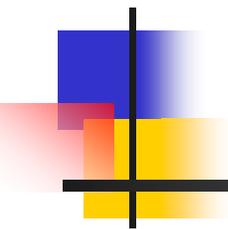


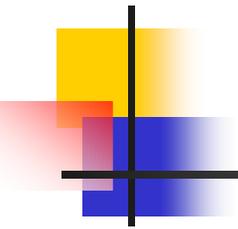
# MEDICARE PART D Legislative Overview



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April 7, 2005

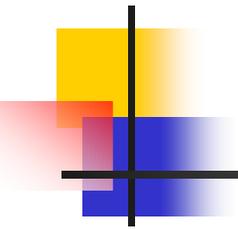
Michael P. Starkowski,  
Deputy Commissioner  
Department of Social Services



# Presentation Goals

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- Provide an overview of Medicare Part D
- Explain the Proposal for the Introduction of Medicare Part D for the Dual Eligibles
- Explain the Proposal for the Introduction of Medicare Part D for ConnPACE Clients
- Identify CT cost savings
- Outreach, Education & Resources



# Medicare Part D

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- Medicare Part D begins January 1, 2006
- New, voluntary Prescription Drug Plan (PDP) for all individuals who receive Medicare benefits
- Center for Medicare & Medicaid Services (CMS) will contract with entities to offer stand-alone PDPs
- Completed application to Social Security Administration (SSA) for subsidy eligibility determination is required
- Enrollment in CMS approved PDP is required

# What Will Medicare Part D Cover?



## Covered:

- Prescription Drugs
- Biological products
- Insulin (and supplies associated with the injection of insulin)
- Vaccines
- Compounded Drugs
- Parenteral Nutrition

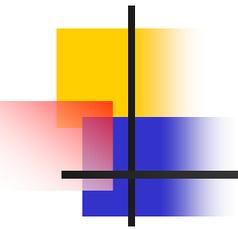
# What Drugs Will Medicare Part D Not Cover?



## Non-Covered:

- OTC's\*
- Weight loss
- Fertility
- Cosmetic
- Certain symptomatic relief of cough & colds\*
- Prescription Vitamins
- Barbiturates\*
- Benzodiazepines\*

\* May continue to be covered under Medicaid and ConnPACE to the extent they are currently covered

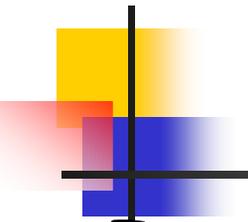


# CT Medicare Beneficiaries

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- CMS has 43 million Medicare beneficiaries nationwide
- According to CMS data, Connecticut has over 535,000 Medicare beneficiaries
  - Of this number of Medicare beneficiaries, we are estimating that approximately 81,000\* annually are receiving Rx benefits through Medicaid as dual eligible recipients
  - Of this number of Medicare beneficiaries, approximately 48,000 are presently receiving Rx benefits through ConnPACE

\* Unduplicated annual figure (at any given time, approximately 61,900 dual eligibles are receiving prescription benefits).



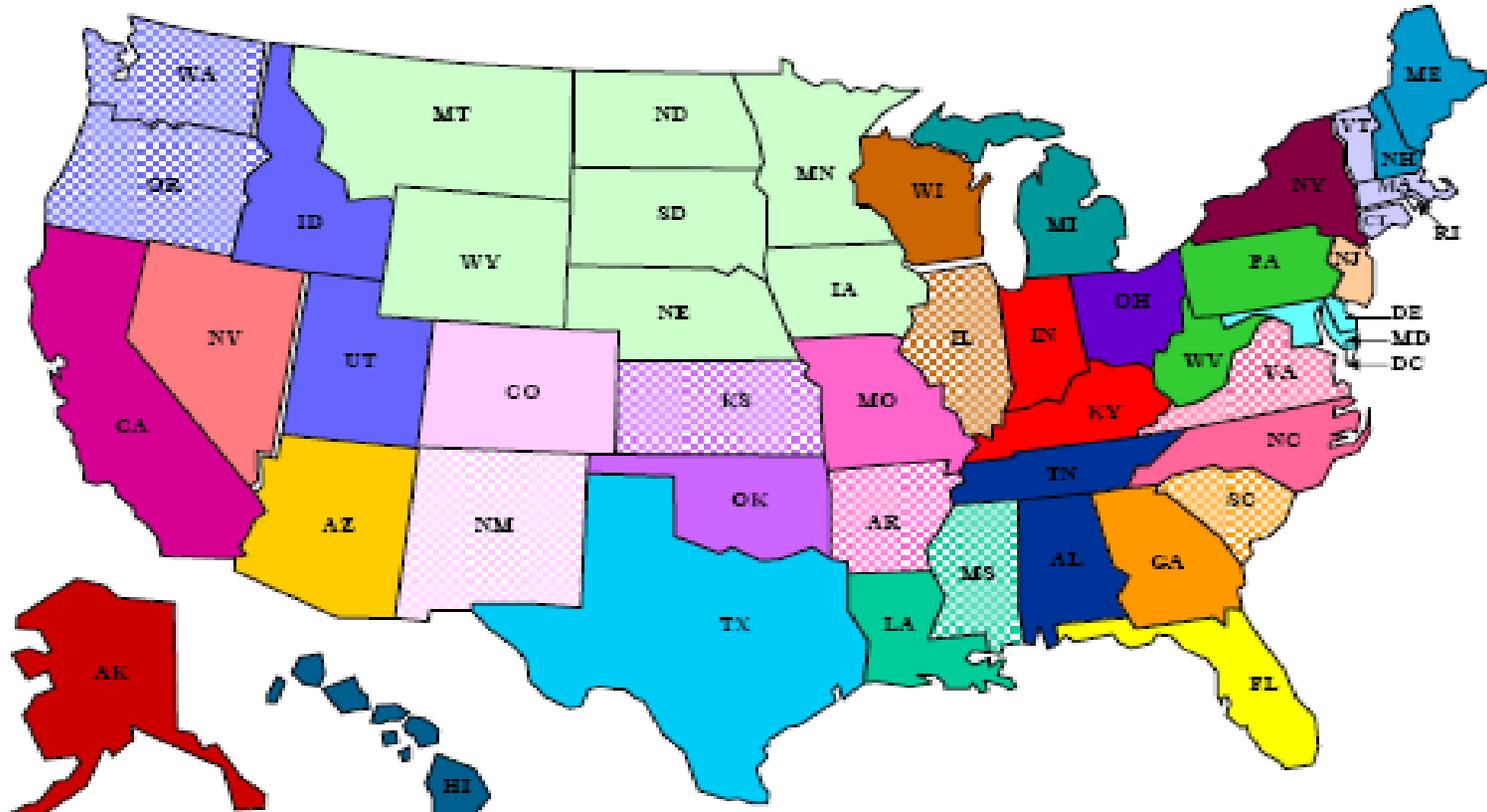
# Medicare Part D

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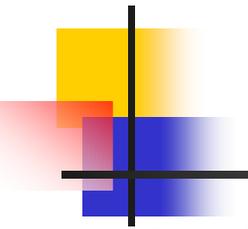
- Income and Asset levels determine co-pay, deductible, premium levels, and out-of-pocket limitations
- Two step process:
  - Beneficiary must apply and be determined eligible by SSA for a low-income subsidy
  - Beneficiary must select and enroll in a PDP
- CMS (Medicare) will auto-enroll full benefit Medicare/ Medicaid eligibles into a PDP if they do not choose one on their own
- Medicare will provide a choice of PDPs to choose from by region

# Medicare Advantage (MA) & PDP Regions

## MA and PDP Regions



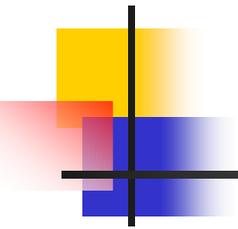
CT, VT, MA & RI  
will be serviced by the same PDPs



# Medicare Part D

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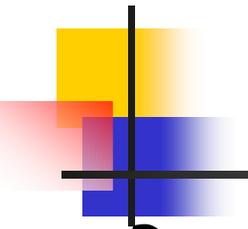
- PDPs will contract with pharmacies and mail order companies and offer various types of coverage
- Based on income, individuals may get a letter with an application from SSA - it is important that this information be filled out by the beneficiary
- SSA will determine if a beneficiary is eligible to receive additional financial assistance
- SSA and CMS will be providing information and notification to beneficiaries



# How Does The Subsidy & Application Process Work

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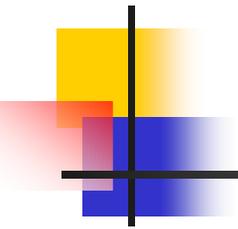
- Individuals can apply at SSA or the State Medicaid office
- Applicants can apply on-line, by phone, by mail, or in person - no financial documents will be necessary at the time of application. SSA will verify most through data matches.
- State responsibility for non-Medicaid
  - Effective 7/1/05, States must make low-income subsidy application forms available and provide assistance. The State is required to make low-income subsidy determination if requested to do so.
  - Medicare Part D beneficiaries must file enrollment with a PDP directly during the Initial Enrollment period of 11/15/05 to 5/15/06.
- Full Subsidy Eligibles : full benefit Medicare/Medicaid duals, SSI recipients, Medicare Savings Groups (QMB, SLMB, QI), institutionalized individuals, deemed as low income subsidy eligible by CMS, no application process required.



# Medicare Part D

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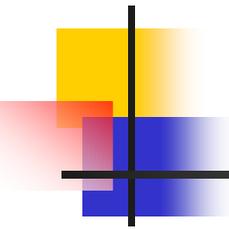
- Beneficiaries must enroll with a PDP directly
- Beneficiary has the option of selecting a PDP annually
- Dual eligible beneficiaries will have flexibility to change PDP more frequently
- Other beneficiaries can change plans only at open enrollment
- Clients level of subsidy from Medicare may differ depending on factors such as income and assets



# Standard Drug Benefit

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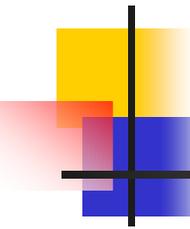
- The standard Part D benefit will have:
  - A \$250 annual deductible
  - A \$37 monthly premium (\$444 annually)
  - Between \$250-\$2,250 in total drug spending, an initial coverage stage where Part D pays 75% of the drug costs and the beneficiary pays 25%
  - Between \$2,250-\$5,100, a gap in coverage called the "donut hole" where Part D pays nothing and the beneficiary pays 100%
  - From \$5,100 on up, a catastrophic coverage stage where Part D pays 95% of drug costs for the rest of the calendar year and the beneficiary pays 5%



# Medicare Part D-Benefits

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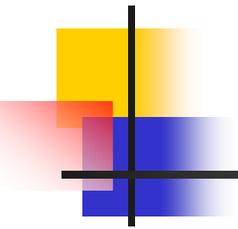
- Groups in between the standard benefit and full benefit coverage will have some deductible, plus premium and co-pay requirements
- Medicare Part D will help lower out-of-pocket prescription drug costs



# Medicare Part D - Formulary

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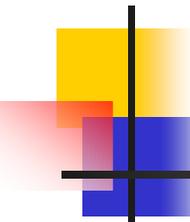
- Must be developed by a P&T Committee
- Must include at least 2 chemically different drugs in each therapeutic category and class, but need not include all drugs within each
- PDPs must give 30 days notice before removing drug, changing formulary or tiered cost-sharing
- PDPs must provide an appeal process for non-formulary drugs - each plan's appeal process will be reviewed as part of CMS approval process



# Medicare Part D - Formulary

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- PDPs must have a process for suggesting generic or lower cost products
- Must provide adequate access to the types of drugs most commonly needed by Part D enrollees, so as not to create disincentives for enrollment

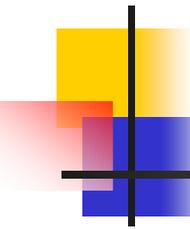


# True Out-of-Pocket (TrOOP)

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- TrOOP is the amount the beneficiary (or the state on the beneficiary's behalf) must spend out-of-pocket on Part D covered drugs to be eligible for catastrophic coverage.
- Certain Medicare beneficiaries enrolled in Part D must have a given level of out of pocket expenses in order to be eligible for catastrophic coverage
- In the standard benefit, TrOOP consists of three pieces that the beneficiary (or the state on the beneficiary's behalf) is responsible for paying.
  - The deductible
  - The 25% coinsurance requirement
  - The coverage gap (\$2,850 in 2006)

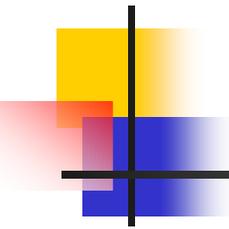
For Calendar Year 2006, the total TrOOP is capped at \$3,600



# True Out-of-Pocket (TrOOP)

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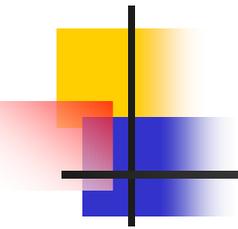
- PDPs must track TrOOP for each beneficiary
- TrOOP does not include payments for drugs *excluded* from a plan's formulary
- The Part D premium is not part of TrOOP
- Catastrophic coverage begins when the beneficiary satisfies the \$3,600 TrOOP requirement
- Beneficiaries cannot meet the TrOOP requirement unless aggregate of \$5,100 in Rx expenses



# Other Considerations

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- Although PDPs can have open formularies, PDPs are expected to include aggressive formularies in order to achieve reduced prices
- State is rolling out preferred drug list (PDL), which will begin in spring 2005
- State will need to collect asset information under ConnPACE to determine federal benefit levels and access federal subsidies under Part D, (Asset information will have no impact on ConnPACE eligibility determination)



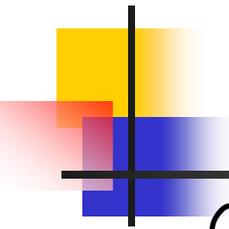
# Grievances, Coverage Determinations and Appeals

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- Part D plan sponsor, for each plan offered, must establish & maintain:
  - Grievance procedure to address issues that do not involve coverage determinations
  - Procedure for making timely coverage determinations and expedited coverage determinations to include situations in which applying the standard procedure may seriously jeopardize the enrollee's life or health
  - Appeal process that involves coverage determinations, if dissatisfied with any part of the coverage determination

## Grievances:

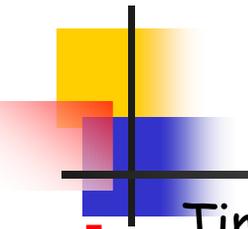
- Expression of dissatisfaction with any aspect of the Part D plans operations, activities, or behavior (other than a coverage determination)



# Grievances, Coverage Determinations and Appeals (cont'd)

## Coverage determinations:

- Each Part D plan sponsor that provides prescription drug coverage through the use of a formulary must establish and maintain complete and reasonable exceptions procedures subject to CMS approval for receipt of an off-formulary drug
- The Part D plan must grant an exception whenever it determines that a drug is medically necessary, consistent with a physician's statement
- A prescribing physician must provide oral or written statement that the requested prescription drug is medically necessary to treat the enrollee, however, this statement does not ensure an exception will be granted
- Medically necessary should include the following:
  - Formulary drug would have adverse effects for the enrollee
  - Formulary drug has been ineffective in the treatment previously



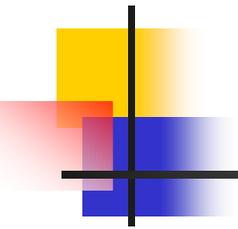
# Grievances, Coverage Determinations and Appeals (cont'd)

## Timeframes:

- Standard coverage determination - no longer than 72 hours after receipt of request
- Expedited coverage determination - as expeditiously as the enrollee's health condition requires but no later than 24 hours after receipt of request

## The Appeal Procedures: The Steps

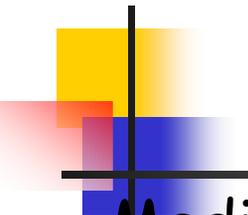
- The right to a redetermination, or expedited redetermination, of the adverse coverage determination by the Part D plan sponsor
- The right to reconsideration, or expedited reconsideration, by an independent review entity (IRE) contracted by CMS
- If the IRE affirms the plan's adverse coverage determination, in whole or in part, the right to an ALJ hearing
- If the MAC affirms the ALJ adverse coverage determination, in whole or in part, the right to a judicial review



# Grievances, Coverage Determinations and Appeals (cont'd)

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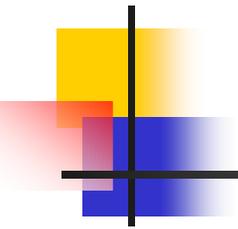
- The Appeal Procedures: The Steps (cont'd)
  - Part D plan sponsor must ensure that all enrollee's receive standardized notice to allow for an appeal
  - Any appointed representative can file an appeal for an enrollee and maintain all the rights and responsibilities of an enrollee



# Medicare Part D - Duals

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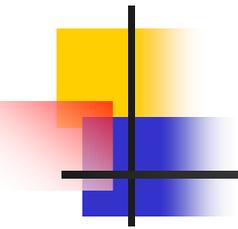
- Medicaid Impact - As of 1/1/06, the following categories of Medicaid beneficiaries must obtain their prescriptions through Medicare:
  - All Medicaid beneficiaries over the age of 65 who are entitled to Medicare Part A or enrolled in Medicare Part B
  - Medicare-eligible disabled persons
  - Medicare beneficiaries who spend-down to Medicaid eligibility. These are the known as "DUAL ELIGIBLES"
  - The federal government will no longer reimburse states for drugs that could be provided under Part B



# Medicare Part D - Duals

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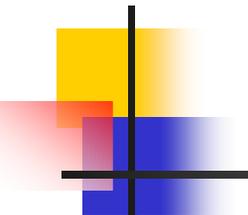
- If a full benefit dual eligible does not select a PDP, CMS will 'auto-enroll' each person in a plan
- Full benefit dual auto enrollment will begin as soon as the PDPs are known (10/05-11/05)
- Beneficiaries have the right to dis-enroll from a plan to which they have been assigned and choose another plan
- If a dual chooses to change plans, CMS will work to ensure continuity of coverage



# Medicare Part D - Duals

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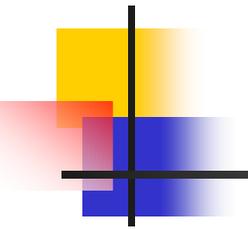
- Premiums for full benefit duals are fully paid by the federal government
- Full benefit dual eligibles will be responsible for a co-pay of \$1/\$2 for generic/preferred formulary drugs or \$3/\$5 for non-preferred formulary drugs
- Institutionalized dual eligibles will not pay premiums, deductibles or co-pays



# Governor Rell's Proposal

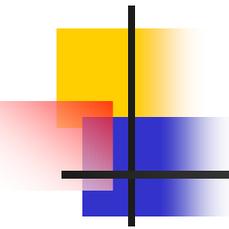
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- State will provide coverage of non-covered Medicare Part D drugs following current program policies (e.g., preferred drug list, prior authorization)
- State will not provide coverage for drugs that are purchased outside of the formulary of the selected PDP
- State will provide coverage during the 'donut hole' in accordance with formulary and covered drug requirements of the selected PDP
- For ConnPACE recipients, co-pays will not exceed the current \$16.25 co-pay requirement; depending on a client's income and asset levels and/or the cost of the drug, an enrollee may pay less than the traditional ConnPACE co-pay (\$16.25)



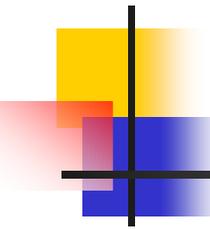
# Governor Rell's Proposal

- Enrollment in Part D as a condition of ConnPACE eligibility is modeled after Medicare drug discount card legislation passed last session
- With mandated enrollment, the state covers all premiums
- Need legislation early in order to:
  - Minimize confusion to clients through public information campaign; need time to develop materials & campaign
  - Garner significant savings from the new federal benefit and maximize the use of federal dollars
  - Ensure the federal government pays its share



# Governor Rell's Proposal-Duals

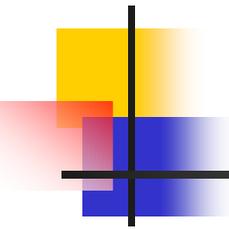
- For those dually eligible for Medicare and Medicaid, who currently receive prescription coverage under Medicaid
  - Prescription drug coverage will be provided by Medicare Part D, effective 1/1/06
  - State will provide coverage for non-covered Part D drugs (within current program policy) to those beneficiaries



# Governor Rell's Proposal-ConnPACE

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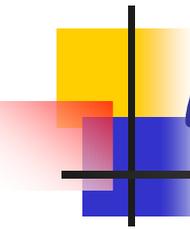
- For ConnPACE beneficiaries determined eligible for the low income subsidy
  - Rx benefits will be provided through Medicare Part D
  - Co-pays will not exceed the current ConnPACE co-pay of \$16.25 for Medicare Part D covered drugs
  - In some instances, co-pays may be less than \$16.25
  - ConnPACE will provide coverage for non-covered Medicare Part D drugs (within current program policy), with co-pays not exceeding the current \$16.25 co-pay requirement



# Governor Rell's Proposal-ConnPACE

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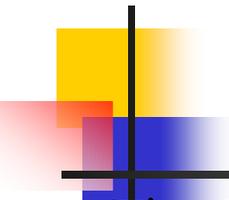
- State will not provide coverage for drugs that are purchased outside of the formulary of the selected PDP
- State will provide coverage during the 'donut hole' in accordance with formulary and covered drug requirements of the selected PDP, with co-pays not exceeding the current \$16.25 co-pay requirement



# Medicare Part D -SPAP Rules

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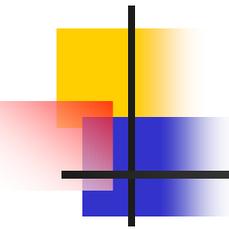
- ConnPACE is considered a State Pharmacy Assistance Program (SPAP) per federal regulations
- SPAP cannot discriminate among plans by steering individuals to particular Part D plans
- SPAP can contribute to cost sharing that will count towards True-Out-Of-Pocket expenses
- State cannot recommend Medicare Part D PDPs based on their financial interest in minimizing their cost of providing SPAP wrap-around



# CT Cost Savings

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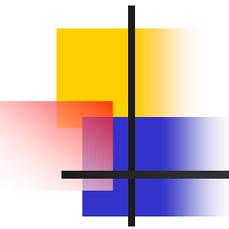
- The implementation of Medicare Part D is a major initiative, which will result in overall state savings of \$38.3 million in SFY 06 and \$68.9 million in SFY 2007
- The federal government will finally pay a share of the ConnPACE benefit
- States are required to pay Medicare on a monthly basis for the Rx costs they would have incurred in Medicaid. This is referred to as "clawback"
- For 2007, the "clawback" amount sent to Medicare is 90% of a CMS trended amount. This percentage drops incrementally through 2014 with a final of 75%
- Moving Medicaid dual eligibles to Part D may actually cost the state money due to the trend line used in the "clawback" computation and the state's recent RX cost savings initiatives
- The federal government will no longer reimburse states for drugs that could be provided under Part D.



# CT Cost Savings

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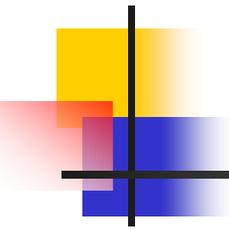
- 28% subsidy for the state drug costs for state retirees = \$28.6 million in FY 07 (included in overall savings figure of \$68.9 million)
- Also, potential subsidy to state for drug costs of retired teachers in state plan
- Towns need to immediately look at federal drug bill for potential subsidy
- These subsidies are only available if retiree plan found to be of sufficient quality that it is actuarially equivalent or more generous than Part D coverage. We are confident that the state retiree plan exceeds the Part D benefit plan



# Add-Back Projections

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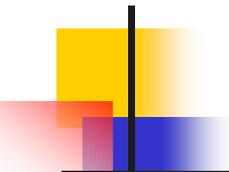
- If the state were to wrap copays for the dual eligibles, the additional cost to the state would be:
    - \$2,713,000 for FY 06
    - \$5,614,290 for FY 07
  - If the state were to cover wrap non-formulary drugs, the additional cost to the state would be:
    - Medicaid: \$14,387,000 FY 06; \$28,555,710 FY 07
    - ConnPACE: \$ 8,245,700 FY 06; \$14,268,200 FY 07
- Total Formulary Wrap: \$22,641,700 FY 06; \$42,823,910 FY 07



# Outreach & Education

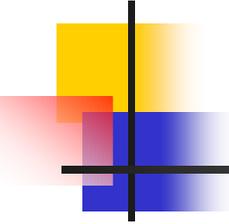
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- Received Federal Grant for \$2.5 million for FFY's 05 & 06
- Public Information & education campaign partners
  - CHOICES
  - 5 Area on Aging Agencies
  - Infoline
  - Center for Medicare Advocacy
  - Conn. Pharmacists Association
- Presentations & material distribution
  - DSS staff, senior centers, elderly/disabled housing complexes, pharmacies, hospitals/physicians offices, churches, nursing homes, agencies that serve dual eligible, etc.
- Training sessions
  - DSS staff, senior center staff, municipal agents, town & nursing home social workers, hospital discharge planners, medical staff, resident service coordinators, case managers for dual eligible, church leaders, CAA staff, etc.



# Outreach & Education

- Mobile Eligibility/Enrollment Bus
  - Advance notice of scheduled stops
    - Senior centers, assisted living facilities, residential care homes, community centers, shopping malls, faith based centers (churches, synagogues, chapels), etc.
    - Clients advised (in advance) of material to bring for eligibility determination
  - Manned by trained eligibility staff
    - Ability to determine Medicare Part D eligibility, ConnPACE eligibility, Medicaid Eligibility,
    - Other DSS program info available
  - Pharmacy consultant to assist in PDP selection/enrollment
  - Equipped with
    - PCs, WiFi network & software
    - Laptops for service provision in site building



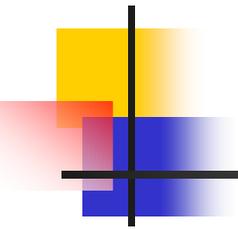
# Glossary

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- ALJ - Administrative Law Judge
- CMS - Centers for Medicare & Medicaid Services
- ConnPACE - Connecticut Pharmaceutical Assistance Contract for the Elderly and the Disabled
- CY - Calendar Year
- FPL - Federal Poverty Level
- FUL - Federal Upper Limit
- FY - Fiscal Year
- MA - Medicare Advantage
- Full Dual Eligible - Medicare & Medicaid client with full Medicaid benefits
- Partial Dual Eligible - Medicare enrollees (QMB, SLMB, QI) with premiums and/or deductibles paid for by Medicaid but no Medicaid coverage provided
- MAC - Medicare Appeals Council
- MSIS - Medicaid Statistical Information System
- NDC - National Drug Code
- OTC - Over-the-Counter
- PA - Prior Authorization
- PBM - Pharmacy Benefits Manager
- PDL - Preferred Drug List
- PDP - Prescription Drug Plan
- P&T Committee - Pharmaceutical & Therapeutics Committee
- SSA - Social Security Administration
- SPAP - State Pharmaceutical Assistance Program
- TrOOP - True-Out-of-Pocket Expenditures
- LIS - Low Income Subsidy

# Timeline for States

<p>1/05 to 3/05</p>	<p><b>January:</b> Final rule is issued <b>February:</b> Awareness campaign begins <b>March:</b> CMS accept State test enrollment files; Plan applications due</p>
<p>4/05 to 6/05</p>	<p><b>May:</b> Initial deemed population identified &amp; mailings to potential low income subsidy eligibles <b>June:</b> Plan Bids Due &amp; State submit monthly enrollment files</p>
<p>7/05 to 9/05</p>	<p><b>July:</b> MSIS eligibility &amp; claims files sent for CY03; States/SSA begin accepting Low Income Subsidy Applications <b>August:</b> All new data exchanges in production <b>September:</b> Plan Contracts Awarded</p>



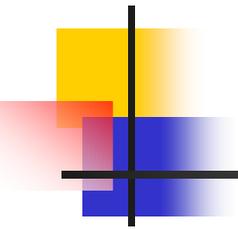
# Timeline for States

10/05  
to  
12/05

**October:** Plans market, 2006 "Medicare & You" Mailing;  
2006 Baseline of Per Capita Drug Costs to States  
**November:** Enrollment period begins  
**December:** Month Medicaid drug coverage  
ends on 12-31-05

1/06  
to  
3/06

**January:** Part D Begins; auto-enrollment effective for  
duals; States billed for first monthly payment  
**February:** States monthly payment begins



# *For Questions/Assistance*

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- [www.medicare.gov](http://www.medicare.gov)
- 1-800-MEDICARE (1-800-633-4227)
- [www.medicareadvocacy.org](http://www.medicareadvocacy.org)
- [www.socialsecurity.gov](http://www.socialsecurity.gov)
- CHOICES 1-800-994-9422
- ConnPACE 1-800-423-5026 toll-free
- ConnPACE (860) 832-9265 (Hartford area)