrugCovisavailEnglish.pdf>

CMS “Medicare Covers America” tri-fold brochure in Spanish

<http://www.cms.hhs.gov/medicarerereform/DrugCovisavailSpanish.pdf>

CMS General Part D Timeline (color poster):

<http://www.cms.hhs.gov/medicarerereform/pdbma/GeneralTimeline.pdf>

CMS Beneficiary Calendar (color poster):

<http://www.cms.hhs.gov/partnerships/calendar/BeneficiaryCalendar.pdf>

Beneficiary Calendar in Spanish (color poster)

http://www.cms.hhs.gov/partnerships/calendar/SPMedicareRxCalendar_062005.pdf

Fact Sheets, Tip Sheets, and Mailings for Specific Medicare Beneficiary Populations:

<http://www.cms.hhs.gov/medicarerereform/factsheets.asp> (CMS)

Medicare Outreach Posters for Low-Income Subsidy:

<http://www.socialsecurity.gov/organizations/medicareoutreach2/posters.htm> (SSA)

CMS Frequently Asked Questions about Retiree Drug Coverage and the New Medicare Prescription Drug Coverage: <http://www.cms.hhs.gov/medicarerereform/pdbma/11162-retireefact-web.pdf>

AARP Part D Information Center

http://www.aarp.org/health/medicare/drug_coverage/guide_to_the_new_medicare_prescription_drug_covera.html

Medicare Rx Education Network:

<http://www.medicarerxeducation.org/> (Medicare Rx Education Network)

Pharmaceutical Research and Manufacturers of America, "The New Drug Benefit: FAQs and Glossary": <http://www.phrma.org/publications/publications//2005-04-28.1167.pdf>

Families USA Medicare Rx Calculator:

http://www.familiesusa.org/site/PageServer?pagename=medicare_calc

Access to Benefits Coalition (ABC)BenefitsCheckUpRx®:

<http://www.accesstobenefits.org/Helpful%20Resources/Tools%20You%20Can%20Use/default.aspx#decision>

ABC Decision Support Tools for Making Enrollment Decisions:

<http://www.accesstobenefits.org/Helpful%20Resources/Tools%20You%20Can%20Use/default.aspx#decision>

CMS Search Tool for State Health Insurance Counseling Programs:

<http://www.medicare.gov/contacts/Static/SHIPs.asp?dest=NAV%7CHome%7CRelatedWebsites%7CSHIPs>

Medicare Drug Benefit Calculator: <http://www.kff.org/medicare/rxdrugscalculator.cfm> (KFF)

State Pharmacy Assistance Program Search Tool:

<http://www.aarp.org/bulletin/prescription/statebystate.html> (AARP)

Medicare Drug Benefit Consumer Handout:

http://www.medicarerights.org/partd_onepager.pdf (Medicare Rights Center)

National Patient Advocate Foundation "What Does Medicare Part D Mean for Me?"

<http://www.patientadvocate.org/index.php?p=299>

National Patient Advocate Foundation, "A Greater Understanding Medicare Modernization Act of 2003's Prescription Drug Coverage through Part D":

http://www.patientadvocate.org/pdf/paf_medicare_partd.pdf

Medicare 101

Medicare Modernization Act homepage: <http://www.cms.hhs.gov/medicarereform/> (CMS)

CMS Outreach Toolkit for Providers: <http://www.cms.hhs.gov/medlearn/provtoolkit.pdf>

Medicare Prescription Drug Coverage Scripts for Partners (to use in talking to beneficiary subpopulations): <http://www.cms.hhs.gov/partnerships/news/mma/scripts.pdf> (CMS)

Medicare Preferred Terminology to Use with Beneficiaries:

<http://www.cms.hhs.gov/partnerships/tools/materials/preferredterms.pdf> (CMS)

Vignettes (to explain how Medicare Part D works with and affects other types of health care coverage): <http://www.cms.hhs.gov/partnerships/news/mma/vignettesfinal.pdf> (CMS)

Tools You Can Use to Help Enroll Medicare Beneficiaries with Limited Incomes

<http://www.accesstobenefits.org/Helpful%20Resources/Tools%20You%20Can%20Use/default.aspx> (ABC)

Fact Sheet on Low-Income Assistance Under the Drug Benefit:

<http://waysandmeans.house.gov/media/pdf/healthdocs/lowincome1.pdf> (House Ways & Means Committee)

MedLearn Matters (for providers):

<http://www.cms.hhs.gov/medlearn/matters/default.asp?link=mma> (CMS)

Caregiver Publications:

<http://www.cms.hhs.gov/partnerships/tools/materials/caregiversresources/default.asp> (CMS)

Talking About Medicare and Health Coverage:

<http://my.webmd.com/content/article/101/106085> (WebMD)

Resources on the Medicare Drug Benefit: <http://www.kff.org/medicare/rxdrugdebate.cfm> (KFF)

Medicare Drug Benefit Resource Area:

<http://www.chcf.org/topics/healthinsurance/drugbenefit/index.cfm?CFID=1232460&CFTOKEN=66241879> (California Healthcare Foundation)

Medicare Drug Coverage 101: Everything You Need to Know:

<http://www.medicarerights.org/newlawframeset.html> (Medicare Rights Center)

Prescription Drug Benefit Q&A:

http://www.reformmedicare.org/New_Medicare/RxCoverQ_A/rxcoverq_a.html (Alliance to Improve Medicare)

Medicare Resource Center for Pharmacists: <http://www.medicareresourcecenter.com/>

(National Community Pharmacists Association)

FamiliesUSA Medicare Central Information Clearinghouse:

http://www.familiesusa.org/site/PageServer?pagename=Medicare_Central_Index&autologin=true&JServSessionIdr009=gjeer14u11.app20a

Health Assistance Partnership About the Medicare Prescription Drug Benefit:
<http://www.healthassistancepartnership.org/site/PageServer?pagename=MedicareRxDrugBill>

Center for Medicare Advocacy Medicare Part D Information:
http://www.medicareadvocacy.org/FAQ_PrescDrugs.htm

American Academy of Family Physicians FAQs: The New Medicare Prescription Drug Coverage (for providers): <http://www.aafp.org/x37352.xml>

American Academy of Family Physicians Medicare Prescription Drug Coverage (info for providers): <http://www.aafp.org/x37342.xml>

Events/Presentations/Webcasts

Centers for Medicare & Medicaid Services events:
<http://www.cms.hhs.gov/events/default.asp>

CMS Partner Center News-- Webcasts About Medicare Prescription Drug Coverage:
<http://www.cms.hhs.gov/partnerships/news/>

CMS Part D Plan Finder Tool webcast: <http://media.cms.hhs.gov/>

National *Medicare & You* Training workshops: <http://www.2005medicaretraining.com>
(CMS)

National Medicare & You Training Online Course:
<http://www.cms.hhs.gov/partnerships/tools/materials/medicaretraining/default.htm>
(CMS)

Webcast on the Basics of the Medicare Program:
http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1431
(Henry J. Kaiser Family Foundation (KFF))

Recent and Upcoming SSA Events in the Philadelphia Region (Maryland, Pennsylvania, Delaware, District of Columbia, Virginia, West Virginia):
<http://www.ssa.gov/phila/community.htm#upcoming>

Upcoming SSA Events in the Denver Region (Colorado, Minnesota, Montana, North Dakota, South Dakota, Wyoming, Utah): <http://www.ssa.gov/denver/findevents.htm>

Information about Partnering with SSA to Sponsor an Event in the New York Region (New Jersey, New York, Puerto Rico, U.S. Virgin Islands):

<http://www.ssa.gov/ny/community.htm>

Upcoming SSA Events in the Seattle Region (Alaska, Idaho, Washington, Oregon):

<http://www.ssa.gov/seattle/events/FindEvents.htm>

National Association of Community Health Centers (NACHC) Annual Conference:

<http://www.nachc.org/>

Community Health Center Week: <http://www.healthcenterweek.com/> (NACHC)

Medicare Rx Forums: <http://www.medicareresourcecenter.com/> (National Community Pharmacists Association)

Medicare Part D Local Training Calendar:

<http://www.asaging.org/medicare/calendar.cfm> (American Society on Aging)

“Why Medicare Prescription Drug Coverage Matters to You” webcast:

<http://www.cms.hhs.gov/cable/> (CMS Medicare Covers America series)

“Getting the Most out of Medicare” webcast:

<http://www.videonews.com/event.asp?id=27373> (National Kidney Foundation)

Medicare: How It’s Changing to Help More People teleconference series for Healthcare Professionals: <http://www.kidneydrugcoverage.org/index.htm> (Kidney Medicare Drugs Awareness and Education Initiative)

Center for Medicare Advocacy Web-based Seminar: The Medicare Part D Prescription Drug Program: Ready or Not, Here it Comes!:

http://www.medicareadvocacy.org/Projects_WebSeminars.htm#PDDrugs

Health Assistance Partnership Upcoming Events: What Do the Part D and Medicare Advantage Marketing Rules Mean for Beneficiaries? Plus a Conversation About Counseling on Part D Plan-Selection-Decision-Making Factors:

<http://www.healthassistancepartnership.org/site/PageServer?pagename=Medicare&JServSessionIdr010=jabgu4p9y2.app6b>

How to Enroll/Applications

Low-income Subsidy Application: <https://s044a90.ssa.gov/apps6a/i1020/main.html> (Social Security Administration (SSA))

CMS Part D Online Enrollment Center (Expected to be available in November 2005)

CMS Medicare Prescription Drug Plan Price Comparison Tool: (Expected to be available October 13, 2005)

Special Populations

HORIZONS Communication Toolkit for Outreach (for populations with barriers to receiving healthcare information due to language, literacy, location or culture):

<http://www.cms.hhs.gov/partnerships/tools/materials/horizons/default.asp> (CMS)

Medicare Information for the Hispanic Population:

<http://www.hispanichealth.org/medicare.lasso> (National Alliance for Hispanic Health)

Su Familia Health Helpline: <http://www.hispanichealth.org/helplines.lasso> (National Alliance for Hispanic Health)

Center for Medicare Advocacy and National Multiple Sclerosis Society Medicare Education Advocacy Project Introduction to Medicare for People with Multiple Sclerosis:

http://www.medicareadvocacy.org/FAQ_MS.htm

National Multiple Sclerosis Society Basic Facts about Medicare Rx Coverage for People with Multiple Sclerosis: http://www.nationalmssociety.org/medicare_basics.asp

The New Medicare Drug Plan and Beneficiaries With Mental Illness:

http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/The_New_Medicare_Drug_Plan_and_Beneficiaries_with_Mental_Illness.htm (National Alliance for the Mentally Ill)

American Psychiatric Association Medicare Part D Information (for mental health physicians):

http://www.psych.org/psych_pract/pract_mgmt/MedicarePartDInfoRev.pdf

Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who are Nursing Home Residents or Live in Certain Types of Long-term Care Facilities

<http://www.cms.hhs.gov/medicarerreform/nursing%20home.pdf> (CMS)

Information Partners Can Use on People with Medicare and HIV/AIDS:

<http://www.cms.hhs.gov/medicarerreform/AIDS.pdf> (CMS)

Medicare Information for Diabetes Patients: <http://www.diabetes.org/advocacy-and-legalresources/healthcare/healthinsurance/medicare.jsp>

(American Diabetes Association)

For Anyone with Kidney Disease and Medicare:

http://www.kidneydrugcoverage.org/patients_fs_wysk.htm (Kidney Medicare Drugs Awareness and Education Initiative)

Quick Facts about Medicare Prescription Drug Coverage for People who Have Medicare and Get Housing Assistance from the Department of Housing and Urban Development: <http://www.cms.hhs.gov/medicarerreform/hud.pdf> (CMS)

Quick Facts about Medicare's New Coverage for Prescription Drugs for People with Limited Income and Resources: <http://www.medicare.gov/Publications/Pubs/pdf/11105.pdf> (CMS)

Quick Facts about Medicare's New Coverage for Prescription Drugs for People who Get Supplemental Security Income Benefits or Help from Their State Medicaid Program Paying Their Medicare Premiums: <http://www.medicare.gov/Publications/Pubs/pdf/11116.pdf> (CMS)

Quick Facts about Medicare's New Coverage for Prescription Drugs for People with Medicare and Medicaid, and Medicaid Now Pays for Their Prescription Drugs: <http://www.medicare.gov/Publications/Pubs/pdf/11106.pdf> (CMS)

Quick Facts about Medicare's New Coverage for Prescription Drugs if you Applied for Extra Help: <http://www.medicare.gov/Publications/Pubs/pdf/11130.pdf> (CMS)

[Quick Facts about Medicare's New Coverage for Prescription Drugs for People who Get Help from Their State Pharmacy Program to Pay for Their Prescriptions:](http://www.medicare.gov/Publications/Pubs/pdf/11108.pdf) <http://www.medicare.gov/Publications/Pubs/pdf/11108.pdf> (CMS)

CMS guidance for Submitting Prescription Drug Event Data: Rules for PACE Organizations: <http://www.cms.hhs.gov/pdps/FinalPace051005.pdf>

Ensuring Continuity of Care for Dual Eligibles with Mental Retardation and Developmental Disabilities: A Guide to Transition From Medicaid to Medicare's Prescription Drug Coverage: <http://www.theDesk.info/PartD>.

SSA subsidy outreach plan (March 1, 2005). Includes outreach timeline, activities to be performed, places they'll be going to perform outreach and groups they will be reaching out to and working with: http://www.cms.hhs.gov/medicarerreform/states/SSA_OutreachPlan.pdf

CMS MMA guide for state legislators (March 2005): <http://www.cms.hhs.gov/medicarerreform/states/mmaguide.pdf>

Attachment B. CMS Low-Income Subsidy Categories

FPL & Assets*	Percentage of Premium Subsidy	Deductible	Co-payment up to out-of-pocket limit	Co-payment above out-of-pocket limit
Full benefit dual eligibles	100%	\$0	1. Institutionalized individuals-\$0. 2. <=100% FPL—The lesser of \$1-generic/preferred multiple source or \$3-other drugs or, the amount charged to other individuals with income below 135% FPL with assets <=\$6,000/<=\$9,000. 3. All other full benefit dual eligibles-- \$2-generic/preferred multiple source-\$5-other drugs.	None
<135% FPL <=\$6,000 <=\$9,000	100%	\$0	\$2-generic/preferred multiple source-\$5-other drugs.	None
<135% FPL >\$6,000-<=\$10,000 >\$9,000-<=\$20,000	100%	\$50	15 percent coinsurance	No more than \$2 for a generic or preferred multiple source drug or \$5 for other drugs
>=135%-<150% <=\$10,000 <=\$20,000	Sliding Scale Premium Subsidy (100%-0%)	\$50	15 percent coinsurance	No more than \$2 for a generic or preferred multiple source drug or \$5 for other drugs

* 2006 assets figures are shown for individuals first, and then couples.

** The premium subsidy is equal to the percentage shown in the above table of the greater of the low-income benchmark premium amount or the lowest basic PDP premium in the region. It also cannot exceed the basic premium for drug coverage under the prescription drug plan selected.

Attachment C.
CMS Model “Can” and “Cannot” Do List
Provider Interactions with Potential Plan Enrollees

Providers Can	Providers Cannot
<ul style="list-style-type: none"> • Provide the names of plans with which they contract and/or participate. (This provision is not clear regarding application to LTC facilities. While LTC facilities do not contract with or participate in plans, their LTC pharmacies do. This provision perhaps suggests that LTC facilities may be able to tell residents the names of plans with which their LTC pharmacies contract. AHCA is trying to get clarification;) • Provide information and assistance in applying for the limited income subsidy; • Provide objective information on specific plan formularies, based on a particular patient’s medications and health care needs; • Provide objective information regarding specific plans, such as covered benefits, cost sharing, and utilization management tools • Distribute PDP marketing materials, including enrollment application forms. Note: Provider must inform individuals where they can obtain information on all available options within the service area (i.e., 1-800-MEDICARE or medicare.gov). • Distribute MA and/or MA-PD marketing materials, including enrollment application forms. NOTE: Provider must inform individuals where they can obtain information on all available options within the service area (i.e., 1-800-MEDICARE or medicare.gov). • Refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, Plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, CMS’s Web site at http://www.medicare.gov/, or calling 1-800-MEDICARE; • Print out and share information with patients from CMS’s Web site; and • Use comparative marketing materials comparing plan information created by a non benefit/service providing third-party. 	<ul style="list-style-type: none"> • Direct, urge, or attempt to persuade, any prospective enrollee to enroll in a particular plan or to insure with a particular company based on financial or any other interest of the provider (or subcontractor); • Collect enrollment applications; • Offer inducements to persuade beneficiaries to enroll in a particular plan or organization; • Health screen when distributing information to patients, as health screening is a prohibited marketing activity; • Offer anything of value to induce Plan enrollees to select them as their provider; • Expect compensation in consideration for the enrollment of a beneficiary; and • Expect compensation directly or indirectly from the plan for beneficiary enrollment activities.