

# **Medicare Modernization Act (MMA)**

**Sally Reyerling, M.D.**

**Mary Ellen Foti, M.D.**

**DMH Clinical & Professional  
Services &**

**Massachusetts Psychiatric Society**

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## Agenda

- Explanation of MMA and who it affects
- Explanation of existing public medical insurance programs
- Enrollment for PDP
- Prescription Drug Plans (PDPs)
- Cost Sharing
  - Low Income Subsidy (LIS) – “Extra Help”
- Formulary Issues/Appeals
- Helpful websites and resources and dates
- Questions

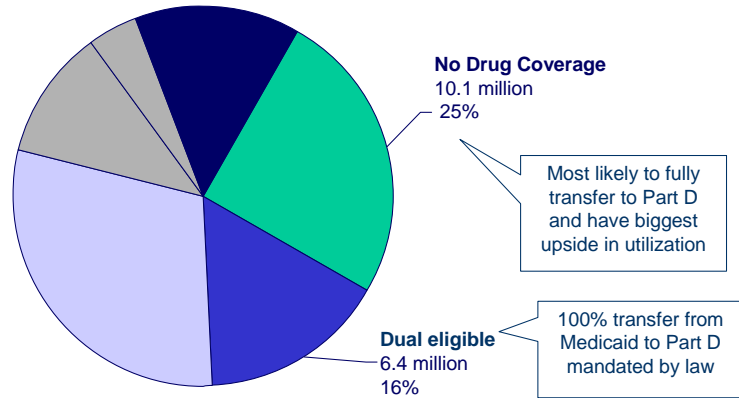
**•The explanation of existing Medicare/Medicaid programs is optional if the audience is familiar with these programs. The idea is not to get bogged down by them, just to have them there as a reference.**

## **MMA: What is it?**

- “Medicare Prescription Drug Improvement, and Modernization Act”
- aka “Medicare Modernization Act” (MMA)
- Adds a voluntary outpatient prescription drug benefit beginning Jan.1, 2006.
- Aka Medicare Part D

- **MMA is the result of the Bush administration’s Medicare reform bill.**
- **A new law from 12/03 which introduces the most comprehensive changes in Medicare since it’s inception in 1965.**
- **MMA currently features a prescription drug discount card which was poorly subscribed in most states. When the Part D takes effect, the discount card will be phased out.**
- **The primary feature of the MMA is the Part D benefit for Medicare beneficiaries.**
- **The term voluntary is relative because for some people it is essential that they sign up now for a Part D plan in order to not incur late enrollment penalties or as a replacement to existing coverage.**
- **Those for whom it is truly optional are those who have no existing drug coverage, and those who have coverage from another source, e.g. a retiree or employee plan which is equal to or better than the Medicare plan.**

## Sources of Rx Coverage for Medicare Beneficiaries, 2003



Source: Kaiser Family Foundation

- The green section of this slide shows that 25% of Medicare beneficiaries have no prescription drug coverage.
- The royal blue section shows that 16% of Medicare beneficiaries are “dual eligible” with both Medicare and Medicaid.

## **Current Medical Insurance Programs:**

- Medicaid
- Prescription Advantage
- Medicare
  - Medicare A
  - Medicare B
  - Medicare C (Medicare Advantage)
  - Medigap/Medicare supplements
- Medicare Savings Programs (MSPs)
- Medigap coverage

**•There is a dizzying array of programs which I will briefly review. These are here mostly for you reference as needed.**

**•Medicaid and Prescription Advantage are two state-administered programs.**

**•Medicare is the federally administered program for the elderly and some disabled and comes in many flavors (A<B<C, and now d)**

**•Medicare and Medicaid are run on the federal level by Center for Medicare and Medicaid Services (CMS), formerly known as HICFA.**

## Medicaid

- Federal and State funded
- State-operated; varies from state to state
  - MassHealth in MA
- low income all ages
- 50 million nationwide

- **Federal and State Funded...**

- **Half is paid by the feds and half by the states.**

- **State Operated...**

- **Medicaid is called MassHealth in MA. This is a potential source of confusion because mailings from CMS refer to “Medicaid,” and do not use the state specific program name.**

- **In MA, MassHealth currently provides prescription drug coverage. Not all states provide prescription drug coverage.**

- **Low income...**

- **In the range of up to 3x Federal Poverty Level**

## **Important!**

- Those eligible for Medicaid (MassHealth) only will not be affected by Part D.
- MassHealth prescription drug benefits will continue as is.

- **This is important to note because of this confusing issue.**
- **Patients could misconstrue that MassHealth will no longer be covering drugs after Jan 1. ( That is true only for dual eligibles after Jan 1)**
- **Mass Health clients need to hold on to their MassHealth cards.**

## **Prescription Advantage**

- State Pharmacy Assistance Program (SPAP)
- Current prescription drug coverage for seniors with no income limit and disabled with some income limits
- Premiums based on income level
- ~77,000 members in MA

•These types of programs (SPAPS) came into being to address the prescription drug needs of low income elderly and disabled populations who did not qualify for Medicaid and hence had no drug coverage in the absence of Medicare prescription drug coverage.

•Prescription Advantage is MA's SPAP.

## Medicare

- Federal dollars
- No income limit, over 65 and some disabled
- 41 million nationwide
- Currently parts A,B, and C
- Heretofore, no outpatient prescription drug coverage in fee for service plans (A,B)

•Came into being during the Johnson administration.

## Medicare Part A

- Covers costs including medication costs for inpatient stays in
  - Hospitals,
  - Skilled Nursing Facilities (SNF's)
  - Hospice
  - And for home health care for homebound
- Premiums paid by Medicare tax after 10 year work history by beneficiary or spouse

### •Premiums...

- **several hundred dollars per month but most individuals do not see these premiums as they have been paid by the Medicare tax through their working years.**

## Medicare Part B

- Supplemental outpatient insurance
  - physician services
  - labs
  - ambulatory surgical services
  - outpatient mental health
  - Medications given in physician's offices
- \$88.00/month premium for 2006

•The outpatient mental health benefits come with a 50% co-pay as opposed to 20% co-pay for other services, hence the “parity” discussions.

•Some medications...

- non-self administered injectables given in conjunction with a physician service.

- Decanoates are currently paid for by part B and as an outpatient prescription by MassHealth.

- There is current confusion about decanoates; some information from CMS suggests they would be covered under both part D and B.

## Medicare Part C/Medicare Advantage

- Managed care option
  - Medicare A and B services and additional benefits
- Not fee for service
- Premiums \$50.00 - \$100/month

•Some examples in MA include

**Tufts,  
BC/BS,  
Fallon Sr.**

•In publications from CMS, the abbreviation MA stands for Medicare Advantage, not Massachusetts!

•E.g. MA-PD on CMS web tool stands for Medicare Advantage Prescription Drug Plan.

## **Medicare Supplements/Medigap**

- Private plans designed to fill gaps in Medicare including prescription drug coverage.
- Premiums example, \$513/month
- Plans with prescription drug coverage will no longer be sold to new subscribers after Jan. 1.

### **Examples in MA**

**BC/BS Med Ex and Med Ex Gold**

**United AARP**

## Medicare Savings Programs

- QMB, SLIMB, QIs
- Medicaid pays the Medicare premiums
  - for these low income individuals who do not qualify for Medicaid.
- ~16,000 in MA

- AKA “Quimby, Slimby”; Stands for Qualified Medicare Beneficiary, Specified Low Income Medicare Beneficiary, Qualified Individual
- Medicaid pays the Medicare premium but they don’t get Medicaid benefits.
- They are not considered dual eligible.

## **Department of Mental Health (DMH)**

- Approximately 20,000 clients
  - 10503 Medicare clients (52%)
    - 1400 Medicare only (7%)
  - 16270 MassHealth clients
    - 7100 MassHealth only (36%)
  - 9100 dual eligible (45%)

## **Medicare Part D Prescription Drug Coverage**

### ***Who is Eligible?***

- Full benefit “dual eligibles”
  - Medicaid with prescription drug benefits AND Medicare
- Medicare A and/or B
  - Includes institutionalized Long Term Care (LTC) Medicare beneficiaries.

***Who is Eligible? (con't)***

- Institutionalized Long Term Care (LTC) Medicare beneficiaries.
  - LTC facility initially defined as skilled nursing facility (SNF).
  - Definition recently expanded under MMA to include
    - mental retardation institutions (ICF/MRs),
    - inpatient psychiatric hospitals

•The criteria for a long term care facility have to do with receipt of Medicare and Medicaid payments.

•This definition includes DMH inpatient facilities.

•The implications involve pharmacy billing which is still being worked out in DMH facilities.

## **Important! Dual Eligibles**

- As of *January 1, 2006*, there will be no more federally funded Medicaid prescription drug coverage for Part D covered drugs for full benefit dual eligibles.
- Dual Eligibles will need to be enrolled in a Part D plan in order to get any prescription drug coverage.

•In MA 187,000 full-benefit dual eligibles.

•6,000,000 duals nationwide.

•A significant number of individuals with schizophrenia and in long-term care are dual eligible.

## Dual Eligibles - Enrollment

- Auto-enrollment (random) of dual eligibles will begin **10/05** so as to ensure coverage by the **1/1/06** start date.
- Duals who are auto-enrolled in **10/05** can change plans from 11/15/05 – 12/31/05 to begin coverage 1/1/06.
- Duals can change plans monthly thereafter.
  - **New plan will take effect 1st day of month after new enrollment.**

### •Auto-enrollment...

- Duals are recognized in the MMA as a vulnerable population.
- They are being auto-enrolled by CMS to ensure that there is no gap in coverage after Jan 1 when their Medicaid outpatient prescription benefits will end.
- Random selection into a standard or basic (low cost) plan with premiums under \$30.
- Duals should receive a letter in October telling them which plan they have been auto-enrolled in.

### •Duals who are auto enrolled...

- The rest of Medicare beneficiaries would be restricted to an annual open enrollment period. Duals have a special enrollment status to endure flexibility in this generally sicker population.
- Duals may need to re-enroll in a different plan that meets their needs (Drugs, local pharmacies) which they can do during the open enrollment period.

## Enrollment

- Coverage begins 1/1/06
- Open enrollment 11/15/05 - 5/15/06 (not retroactive to 1/1/06)
- Late Enrollment Penalties may Apply
  - 1% LIFETIME premium penalty for every eligible month not enrolled
- Facilitated Enrollment starting 6/1/05
  - Auto-enrollment of non-enrolled low income Medicare only to avoid penalties.

### •Open Enrollment

- Coverage begins on 1/1/06 even if you enroll on 12/31/05. But if you enroll after 1/1/06, the coverage is not retroactive to 1/1/06.

### •Late Enrollment

- If there is a lapse in creditable coverage after the enrollment period, there will be a 1% premium penalty added to premiums for every month not enrolled. Penalty remains *For LIFE*.
- At 1%/month, that would be approx. \$.30 /month.
- The penalties are similar to those in place for late enrollment in Medicare A/B. Like other insurance products, if you wait until there is an event to get insured, insurance will be more expensive and difficult to obtain.
- Late enrollment penalties do not apply to Duals. If duals are missed they will be retroactively enrolled.

### •Facilitated Enrollment

- CMS will be automatically enrolling low income, i.e. Medicare Savings Program members and identified low income Medicare beneficiaries who have not enrolled by 6/1/05 so that these beneficiaries can avoid penalties, (e.g. people who have been approved for LIS but not enrolled in a plan; not duals) .

## Creditable Coverage

- Existing prescription drug coverage needs to meet Medicare standards referred to as “creditable coverage”.
- As good as or better than standard or basic PDP plan coverage.
- Existing plans need to notify their beneficiaries as to whether or not the plan meets “creditable coverage” criteria.
- If not, they will incur penalties if they enroll later.

•**Health plans need to send notification by letter or newsletter as to whether or not they meet “creditable coverage standards”.**

•**Instruct people to hold onto those letters in case need to prove creditable coverage later, e.g. if their retirement coverage ends or they opt for Medicare Part D later.**

•**Previous reference to “voluntary” nature of Part D refers to folks with creditable coverage who always have the option to enroll in Part D during open enrollment and will not incur penalties if they have had “creditable coverage” all along.**

## SUMMARY

- Every Medicare beneficiary needs to make a decision:
  - If creditable coverage currently, Part D or current private plan
  - If not creditable coverage, choose a Part D plan in initial enrollment period or face lifetime penalties.

## SUMMARY

- Enrollment
  - Auto-enrollment of duals will occur this month; look for letter from Medicare.
  - Open enrollment for all beneficiaries 11/15/05 – 5/15/06
  - Facilitated enrollment for Medicare Savings Program members and other low-income non-dual who have not enrolled by 5/15/06.

- **Auto enrolled**

- **Prescription Advantage; will also be auto-enrolled and will be required to apply for the low-income subsidy watch for mailings.**

- **Open Enrollment...**

- **for all beneficiaries including Medicare Savings Program Members.**

- **Medicare Advantage – should hear from their plan about their offered PDP's.**

- **Facilitated Enrollment;**

- **CMS will identify MSP members and people who have been approved for LIS who have not yet enrolled and will auto-enroll them so as to not incur penalties.**

## Medicare Part D Prescription Drug Plans (PDPs)

- Medicare (CMS) is contracting with private plans to administer the drug benefit. These plans bid to CMS to service entire regions.
- The drug benefit will be managed by the private sector PDP and reimbursed by CMS.

### •The drug benefit...

- Some estimates state that the federal government could be the purchaser of up to 50% of US pharmaceuticals in the future.

•(Estimates based on multiple sources: U.S. Census Bureau; Kaiser Family Foundation; Health Day News; NIH)

## **PDP Regions**

- MA is in the Central New England region with Rhode Island, Vermont, and Connecticut.
- CMS goal of two PDPs per region for competition.
- 10 national organizations covering multiple regions.
- 44 stand alone plans offered by 17 organizations sponsoring plans in our region.
- 11 plans with premiums at or below low income subsidy benchmark

### **•10 National Organizations**

- Aetna, Cigna Pacificare, Medco to name a few.

### **•44 stand alone...**

- “stand alone “ refers to a non Medicare Advantage Plan, a free standing plan.

### **•11 plans...**

- These are the plans that duals will be auto-enrolled into. No premium for duals for monthly premium <\$30.27.

## MASS PDP's

- Aetna – 3 ● \$38 -\$66
- BC/BS - 3 ● \$29 - \$50
- Cigna- 3 ● \$37 - \$51
- Coventry –3 ● \$19 - \$42
- Health Net - 2 ● \$20, \$24
- Humana – 3 ● \$7 - \$55
- Medco ● \$30
- MemberHealth ● \$31 - \$44
- Unicare - 3 ● \$19 -\$36
- [www.medicare.gov/medicare-reform/mapdpdocs/PDPLandscapema.pdf](http://www.medicare.gov/medicare-reform/mapdpdocs/PDPLandscapema.pdf)

•These are some samples of Mass PDPs. They are available on CMS website [www.medicare.gov/medicare-reform/mapdpdocs/PDPLandscapema.pdf](http://www.medicare.gov/medicare-reform/mapdpdocs/PDPLandscapema.pdf)

•As you can see, there is a wide range of monthly premiums. The benchmark average price CMS was shooting for was \$32 and they came in at \$30.

•Basic or standard and enhanced coverage. Some of the enhanced packages are coming in at under \$30 which has relevance in our discussion of the low income subsidy.

## **PDP Variables**

- Formulary
- Benefit Management Tools
- Premiums
- Deductibles
- Co-pays/co-insurance
- Participating pharmacies

## How to Choose a PDP

- Medicare and You handbook currently being mailed to all beneficiaries with plan info.
- [www.medicare.gov](http://www.medicare.gov)
  - **Plan Finder Tool**
  - **Formulary Finder**
- Other local resources (see slide at end of presentation)
  - **SHINE**
  - **Mass Medline**

• Medicare and You is the annual mailing from Medicare and is the only mailing about Part D that is going to all beneficiaries. It will contain plan information.

• It was sent out with a significant error which is now corrected.

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

• Geared to beneficiaries.

• **Formulary Finder tool.** Plug in medicines and state and it will give plans which cover those meds.

• **Plan finder tool** asks for beneficiary name, ss#, etc and walks through, asks what variables you want to base choice on, etc. Gives plan contact info.

• **No standard application done through Medicare!** The plan finder tool directs you to the plan for an application.

• **Mass Medline** is run by the Mass College of Pharmacy and has staffed up to assist with plan choice.

• **SHINE** is a SHIP (State Health Insurance Assistance Program)

• **Serving the Health Information Needs of Elders;** federal program of local volunteers who are medical insurance experts.

## How to Enroll

- Enrolling with a plan is how you enroll in Medicare Part D.
- The plan will let Medicare know that beneficiary is enrolled.
- Obtain application directly from the plan.

### •MEDICARE AND YOU Handbook

- Error listed all PDP for Low Income Subsidy as no premium. This is not true; only the basic, not “enhanced” plans, are no premium.
- Some in Congress are advocating to require CMS to mail out correction.
- Currently correction is only made on website.
- Plan finder; web-based tool; helps sort by premium and deductible price, plug in medications, lists plans that fit your criteria.
- Webcast not ready yet but slides were if you want to take a look at plan finder.

## Cost Sharing

- Part D benefits entail significant cost-sharing to minimize impact on federal deficit;
  - monthly premiums,
  - deductibles,
  - tiered co-payments,
  - formulary controls.

•In order to assist with these costs, a low income subsidy is being offered to low income individuals. Next slide.

## **Low Income Subsidy (LIS)**

- “Extra Help”
- Social Security Administration (SSA)
- Partial subsidy 135% - 150% FPL
  - Non duals
- Full subsidy

- CMS mailings to beneficiaries call the LIS “Extra Help.”**
- Social security admin is processing LIS applications. They are currently taking two months to process.**
- Determinations are based on social security check size, no access to IRS data.**
- State Medicaid offices are also able to accept applications.**

## **Full Subsidy (LIS)**

- No deductibles
- No premiums
- Co-pays
  - \$1- \$3 for 100% FPL for non-duals and duals
  - \$2-\$5 at 100-135% FPL for higher income duals and non-duals
  - \$0 for institutionalized duals
- Deemed Eligible
  - No need to apply; automatically enrolled by CMS
    - Duals, SSI recipients, Medicare Savings Program

•Full LIS covers deductibles, premiums, co-insurance except for small co-pays.

•Deemed Eligible...

•A letter went out in May informing duals and the above-mentioned categories that they are deemed eligible for the “extra help” and don’t need to apply.

•If they didn’t get this letter, SSA needs to be contacted.

•No premiums for basic plans.

•Duals would have to pay premium difference between basic and enhanced coverage if they desired a more expensive plan.

•This is where the error in the Medicare and You handbook is. Gave zero premium for all plans not just the basic plans.

•\$30.27 targeted benchmark premium. Some plans are enhanced coverage still for < \$30.27.

## Low Income Subsidy (con't)

- Non-Deemed Eligible
  - Need to apply
  - < 150% FPL
  - subsidies based on liquid assets
- In May - June 2005 applications were sent to 20 million Medicare beneficiaries thought to meet income guidelines.

### •Non-deemed

•Liquid assets mean not primary home or one car.

•Only 4 million have been returned. SSA has hired a firm to make 16 million phone calls to folks they think are eligible based on SSA check size. Determinations are currently taking several months.

•Applications are able to completed on-line or call SSA for an application (not downloadable).

## Current MassHealth Costs vs. MMA

- Current out-of-pocket limit of \$200.00 for MassHealth
- \$1/\$3 co-pays (optional; pharmacists has to dispense by law)
- Under MMA, there is no requirement for pharmacies to dispense the drug when not receiving a co-pay.

**•In fact pharmacists are expected to collect co-pays with few (non-routine, non advertised exceptions).**

- This is impossible to understand.
- This is the standard benefit.
- Plan cost sharing is actuarially equivalent to this standard benefit.

• Standard benefit means it can't get any worse. Plans can compete and offer better benefits, e.g. cover uncovered parts of the standard benefit.

• Green represents out of pocket spending; blue represents what the plan pays.

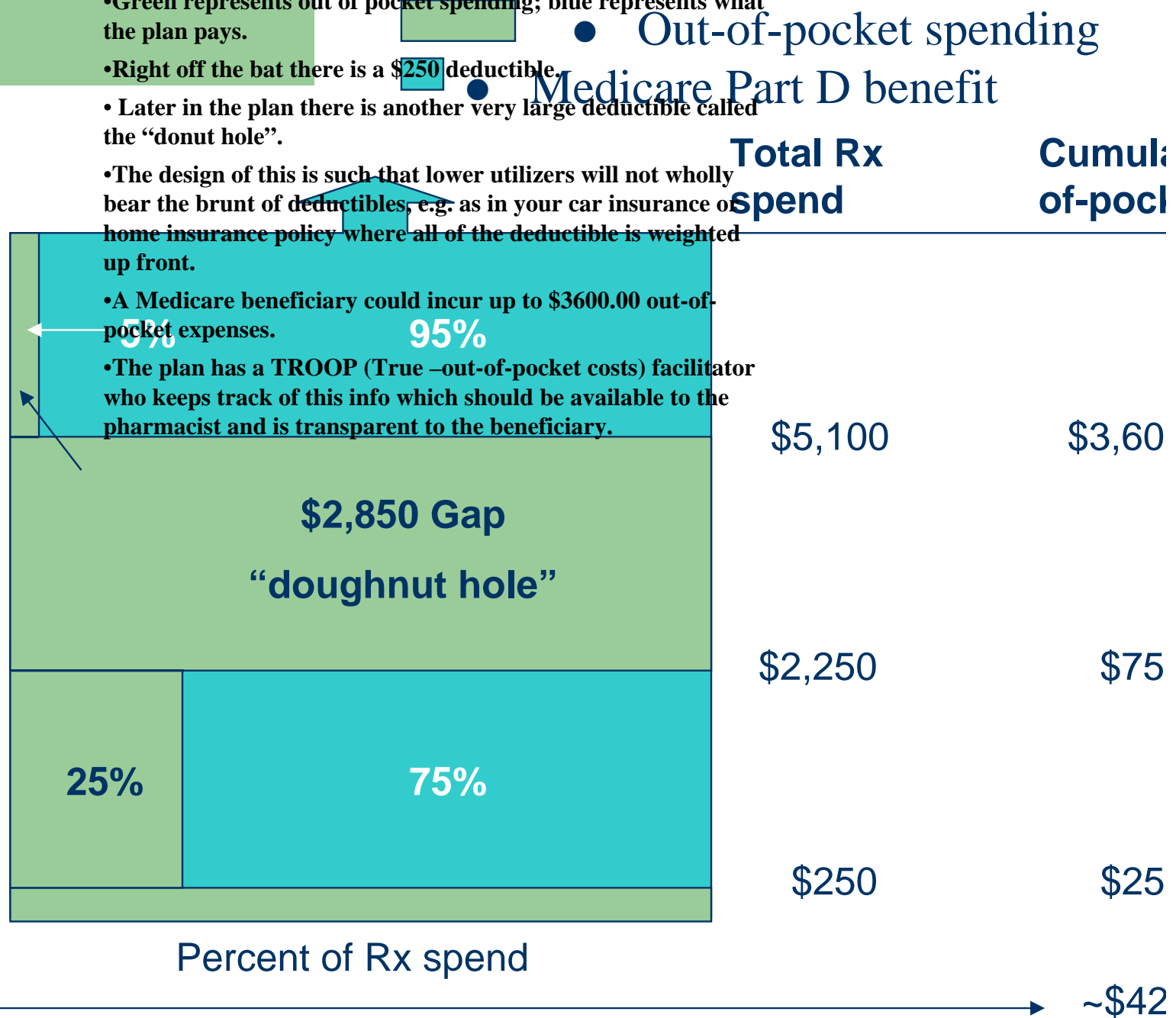
• Right off the bat there is a \$250 deductible.

• Later in the plan there is another very large deductible called the "donut hole".

• The design of this is such that lower utilizers will not wholly bear the brunt of deductibles, e.g. as in your car insurance or home insurance policy where all of the deductible is weighted up front.

• A Medicare beneficiary could incur up to \$3600.00 out-of-pocket expenses.

• The plan has a TROOP (True -out-of-pocket costs) facilitator who keeps track of this info which should be available to the pharmacist and is transparent to the beneficiary.



## **SUMMARY**

- Low Income Subsidy;
  - Deemed eligibles should have received a letter.
  - Other (non-deemed) low income individuals should have received an application.

## **Formulary Review Guidance**

- Two key requirements;
  - Provision of medically necessary treatment
  - No discrimination against any beneficiaries based on cost of their treatment.

### **CMS Guiding Principles;**

**Relying on Best Practices,**

**Access to medically necessary drugs**

**Flexible benefit design**

**Administrative efficiency**

## **Formulary Benefit Management Tools**

- CMS will scrutinize plans to make sure that their use of tools is not discriminatory.
  - Tiered co-pays
  - Step therapy
  - Prior authorization
  - Quantity limitations
  - Generic substitution

## Pharmacy & Therapeutics Committee

- Required membership
  - majority physicians
  - pharmacists;
  - at least one independent, elderly, disabled specialists.
- Participate in coverage determinations.

•Role is defining policy for utilization management, access to non-formulary, prior authorization, quantity limitations, generic substitution, etc. and

## Formulary Lists

- Best Practices from Medicaid and private sector
- Scrutiny of any “outliers”.
- Based on United States Pharmacopoeia list of categories and classes of drugs
  - [www.usp.org/pdf/drugInformation/mmg/finalModelGuidelines2004-12-31.pdf](http://www.usp.org/pdf/drugInformation/mmg/finalModelGuidelines2004-12-31.pdf)
  - [www.usp.org/pdf/drugInformation/mmg/attachments\\_USPComments2004-12-30.pdf](http://www.usp.org/pdf/drugInformation/mmg/attachments_USPComments2004-12-30.pdf)
  - **Statutory Requirement: Formulary must require at least two drugs in every category and class.**
  - **CMS expectation: at least one drug from each type.**

## USP Model Guidelines

<i>CATEGORY</i>	<i>CLASS</i>	<i>e.g. DRUGS</i>
<b>Antidepressants</b>	<b>MAOI Type A</b>	<b>phenelzine</b>
	<b>Reuptake Inhibitors</b>	
	<b>Other</b>	<b>bupropion,</b>
		<b>mirtazapine</b>
		<b>trazodone</b>
<b>Anxiolytics</b>	<b>Antidepressants</b>	
	<b>Other</b>	<b>buspirone</b>
		<b>meprobamate</b>

- Samples from the USP (United States Pharmacopoeia), a drug management company.
- These guidelines reflect statutory influence, e.g. benzodiazepines are not listed as a class of anxiolytics.

## Formulary (con't)

- Special scrutiny
  - dementia,
  - depression,
  - bipolar disorder, and,
  - schizophrenia

•CMS guided the PDP's about populations and illnesses about which they were especially concerned.

CMS will scrutinize for accepted national treatment guidelines indicative of best practice for, among a long list of illnesses (e.g. asthma, diabetes, HPTN, heart failure)

•Mental illnesses were featured prominently on the list.

•Formularies made public Oct. 17, 2005

## **“All or Substantially All”**

- Formularies will contain “all or substantially all” of drugs within the following six classes;
  - antidepressants,
  - antipsychotics
  - anticonvulsants
  - antiretrovirals
  - immunosuppressants
  - antineoplastics

**•These six classes represent an extra step toward protection of vulnerable populations.**

**•It is a CMS expectation (but not statutory requirement) that all drugs in these classes be included on plan formularies.**

## “All or Substantially All”

- No prior authorization or step therapy for patients “already stabilized” on drugs in these classes.
- “Beneficiaries should be permitted to continue utilizing a drug in these categories that is providing clinically beneficial outcomes.”
- “...Interruption of therapy in these categories could cause significant negative outcomes to beneficiaries in a short timeframe.”
- However, expect that utilization management tools will be used for new subscriptions.

- **No PA... unless the plan can demonstrate extraordinary circumstances.**
- **This “all or substantially all” standard is in place for 2006 only.**

## PART D Excluded Drugs

- Drugs for weight loss, weight gain
- Fertility
- Cosmetic
- OTC
- Part A or B covered drugs
- Benzos/Barbs
  - Benzos/Barbs currently covered by MassHealth.
    - MassHealth will continue to cover.
    - Prescription Advantage will cover Benzos

- **Medicare currently does not cover benzo's/barbs by statute over fears of abuse/addiction.**
- **There is a bill before Congress that this benzo prohibition in the statute will be repealed.**
- **Duals, don't throw away the MassHealth card!**

## Decanoates

- ? Part B or Part D covered drugs.
- Stay tuned.

•**Current lack of clarity from CMS as to whether these are part B or D covered drugs.**

## **Formulary (con't)**

- Plans can only change drug categories and classes at beginning of each year.
- Plans can add/delete/tier change monthly 30 days after approval by P&T committee.

## Summary

- All or substantially all psychiatric drugs covered for those stabilized on the drugs for 2006.
- New prescriptions susceptible to benefit management tools.
- Benzos covered by MassHealth and Prescription Advantage

## Formulary Transition Processes

- Transition Periods
  - The initial roll-out
  - New Medicare beneficiaries on an ongoing basis
  - Switched PDPs
  - Changes in treatment setting, e/g/ long term care to outpatient
- Suggested Remedies
  - **Temporary first fill, e.g. 30 day supply**
  - **Streamlined appeals process**

### •Transition Periods...

- To address needs of new enrollees stabilized on a drug regimen that is not covered on PDP formulary during times of transition.
- CMS asked plans to plan for a scenario of a beneficiary presenting to a pharmacy without knowledge that a drug is not covered. CMS suggested 30 day supply.
- Bill before legislature from Romney administration to mandate MA PDPs to provide 30 day supply.
- This is worth looking at in plan information.

## Appeals Process

- Coverage determination or Exception;
  - Request if preferred drug is not on formulary or in unfavorable formulary tier.
  - PDP has 72 hours to make a written coverage determination.
  - Expedited 24 hours.
  - Physician expedited requests automatically approved.

• Exceptions process is the 1<sup>st</sup> level of appeal. Asking the PDP to make a formal decision to cover a drug not on its formulary or preferred tier.

• A written coverage determination is the first step.

• Appeals process discussion is next.

• Expedited requests may be made if the standard timeline would be medically inappropriate for your patient's health condition.

• Expedited requests by physicians must be granted,

• so instruct patients to let physician make expedited requests.

• If the expedited request is approved, the drug plan must make a decision within 24 hours or the request moves to the next level of appeal.

## **Coverage Determination/Exception**

- Need to establish following conditions;
  - Medically necessary
  - Other drugs not as effective and/or
  - Other drugs cause adverse effects

## Appeals Process (con't)

- Six levels of appeal
  - Coverage determination (Exception)
  - PDP Redetermination
  - Independent Review
  - Administrative Law Judge
  - Medicare Appeals Court
  - Federal Court
- Timeframes
  - Standard 7 days
  - Expedited 72 hrs

•There are also similar processes for filing grievances against the plan.

## **CMS Outreach Campaign**

- **Multi-phased message platform**
  - **Awareness (January–June 2005)**
    - **Focus on Prevention and Develop Partnerships**
  - **Decision (July–December 2005)**
    - **Motivate and Educate Beneficiaries**
  - **Urgency (January–June 2006)**
    - **Target Beneficiaries that have not yet enrolled in order to avoid increased premiums**

## Key Dates

- April, 2005. CMS outreach campaign begins.
- Mid May, 2005; Mailing to duals about deemed eligibility for LIS.
- May 26, 2005; Mailing of LIS application by SSA.
- June 6, 2005; Final bids due on PDPs.
- October, 2005; PDP marketing begins; Formularies public; Duals auto-enrolled.
- Nov. 15, 2005 - May 15, 2006; Open enrollment.
- Jan. 1, 2006; Part D coverage begins.
- June 1, 2006; Facilitated enrollment of all Medicare Savings Program members and other low-income subsidy individuals

## Resources

### Links for professionals:

[www.cms.hhs.gov/medicarereform](http://www.cms.hhs.gov/medicarereform)

[www.cms.hhs.gov/medlearn/drugcoverage.asp](http://www.cms.hhs.gov/medlearn/drugcoverage.asp)

### Links for Professionals and Consumers:

[www.mentalhealthpartd.org](http://www.mentalhealthpartd.org)

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

- First address is CMS Website. State specific info. Can get on list serve (information, releases, announcements), All-State Calls.**
- 2nd address can be accessed from 1st. Has CME/CEU PowerPoint.**
- 3rd address is best web site in my opinion. APA, NAMI, Assoc. Community Psychiatrists**
- 4<sup>th</sup> address is geared to beneficiaries but also has plan finder and formulary finder links critical to finding a plan.**

## Resources

- Medicare
  - 1-800-MEDICARE
    - [www.medicare.gov](http://www.medicare.gov)
- Social Security
  - 1-800-772-1213
  - [www.socialsecurity.gov](http://www.socialsecurity.gov)
- The Shine Program
  - 1-800-243-4636, option 2
  - [www.medicareoutreach.org/low\\_income\\_assistance.htm](http://www.medicareoutreach.org/low_income_assistance.htm)
  - 1-866-633-1617
- MassMedline
  - 1-800-243-4636 option 1
    - [www.800ageinfo.com](http://www.800ageinfo.com)

•**Shine (Solving Health Information Needs of Elders) is an essential resource and can also be used as a plan finder resource. Will make app'ts with individuals at Sr. Centers, setting up with computers in malls, etc.**

•**SHINE is a SHIP (State Health Information Program), federally funded, staffed largely by trained volunteers.**

•**Medicare Outreach web address puts you on Shine's home page.**

•**MassMEDline is Mass College of Pharmacy**