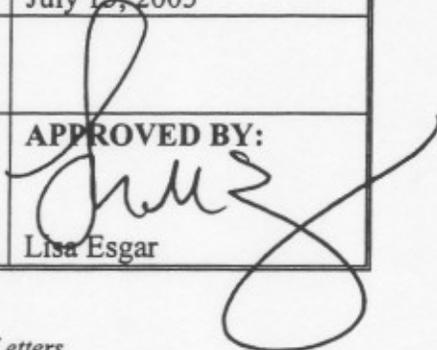


Colorado Department of Health Care Policy and Financing 1570 Grant St., Denver, CO 80203-1818	NUMBER: HCPF 05-009
	CROSS REFERENCE:
DIVISION OR OFFICE: Operations and Finance Office	DATE: July 15, 2005
SUBJECT AREA: Medicare Part D	
SUBJECT: Background Information Regarding Medicare Part D	APPROVED BY:  Lisa Esgar
TYPE: Informational	

*HCPF Agency Letters can be accessed online at:
www.hcpf.state.co.us >>Reference Material >>Agency Letters*

Purpose:

The purpose of this letter is to provide counties with information regarding the Medicare Part D prescription drug benefit that will become effective January 1, 2006. Most of this information is not required for county agency staff, but could be very helpful in understanding how the new Medicare benefits will affect you clients. Please share this agency letter with all affected Adult, LTC and MSP Medicaid eligibility staff, supervisors and outside agencies, as appropriate.

Background:

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) establishes a new Part D program for prescription drug coverage. The prescription drug benefit will be managed by the Federal Centers for Medicare and Medicaid Services (CMS) and administered by private health plans. On January 1, 2006, responsibility for most outpatient Part D prescription drugs will be transferred from Medicaid to Medicare.

Those people who have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance), can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. If they join by December 31, 2005, their Medicare prescription drug plan coverage will begin on January 1, 2006. If they join after that, their coverage will become effective the first day of the month after the month they join. In general, they can join or change plans once each year between November 15 and December 31.

1. Prescription drug benefit.

For individuals who are only eligible for Medicare, enrollment into this federal program is voluntary. Those individuals are not required to participate in the prescription drug

benefit. Individuals who are both Medicaid and Medicare eligible (dual eligibles) are deemed eligible for the drug benefit and they will be automatically enrolled if they do not choose a plan. The deemed eligible population that are not in nursing facilities or ICFMRs will pay a small co-payment for their prescription drugs, will have no deductible and no monthly premium payment. The deemed eligible population who are in nursing facilities will have no co-payment, no deductible and no monthly premium payment because those payments will be covered by CMS through the low-income subsidy.

2. Low-income Subsidy (LIS).

The Medicare drug benefit includes a low-income subsidy. The subsidy will assist Medicare beneficiaries who have limited financial means (limited resources and income below 150% of the federal poverty level) to pay for co-payments, gaps in coverage, deductibles or premiums, depending upon their resources and income. Eligibility for low-income subsidies will be determined by the Social Security Administration (SSA) or state Medicaid eligibility sites. Additional information regarding the low-income subsidy is set forth in Agency Letter Number HCPF 05-010.

There are three main functions that counties will have to perform to comply with MMS.

1) Effective July 1, counties must be prepared to provide Social Security Administration applications for low-income subsidies to clients who request them, and assist them with filling them out. In such cases, SSA is responsible for all redeterminations, appeals, and noticing.

2) Counties must also process applications for those clients who INSIST on using the State process. In the beginning, the Department will put in place a manual process to meet these federal requirements. It is expected that the State will create a Colorado Application then have those applications sent to a central location for processing. Once CBMS has been revised to accommodate this screening, counties will be required to screen applying clients who INSIST on using the State process in CBMS. In such cases, the county and State are responsible for all redeterminations, appeals, and noticing.

3) Counties must screen applicants for low-income subsidies in CBMS for eligibility for Medicaid programs. For clients who complete an SSA low-income subsidy application, and who are not dual-eligibles, SSA will send notices informing them that they may be eligible for Medicaid and to go to their local Medicaid office for screening. For clients who apply under the State-insisted process, counties will screen these clients for Medicaid through CBMS when they apply for the low-income subsidy.

To help the federal government fund this benefit, states will pay a "clawback" to the federal government to defray a portion of the Medicare drug expenditures. Each state will pay 90% of the estimated savings in the first year (January 2006). The percentage decreases from 90% to 75% over a ten-year period. After the tenth year, the states will continue to pay 75% as long as Part D exists. The estimated savings are calculated by the federal government. The amount paid

to the federal government is based on a 2003 estimate therefore may not be proportionate to the amount Colorado would have actually spent on dual eligibles.

Procedure/Information:

For full benefit dual eligible individuals, CMS will hold an open enrollment period for the drug benefit from November 15, 2005 through December 31, 2005. Full benefit dual eligibles will have the option to enroll in any plan up to December 31, 2005. If they fail to voluntarily enroll in a prescription drug plan, they will be enrolled into the plan assigned by CMS by December 31, 2005. CMS will notify them of this option. Clients in Medicare Savings plans have until May 2006 to enroll at which time they will be auto-enrolled if they have not selected a plan by then.

As indicated, beginning January 1, 2006, Medicare will provide coverage for most prescription drugs to dually eligible beneficiaries. Drugs that are excluded from coverage under Part D may be covered by the Department of Health Care Policy and Financing. The Department will provide additional information regarding the specific drugs that will be covered at a later time.

In general terms, non-covered Part D drugs include agents when used for anorexia, weight loss, weight gain; agents used for cosmetic purposes or hair growth; agents used for the symptomatic relief of cough and colds; agents used to promote fertility; prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; nonprescription drugs; barbiturates and benzodiazepines. Colorado has statutory permission to cover these drugs.

Plans must have at least two drugs in each category and class unless only one drug exists in that category and class or there are only two drugs and one is determined to be clinically superior than the other. The two drugs per category/class is meant to be a floor rather than a norm or ceiling. CMS expects that most formularies will contain more than two drugs per category and class in order to maintain a good clinical formulary. Limited coverage could lead to medical complications, resulting in additional costs to the state as secondary payer (primary on long term care).

CMS has a responsibility under the MMA to make sure beneficiaries receive clinically appropriate medications so that formularies are not discriminatory. CMS decided that antidepressants, antipsychotics, anticonvulsants, anticancers, immunosuppressants, and HIV/AIDS drugs would have to be on plan formularies and that beneficiaries should have uninterrupted access to all drugs in these classes. CMS has consistently explained that this meant that access to "all or substantially all" drugs in these specific categories needed to be addressed by plan formularies. Beneficiaries should be permitted to continue utilizing a drug in these categories that is providing clinically beneficial outcomes. Therefore, CMS is expecting formularies to include substantially all drugs in these six categories that are available on January 1, 2006 (including generics and older branded products). Drugs that come onto the market after January 1, 2006 will be subject to the normal Pharmacy and Therapeutic Committee review process. This policy is in place for 2006, the first year of the Medicare drug benefit and a unique year in terms of a large number of beneficiaries transitioning to new formularies. They will reevaluate the formulary guidance for these categories for 2007.

The law requires that drug plans have exceptions processes when people wish to challenge the exclusion of a particular drug from the formulary. Beneficiaries should contact their plan first when they find out that their drug isn't on the formulary or is a "non-preferred" drug to request an "exception". Under such an exception, a non-formulary drug could be covered, or a non-preferred drug could be covered under the terms applicable for a preferred drug under certain conditions. Plans will have flexibility to design their exceptions criteria. Plans must grant exceptions when they determine that it is medically appropriate to do so. If the exception request involves a "non-preferred" drug, the Part D drug being prescribed may be covered if the prescribing physician determines that the preferred drug for treatment of the same condition would not be as effective as the non-preferred drug or would have an adverse effect for the enrollee, or both. If the enrollee is requesting coverage of a non-formulary drug, the drug may be covered if the prescribing physician determines that all of the drugs on the formulary would not be as effective as the non-formulary drug or would have adverse effects for the enrollee, or both.

Requiring plans to use an exceptions process to review requests for coverage of non-formulary drugs will create a more efficient and transparent process and will ensure that enrollees know what standards are to be applied. In addition, this requirement is consistent with the industry standard where private plans allow enrollees to file exceptions to receive non-formulary medications. If the plan denies an exception, then the beneficiary can further appeal the plan's decision. In general, the appeals system will follow the Medicare Advantage process, which includes access to independent reviews of plan decisions. Beneficiaries, prescribing physicians, or beneficiaries' appointed representatives can begin the appeals process.

Food stamp and HUD recipients who qualify for extra help paying for a Medicare prescription drug plan will be better off enrolling in a Medicare prescription drug plan, even if this new coverage reduces their food stamp or HUD benefits. They will get significantly more help and protection in drug coverage than they will lose from the reduction in food stamps or HUD.

Beneficiaries who get help with home heating/cooling expenses through the Low Income Home Energy Assistance Program (LIHEAP) will not lose their energy assistance. States set eligibility levels for home energy assistance based on income without regard to your medical expenses.

If applicants have questions concerning the Medicare Part D program please have them:

- Call 1-800-MEDICARE (1-800-633-4227)
TTY users should call 1-877-486-2048
- Visit www.medicare.gov on the web
- Look for their "Medicare & You" handbook in the fall.
- Colorado Medicaid Customer Service at (303) 866-3513 or 1-800-221-3943 (outside the Denver Metro Area)

Effective Date:

Federal mailings began May 2005. Application processing for low income subsidy can begin July 1, 2005.

Enrollment into Prescription Drug Plans begin November 15, 2005 – May 15, 2006.

Medicare Part D prescription coverage begins January 1, 2006. Medicaid prescription coverage ends December 31, 2005.

Contact Persons:

Heather Hewitt, Adult Medical Assistance Specialist
303-866-5600
heather.hewitt@state.co.us

Medicaid Customer Service
303-866-3513 (Metro Denver), or
1-800-221-3943 (outside the Denver Metro Area).

To order an application forms, contact Social Security and ask for the *Application for Help with Medicare Prescription Drug Plan Costs (SSA-1020)*.

- Social Security Administration at 1-800-772-1213
(TTY 1-800-325-0778)