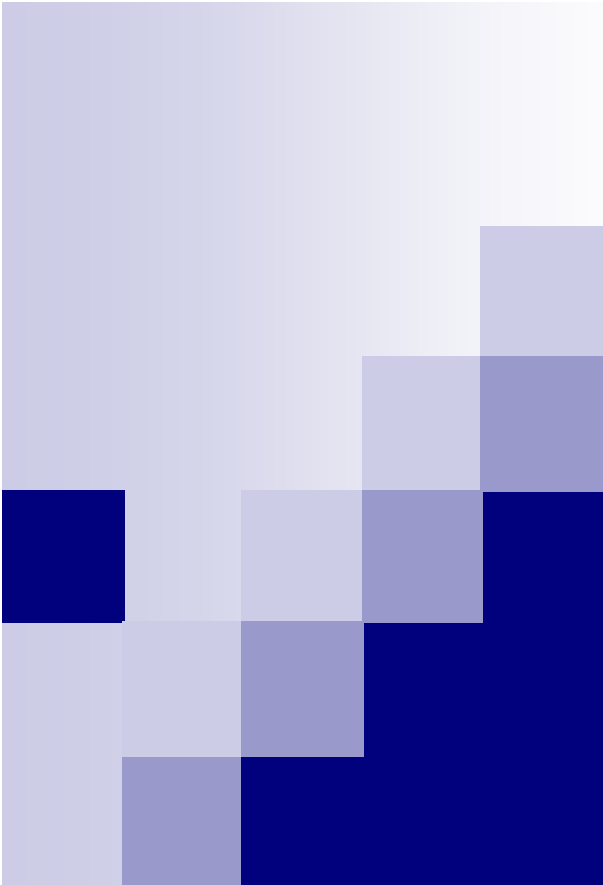




Medicare Prescription Drug Benefit

*2005 Primary Health Care All Grantee Meeting
June 2005*

Centers for Medicare & Medicaid Services



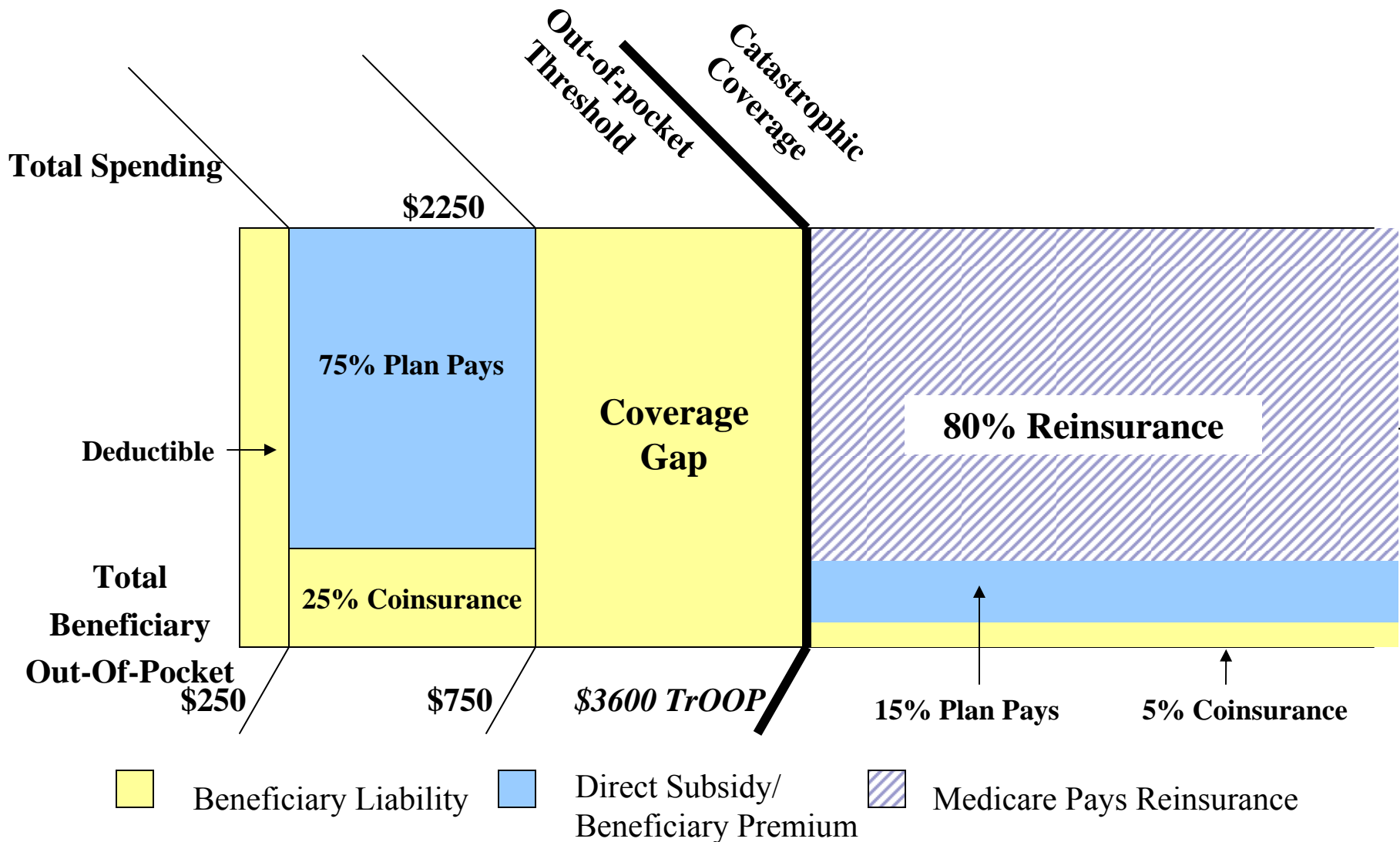
The Part D Benefit Structure



Benefit Design: Standard Coverage

- Defined standard benefit in 2006:
 - \$37 estimated monthly premium
 - \$250 beneficiary deductible
 - Beneficiary cost-sharing of 25% between \$251 and \$2,250 in total drug expenditures
 - Beneficiary cost-sharing of 100% of drug costs between \$2,250 and \$5,100 in total drug expenditures (“the coverage gap”)
 - After \$3,600 in true out-of-pocket (TrOOP) spending, or \$5100 in total drug expenditures, beneficiary must pay only the greater of \$2/\$5 copays or 5% coinsurance
- Actuarially equivalent standard coverage varying defined standard benefit cost-sharing (e.g., by using tiered cost-sharing designs) may also be offered

Standard Benefit in 2006





Benefit Design: Alternative Coverage

- Alternative coverage:
 - Basic alternative coverage is actuarially equivalent to the defined standard benefit
 - Enhanced alternative coverage has an actuarial value greater than the defined standard benefit
- Enhanced alternative coverage includes supplemental benefits, which are limited to:
 - Further cost-sharing reductions (e.g., filling in the coverage gap, lowering the deductible)
 - Coverage of drugs excluded as Part D drugs



TrOOP/Incurred Costs

- TrOOP (true out-of-pocket costs)/"incurred costs" is the amount a beneficiary must spend on covered Part D drugs to reach catastrophic coverage. It is based on the standard benefit design:
 - \$250 deductible
 - + \$500 beneficiary coinsurance during initial coverage
 - + \$2,850 coverage gap
 - = \$3,600
- The above numbers are for 2006 and will increase by law in subsequent years
- Part D premium is not part of TrOOP



TrOOP/Incurred Costs (§423.100)

- Payments count toward TrOOP if:
 - They are made for covered Part D drugs (or drugs treated as covered Part D drugs through a coverage determination or appeal)
 - They are made by:
 - The beneficiary
 - Another “person” on behalf of a beneficiary
 - CMS as part of the low-income subsidies
 - A State Pharmaceutical Assistance Program (SPAP)



TrOOP/Incurred Costs (§423.100)

- Payments DO NOT count toward TrOOP if they are made by:
 - A group health plan
 - Insurance or otherwise
 - Another third-party payment arrangement
- Examples of entities whose wraparound coverage does not count toward TrOOP:
 - MA plans
 - PACE organization
 - SCHIP program
 - Medicaid, including 1115 waiver programs
 - VA or TRICARE
 - Indian Health Service
 - AIDS Drug Assistance Programs (ADAPs)
 - Federally Qualified Health Centers (FQHCs)



Coordination of Benefits (§423.464(a))

- COB must ensure effective coordination with regard to:
 - Payment of premiums and coverage
 - Payment for supplemental prescription drug benefits
- Coordination elements include: (1) enrollment file sharing; (2) claims processing, payment, and reconciliation reports; and (3) application of protection against high out-of-pocket expenditures
- CMS will establish COB requirements before the statutory deadline of July 1, 2005



Coordination of Benefits (§423.464(a) and (f))

- Plans must permit the following entities to coordinate benefits:
 - State Pharmaceutical Assistance Programs (SPAPs)
 - Medicaid programs (including 1115 waiver programs)
 - Group health plans
 - FEHBP plans
 - TRICARE and VA
 - IHS
 - Rural Health Centers
 - Federally Qualified Health Centers
 - Other entities as CMS determines



Implementing TrOOP

- CMS will implement new electronic COB system for tracking of TrOOP expenditures
- Solution CMS will use was developed with technical input from a variety of experts and builds on existing technologies providing electronic support for pharmacy transactions nationwide
- CMS recently awarded contract to TrOOP Facilitation Contractor



Contracting with Safety- Net Pharmacies



Contracting with Safety-Net Providers

- Part D plans are not required to contract with safety-net providers
- In order to receive reimbursement for covered Part D drugs, however, safety-net pharmacies must participate in Part D plan networks
- Generally, only retail pharmacies count toward plans' TRICARE access requirements
- As an incentive to contract with some of these providers, we allow plans to count FQHCs and RHCs toward the TRICARE access requirements.



Contracting with Safety-Net Providers

- HRSA (with CMS input) has developed materials for Part D plans to facilitate contracting with safety-net pharmacies:
 - Model contract addendum
 - List of safety-net pharmacies and their locations
 - Fact sheet on safety-net pharmacies
- HRSA materials should be available on HRSA's website (with a link from CMS's website) shortly
- CMS will make plans aware that the materials are finalized via our own communication channels with Part D plan applicants
- Plan network information is due to CMS August 1.



Part D Eligibility & Enrollment




Eligibility for Medicare Prescription Drug Coverage

- An individual is eligible for Medicare prescription drug coverage, provided that he or she
 - Is entitled to Part A OR enrolled in Part B
 - Lives in the service area of a prescription drug plan plan



Enrollment Options

- Someone who is eligible for Medicare Rx coverage can enroll in a
 - Prescription Drug Plan (PDP) or
 - Medicare Advantage Prescription Drug plan (MA-PD plan)
- Generally, someone must have Medicare Part A and Part B to join a Medicare Advantage Plan.
- Current MA members will generally be assigned to an MA-PD.




What is the low-income subsidy?

- Provides people with limited income and resources extra help with their Medicare prescription drug plan costs, including their premiums and cost sharing.
- A person must enroll in a Medicare prescription drug plan to receive this assistance.



Who is eligible?

- People with limited income (\$14,355/single and \$19,245) and resources (less than \$11,500/single and \$23,000/couple).
- Certain groups are automatically eligible for a full subsidy.
- These groups are:
 - Full-Benefit Dual Eligible Individuals (People with Medicare and full Medicaid benefits)
 - SSI recipients (but no Medicaid)
 - Medicare Savings Program Groups (QMBs, SLMBs, and QIs)



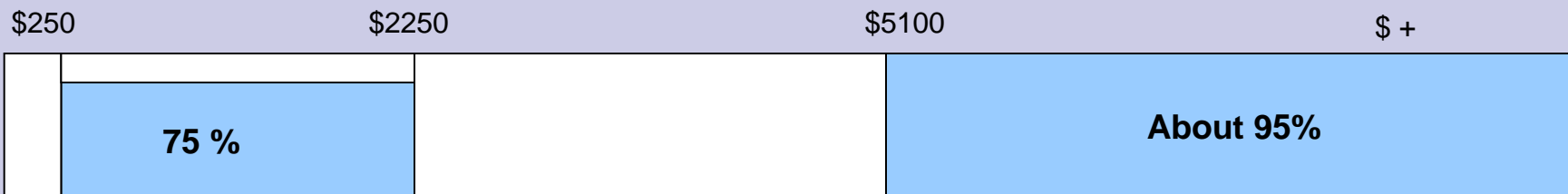
What is the amount of assistance available?

- Full Subsidy (Deemed groups)
 - Full premium assistance up to the premium subsidy amount.
 - Nominal cost sharing up to out-of-pocket threshold. (\$1/\$3, \$2/\$5)
 - No coverage gap.
- Other Low-Income Subsidy
 - Sliding scale premium assistance.
 - Reduced deductible.
 - Reduced coinsurance.
 - No coverage gap.

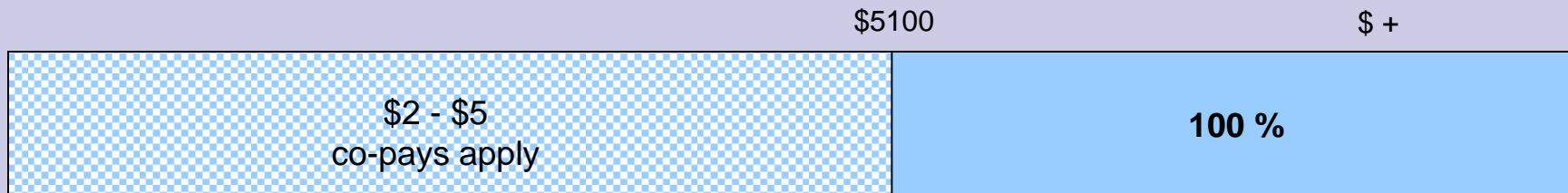
Numbers are for 2006

Plan Pays
Beneficiary Pays

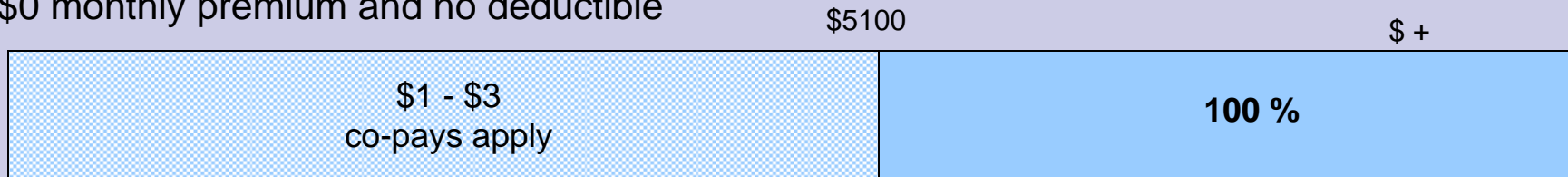
Standard Drug Benefit for beneficiaries with income >150% FPL or less than 150% FPL but more than the resource limit
\$37 monthly estimated premium



Full-benefit dual eligibles with income >100% FPL
\$0 monthly premium and no deductible



Full-benefit dual eligibles with income ≤ 100% FPL*
\$0 monthly premium and no deductible

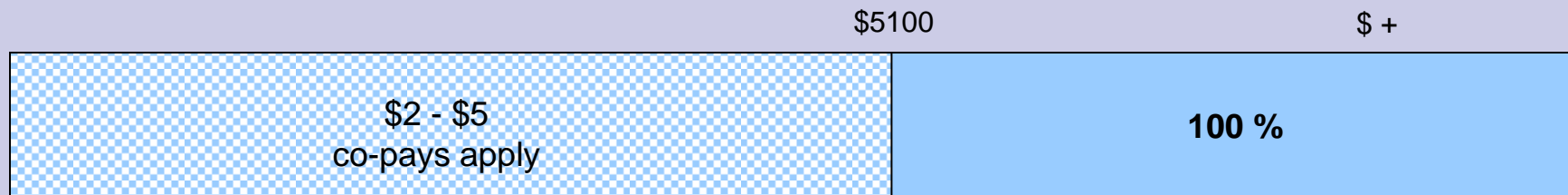


*Cost sharing is \$0 if the beneficiary is a full-benefit dual eligible and institutionalized.

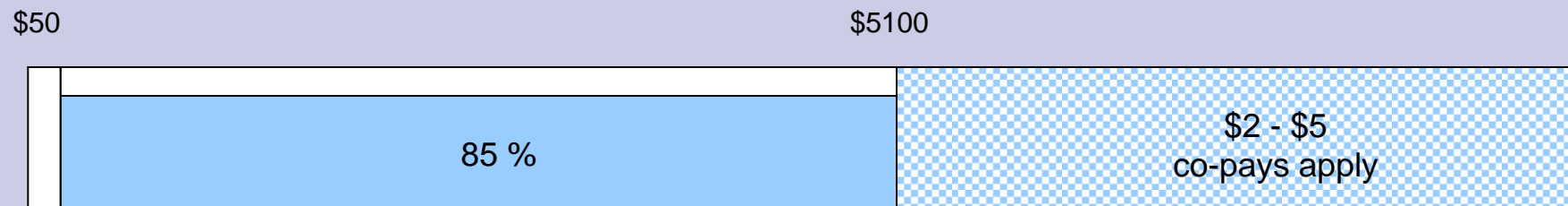
Numbers are for 2006


 Plan Pays
 Beneficiary Pays

SSI Recipients, Medicare Savings Programs Groups, Applicants with income < 135% FPL who also meet resource test (\$7,500 individual / \$12,000 couple)
\$0 monthly premium and no deductible



Applicants with income <150% FPL who also meet resource test
(\$11,500 individual / \$23,000 couple)
Sliding scale premium assistance

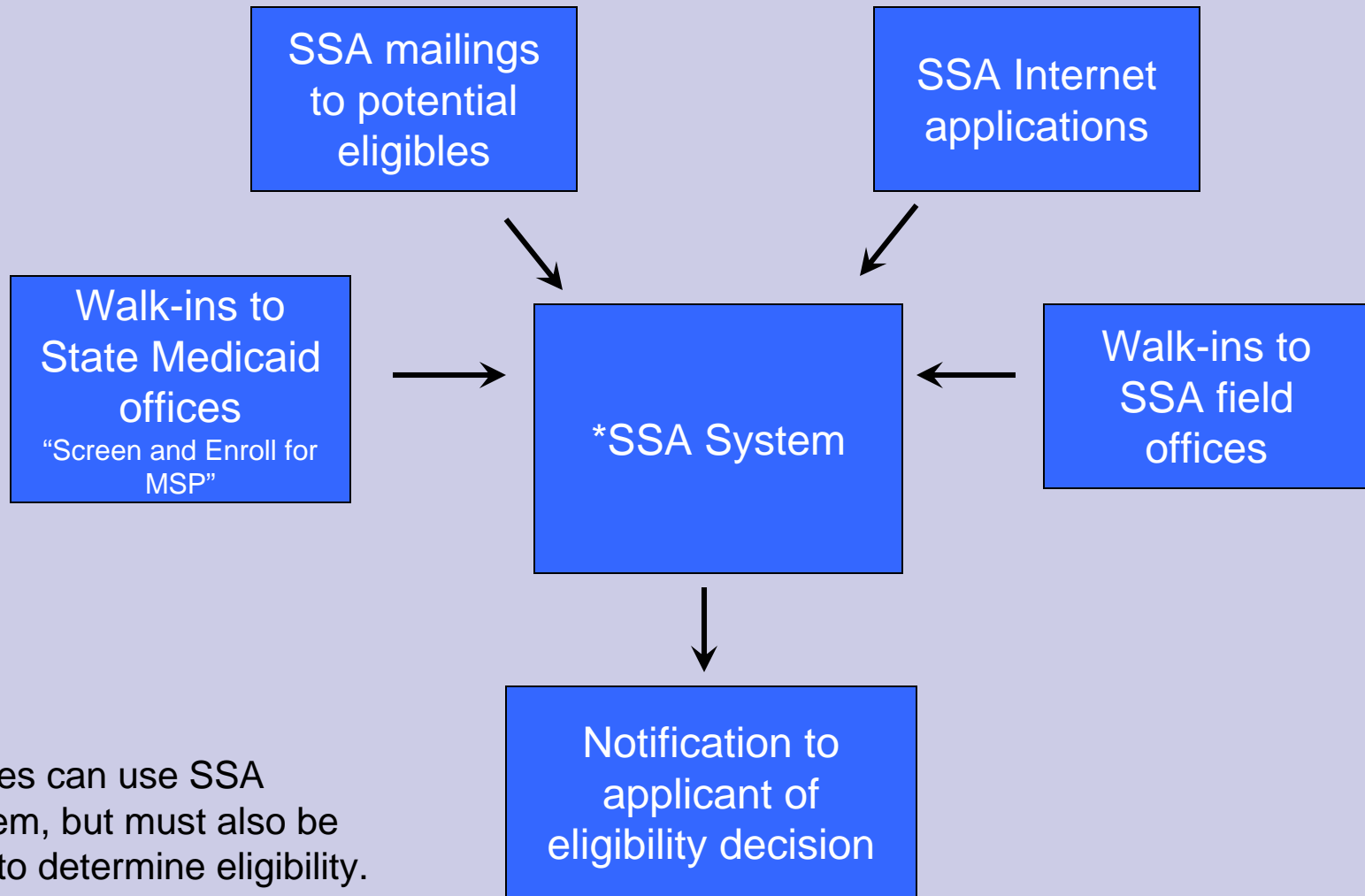




How will people know they automatically qualify?

- CMS will notify beneficiaries who are deemed eligible for the low-income subsidy and do not need to apply.
- This notice will explain the following:
 - On January 1, 2006, all people with Medicare can get Medicare prescription drug coverage.
 - Some people will get mail from SSA telling them to apply to get help. You don't need to apply for this help.
 - This fall 2005, your "Medicare and You 2006" handbook will include information about how to pay for your drug costs and what you need to do.
 - Medicaid will stop paying for your prescription drug coverage after December 31, 2005. (Specific to dual eligible notice)

How does someone apply?



*States can use SSA System, but must also be able to determine eligibility.



Auto-Enrollment Procedures

- LIS Application + Plan Enrollment =
Drug Coverage
- Full-benefit dual eligible beneficiaries will be enrolled based on where they currently get their Medicare Part A and/or Part B benefits, and the amount of the prescription drug plan's premium.
- Dual eligibles have a permanent Special Election Period and can change plans at any time.



Auto-Enrollment Notification

- Starting in October and monthly thereafter, CMS will notify full-benefit dual eligibles of their auto-enrollment.
- This notice will provide:
 - An explanation of how to choose a Medicare prescription drug plan.
 - The name of the Medicare prescription drug plan that Medicare will enroll them in if they don't choose a plan by 12/31/2005. We will also include that plan's toll free member services number and website.
 - A reminder that their Medicaid drug coverage ends 12/31/2005; they qualify for extra help with their drug plan costs; and they can change plans at anytime.
 - An explanation of their right to affirmatively decline Part D.
 - The 1-800-MEDICARE number for questions.



Facilitated Enrollment Procedures and Notification

- CMS is going to facilitate the enrollment of additional categories of beneficiaries if they do not choose a plan on their own by the end of the initial enrollment period.
- These categories include MSPs, SSI recipients, and people who apply and are determined eligible for the low-income subsidy.
- Starting in April 2006, we will notify these individuals if they do not choose a plan by May 15, 2006, then we will facilitate their enrollment in a plan on their behalf, with coverage effective June 1, 2006.



Key Dates Leading up to Enrollment

- Mid-May to Early June – CMS starts mailing to people who automatically qualify for the low-income subsidy and do not need to apply.
- End of May to Mid-August – SSA mails low-income subsidy application to potential eligibles.
- Mid-June – CMS mails notice to SSI-only population who are deemed eligible for the low-income subsidy.
- Mid-September – Final plan approvals.



Key Dates Leading up to Enrollment

- In October, CMS conducts the following activities:
 - Mails the 2006 Medicare and You handbook with comparative drug plan information to every beneficiary in the country.
 - Begins monthly mailing schedule of deemed notices.
 - Notifies full-benefit dual eligibles of the plan in which Medicare will enroll them, effective Jan. 1, 2006, if they do not choose a plan on their own by Dec. 31, 2005.
 - Notifies Medicare prescription drug plans of the dual eligible beneficiaries assigned to their plan.



Key Dates for Enrollment

- November 15th – Enrollment begins.
- December 31st –
 - Last day to enroll for a January 1st effective date.
 - Full-benefit dual eligibles must opt-out of their assigned plan by this date or they will be auto-enrolled.
 - Medicaid drug coverage ends for full-benefit dual eligibles.
- January 1st – Medicare prescription drug coverage begins.



Key Dates for Enrollment

- February – CMS mails a reminder notice to people who have not yet enrolled in a plan.
- April – CMS mails a notice to people who qualify for the low-income subsidy, identifying the plan in which Medicare will facilitate their enrollment, effective June 1, 2006, if they do not choose a plan on their own by May 15, 2006.
- May 15th – Initial Enrollment Period ends for people who are currently eligible.



SPAP Timeline

July 1

- Give further qualified SPAP guidance to SPAPs.
- Share qualified SPAP checklist with SPAPs.
- Release Q&A's on qualified SPAPs on our website.

July 29

- Deadline for SPAPs to submit checklist and narrative

August 12

- Deadline for CMS to review checklists and narratives.

August 19

- CMS posts SPAP master chart on the web, including qualified SPAP status.



Part D Transitional Issues



Comprehensive Drug Benefit

- Formulary review process
 - Rely on existing best practices
 - No discrimination through formulary design
 - Includes review of tiering, prior authorization rules, step therapy
 - Work with outlier plans



Drug Categories

- Based on USP categories and classes
- At least two drugs per category and class
- Comparison to American Hospital Formulary System if not USP structure
- Substantially all drugs required in 6 drug classes (including antidepressants, antipsychotics, HIV drugs)



Formulary: Excluded Part D Drugs

What is excluded as a Part D drug?

- Drugs for which payment “as so prescribed and dispensed or administered” to an individual is available under Parts A and B
- Drugs/classes of drugs which may be excluded under Medicaid, except for smoking cessation agents (excluded drugs may be paid for by Medicaid)



Formulary: Excluded Drugs

- Agents when used for anorexia, weight loss, or weight gain;
- Agents when used for anorexia, weight loss, or weight gain;
- Agents when used to promote fertility;
- Agents when used for cosmetic purposes/hair growth;
- Agents when used for symptomatic relief of cough & colds;
- Prescription vitamins & mineral products (except prenatal vitamins & fluoride preparations);
- Nonprescription drugs;
- Covered outpatient drugs when manufacturer seeks to require associated tests or monitoring as a condition of sale;
- Barbiturates;
- Benzodiazepines



Transition Requirements

- Each plan must establish transition requirements
- No authority to require continued coverage, but strongly encouraged



Appeals Overview

- Modeled after Medicare Advantage
- Efficient, accessible “last resort”
- Same structure, shorter time frames
 - Coverage determination—24/72 hours
 - Redetermination—72 hours/7 days
 - IRE Reconsideration—72 hours/7 days
- Shorter timeframes are for “expedited” cases where a person’s life is in jeopardy.



Coverage Determinations

- Tiering Exceptions—obtain higher tiered drug at lower-tier cost sharing terms
- Formulary exceptions—obtain Part D covered drugs that are not on formulary
- Also includes all other payment/benefit issues



Providers and the New Medicare Prescription Drug Coverage



Medicare Covers America

- National grass roots and grass tops campaign.
- Designed to point people with Medicare to local resources that can help them fill out applications and help them choose a plan.
- Committed to reaching families with news about Medicare drug coverage where they live, work, play and pray.



Medicare Covers America

- Recognize the value of their clinical time and that 49% of the people with Medicare will be contacting their provider to ask what they think of the benefit.
- Trying to simplify the message and provide local resources and expertise that can help patients directly.



Medicare Covers America

- There is new coverage that pays for medicine for anyone who receives Medicare, no matter what their income.
- There is extra help for your patients who need it.
- For those that get a letter from the Social Security Administration, “If in doubt, fill it out.”



Medicare Covers America

- Target audience for our part of the campaign
 - Physicians, nurses, receptionists, accounts billable, nurse managers, administrators and office managers.
- Target sites
 - Offices, community and rural health clinics, hospitals, home health agencies, etc.



Objectives

- Create confidence within physician offices that the benefit is a good thing for their patients, worth exploring and there are local resources ready to help them apply for the coverage.
- Provide access to local resources so that referral is not a burden to the physician office.
- Create alliances to further the grass roots education effort.



Strategy

- Recruit and supply groups to be conduits for message.
- Customize kits of materials for providers/office staff that make it easy to refer to local partners.
- Assure that all CMS contacts with providers explain the imperative to encourage beneficiaries to explore their options.
- Provide peer to peer coaching and testimonials about the drug coverage and the importance to patients



Provider Strategy

- Ads, PSA, journal and provider articles.
- Cooperative education effort with more than 60 societies and associations.
- Educational videos, cable television, physician offices
- Printed materials in the doctor's offices designed to help patients make good choices.
- Partner tool kit with educational items.
- Provider tool kit with materials designed to help the office and bedside encounter become more efficient.

Checking Up on Your Family's Health Plan

Are your loved ones getting the Medicare services they need and deserve?

It's easy to find out.

1-800-MEDICARE
(1-800-633-4227)
TTY users, call
1-877-486-2048

[www.
medicare.
gov](http://www.medicare.gov)

Age: 41 | Age: 65

- Occupation: Teacher
- Worries about her mother
- Needs her annual physical
- Wonders how her mom will pay for the medicine she needs on a fixed retirement income
- Helped her mom research the benefits and services she qualifies for at www.Medicare.gov
- Looking forward to a family reunion this fall
- Occupation: Retired
- Doesn't want to be a burden to her kids
- Already had one—when she turned 65, and qualified for Medicare
- Covered by Medicare Prescription Drug Coverage, starting January 1, 2006
- Calls 1-800-MEDICARE (1-800-633-4227) to ask questions about her plan
- Ditto!



Medicare_{Rx}
Prescription Drug Coverage

Make the Medicare Connection ...Together



Are you and your family covered?

People with Medicare are entitled to:

- Regular diabetes screenings
- Glaucoma tests
- Colorectal cancer screening
- Annual flu and pneumonia shots
- And many, many more services
- A Welcome to Medicare physical upon joining

Did you also know starting January 1, 2006, Medicare prescription drug coverage will be available to all Medicare members? You can get this new coverage by joining a Medicare prescription drug plan starting in November. Find out if you or a loved one qualify to ensure everyone in your family receives the best health care possible.

1-800-MEDICARE
(1-800-633-4227)
TTY users, call
1-877-486-2048

**www.
medicare.
gov**





Tactics

- Work with Medicare contractors to expand the information.
- Use web-education effort to create awareness of the coverage and the ease of referring patients.
- Deploy partner detail and outreach resources to focus on equipping the physician offices with needed tools.



Measures of Success

- Increased physician referrals 1-800 Medicare or SHIPs;
- Increased traffic to Medline, Medscape, Medlearn, and other DHHS websites for more information;
- Increased downloads of partnership kit;
- Increased distribution of physician partnership kit
- Number of cards and flyer calls received as a result of WebMD distribution
- Increased number of articles in professional publications.
- Increased response to list serves.



Challenges

- Increased response to list serves.
- Patients must apply for extra help this summer.
- Patients must choose a plan by December 31, 2005 in order to get benefits by January 2006
- Coverage is most affordable when purchased early – before May 15, 2006.
- The best plan option will be determined by the medicines that patient takes and the location of the pharmacies. CMS will have an online tool to help select the best plan available in October.



What we need to know

- What are the best tools to talk about this coverage in the office or health setting?
- What is an effective electronic strategy to generate awareness with health professionals?
- How can we make referral to 1-800-MEDICARE or the SHIPs easy for providers?



Where we could use your help

- Explain to health care professionals that this is a good resource for their patients and one worth exploring.
- Encourage providers to link up with local state health insurance programs and other volunteer groups to help get patients covered.
- Engage your difficult to reach populations in understanding the benefit and urging them to apply for extra help through SSA and Medicaid offices.



Questions

