

Medicare Part D

Implementation Toolkit for Self Governance Tribes

Note: Because Medicare Part D is still in the implementation phase, many policies are still unresolved. This document is intended to provide the most recent information so Tribes can begin activities to accommodate this complex legislation. Comments are welcome. Please note the date on this document and discard if more recent updates become available.

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The Importance of the Medicare Modernization Act

The Medicare Modernization Act of 2003 contains numerous provisions that will impact tribal health programs. This document highlights one of the most significant changes, the creation of a new prescription drug benefit for Medicare enrollees, also called "Part D". Tribes will not be able to ignore Part D because:

- All patients with both Medicare and Medicaid (dual eligibles) will have a brand new system for getting prescription drugs on January 1, 2006.
- Similar to the implementation of Medicaid Managed Care, this change will involve moving responsibility for benefits from the State Medicaid agencies to private prescription drug plans.
- All of your Medicare patients are getting a confusing array of mailings and phone calls from several federal agencies (CMS, SSA, IHS) as well as from the private prescription drug plans (PDP).
- Your health and social services staff will be faced with an increasing number of questions from tribal members with Medicare and your staff needs to know how to accurately answer.

To prevent, or at least minimize, program funding losses, Self Governance tribes must educate themselves about this complex new program and take immediate steps to organize their health program activities to accommodate these changes.

Key Dates

| | |
|-------------|--|
| Now | Application for Low Income Subsidy through Social Security |
| November 15 | Enrollment begins. Enrollment is through the PDP. |
| December 31 | Last day to select PDP to receive drug benefit in January |
| January 1 | Dual eligibles lose Medicaid Rx coverage and must switch to Medicare PDP |

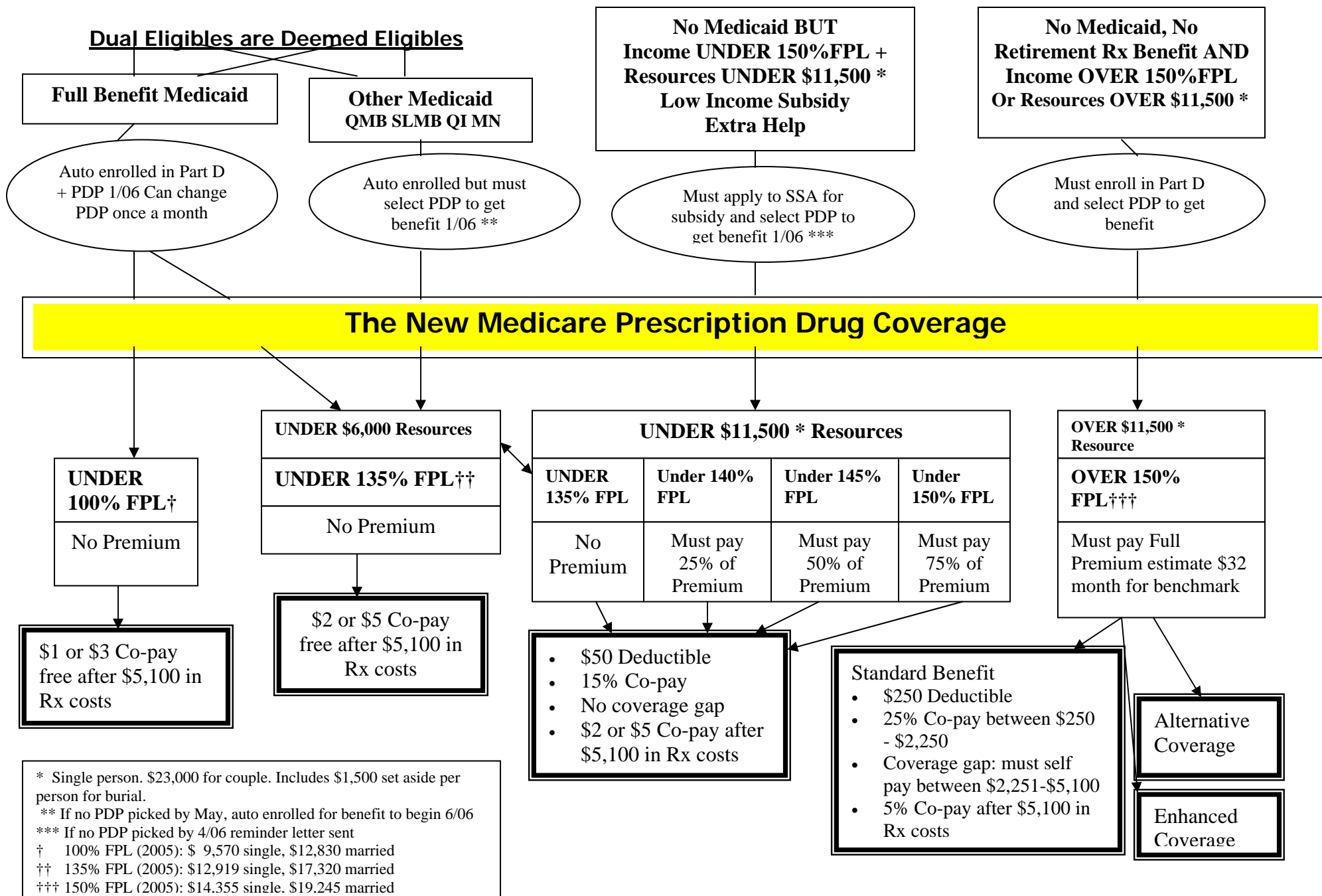
Priorities

1. Develop a written tribal plan (tasks, timeline, person responsible) for managing Medicare Part D changes
2. Identify your Medicare patients and the Rx they use (Rx, dose, number per month)
3. Assess the PDPs in your Region and identify the best fit with your tribe
4. Triage your patients and identify the group they are in (see Triage Tool)
5. Determine whether or not your tribe will pay Part D premiums and then develop your policies and procedures
6. Meet with your State Medicaid program to discuss transition of dual eligibles and Medicaid wrap around drug coverage (*see State contact list at end*)
7. Develop a tracking plan for dual eligibles so they don't get lost in the change – get Rx filled in December.
8. Assist patients with Low Income Subsidy Applications
9. Match patients with best PDP and help them switch or enroll (priority - dual eligibles, low income subsidy, others)

Brief Overview of Medicare Part D

The following chart shows how the Part D benefit is structured. Based on an individual's enrollment in Medicaid, their income and resources, or their retirement benefits, they fall into a specific benefit category.

New Medicare Prescription Drug Coverage – Crosswalk Chart



Key Information about Medicare Part D Beneficiary Groups for I/T/Us

GROUP 1 – Automatically Enrolled – Full Dual Eligibles

Process to Enroll: Each State Medicaid program will send their data on dual eligibles to CMS. CMS randomly “auto enrolls” full dual eligibles in PDPs that are below the regional benchmark premiums and do not offer an enhanced benefit package. Group 1 currently receives Medicaid prescription drug coverage. The October, 2005 mailing from CMS will inform each of your patients which PDP they have been enrolled in. The PDP will send its marketing material to the individual.

Switching PDP: Dual eligibles can change PDP once a month by enrolling in new PDP.

Premium: No Premium

Deductible: No Deductible

Copay: \$1/\$3 if income is below 100% FPL

Other Information

This Group probably accounts for a significant amount of I/T/U pharmacy revenue, even though the number of patients might be small. It is possible that the current Medicaid prescription drug reimbursement you are getting for this group could be cut in half on January 1, 2006 when Part D begins. Reasons: not as many drugs will be covered, reimbursement rates from PDPs may be less than your current Medicaid rates.

GROUP 2 – Automatically Eligible – Other Dual Eligibles (QMB, SLMB, QI, MN)

Process to Enroll: To actually get the Medicare Part D benefit, a patient needs to enroll in a PDP. This Group (Other Dual Eligibles) will NOT be automatically enrolled in a PDP until May, 2006. Therefore, I/T/U staff will need to help them enroll in a PDP before December 31, 2005 so their coverage can begin January, 2006. Because this Group already has been enrolled in a Medicaid program, they are automatically eligible for Part D with no premium or deductible.

Switching PDP: Dual eligibles can change PDP once a month by enrolling in new PDP.

Premium: No Premium

Deductible: No Deductible

Copay: \$2/\$5 if income is between 100% - 135% FPL

GROUP 3 – Low Income Subsidy (Extra Help)

Process to Enroll: There is a two step process for this Group.

1. First they must apply to the Social Security Administration (SSA) for a Low Income Subsidy (also called “Extra Help”). Application can be done on line or with a special paper form. SSA will send the individual a letter approving, disapproving or asking for more information. If the I/T/U wants to monitor the application or pay the premium, use the I/T/U address for the mailing address. This way SSA will send correspondence to the I/T/U so they can monitor eligibility. Based on income, the letter will also notify the individual about how much of the premium they must pay.
2. Second, if the person is approved for a Low Income Subsidy, they must enroll in a PDP to get the coverage starting January 1, 2006. If they do not enroll in a PDP by May, 2006 CMS will auto enroll them.

Switching PDP: For this first year, a person who enrolls in a PDP may switch PDPs only one time through May 15, 2006. After that, PDPs can only be switched once each year during the annual enrollment period November 15 – December 31 for change to take place January 1 the following year. Not clear if “No premium” enrollees (below 135% FPL) will have additional Special Enrollment Periods.

Premium: Sliding fee scale based on income if income between 135%-150% FPL. No premium if income below 135% FPL.

Deductible: \$50 if income is between 135%-150% FPL. If income is below 135% FPL, no deductible

Copay: 15% if income between 135%-150% FPL. If income is below 135% FPL, \$2/\$5 copay.

Other Information: Patients who qualify for the Low Income Subsidy are NOT subject to estate recovery or other Medicaid regulations.

GROUP 4 – Standard Benefit

Process to Enroll: Complete enrollment form through PDP.

Switching PDP: For this first year, a person who enrolls in a PDP may switch PDPs only one time through May 15, 2006. After that, PDPs can only be switched once each year during the annual enrollment period November 15 – December 31 for change to take place January 1 the following year.

Premium: Must pay full premium – amount depends on PDP selected.

Deductible: \$250 deductible per calendar year.

Copay: 25% copay between \$250 - \$2,250 in drug costs. No coverage between \$2,250 - \$5,100 in drug costs. 5% copay after \$5,100 in drug costs.

Other Information

Creditable Coverage – I/T/U patients who are currently eligible for Part D will need a letter from I/T/U if they enroll in Part D after August, 2006, in order to avoid late enrollment penalties.

GROUP 5 – Existing Retirement Benefit

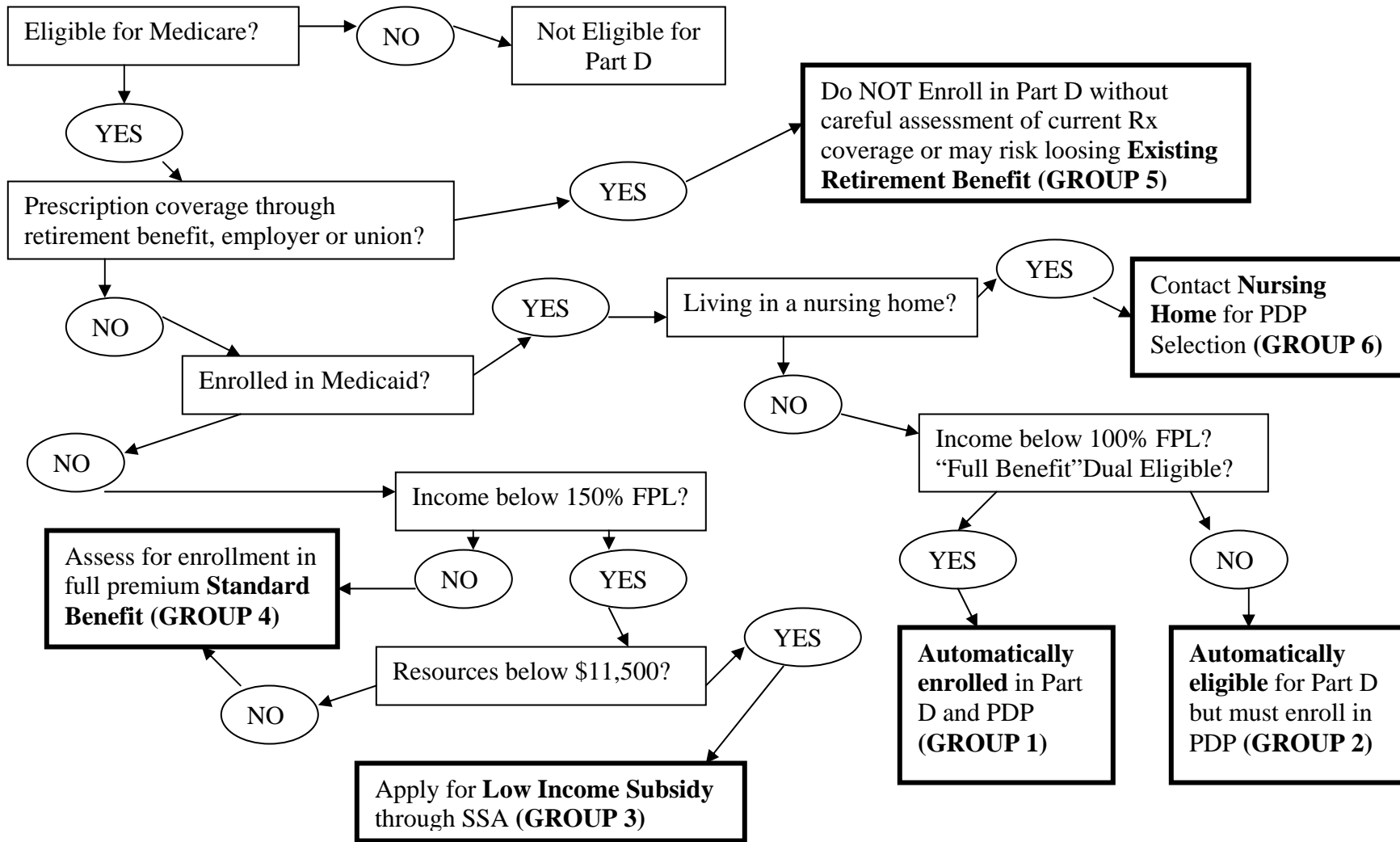
Many people on Medicare have some type of prescription drug coverage through a retirement benefit, union or employer. This coverage may be better than Part D, especially if it covers more of the drugs that the patient uses, has lower deductible or copay and no coverage gap. Before recommending that a patient with existing coverage switch to Part D, conduct a careful analysis. Ask the patient to bring in their letter of Creditable Coverage from their current plan or contact the retirement plan for more information. For this group, switching to Part D could jeopardize their current benefits.

GROUP 6 – Medicaid Nursing Home Resident

For nursing home patients enrolled in Medicaid, contact the nursing home for more information. Special conditions apply.

The following Triage Chart helps to sort patients into the proper Medicare Part D Group.

Triage Tool for I/T/U Staff - Medicare Part D



The Prescription Drug Plans (PDP)

- Medicare contracts with private PDPs to administer the Part D benefit
- PDPs must provide services across an entire Region (there are 34 Regions defined by CMS)
- Each Region has a different set of PDPs and benchmark (average premium)
- Each PDP has a different premium, drug formulary, benefit structure, network of participating pharmacies (including I/T/U)
- Only certain PDPs will auto enroll dual eligibles without a premium (*see 2006 low-income premium subsidy amounts by PDP region at end*)
- The PDP parent organization may have multiple plans with different names and benefits
- All PDPs were required by CMS to offer I/T/U pharmacies contracts in order to meet their Network Adequacy standards.
- More specific information about the Regions and plans is available from CMS at: www.cms.hhs.gov/map/map.asp
- www.medicare.gov also has a new web tool designed to help patients select PDPs.
- At this time detailed information about the PDPs and their formularies is not available to tribes. Contact your CMS Native American Contact for updates (*see Contact List at end*)

PDP Assessment and Selection for I/T/U Staff

American Indians and Alaska Natives (AI/AN), as well as all other Medicare beneficiaries, are entitled to select their own PDP. However, they will certainly appreciate guidance from I/T/U staff who are more familiar with the options. Most of the CMS and IHS information encourages AI/AN to contact staff at their local Indian health programs for information. If the I/T/U will pay premiums or copays, you will probably want to be sure that PDP selection will be coordinated with existing CHS policies. Areas for consideration:

- **Pharmacy Network.** AI/AN will want to be sure the pharmacies they use are included in the PDP's network. This means that if the I/T/U has a pharmacy, select a PDP that contracts with your pharmacy. If no I/T/U pharmacy is available, select a PDP that contracts with the community pharmacies used most often by your CHS program (CHS may be paying for copays and deductibles). Some PDPs are national and would cover Rx in other Regions. This would be helpful for people who tend to travel frequently.
- **Administrative Costs.** The cost to I/T/Us to administer the Part D program will be decreased if the number of PDPs they deal with is limited to as few as possible. It would be cheaper and easier to deal with one PDP than 20. This will reduce the staff time needed to develop working relationships with PDPs for enrollment, billing, contracting, appeals, premium payments, problem resolution, etc.
- **Formulary.** Each PDP may have a different set of drugs they cover. Identifying the drugs a Medicare beneficiary uses and then assessing which PDP covers those specific drugs (especially the more expensive ones) will increase I/T/U reimbursement and decrease CHS expenditures.
- **Benefit Structure.** Each PDP may structure its benefit differently. How the tiers of drugs are identified, out of network cost sharing, enhanced benefits are a few areas to assess.
- **Premiums.** Each plan has a different premium. Dual eligibles will only be auto enrolled in basic PDPs with premiums below the regional benchmark, so they will have \$0 premium. However, depending on other plan characteristics, a PDP with a premium above the benchmark may be well worth the additional monthly cost.
- **Contract Terms with I/T/U.** If you have an I/T/U pharmacy that contracts with PDPs, favorable contract terms like reimbursement rates may also influence your assessment.

- **Other Plan Characteristics.** Plans will have other characteristics or policies that may be favorable or unfavorable, like mail order options or processes to request coverage of a non-formulary drug. These unique plan characteristics may also be a consideration in PDP selection.

Paying Part D Premiums

Tribes should consider paying premiums on behalf of eligible patients because it could increase pharmacy revenue as well as save Contract Health Services funding. Overall, the Medicare Part D prescription drug benefit is subsidized by the federal government at about 75%.

- Group 3 (Low Income Subsidy) and Group 4 (Standard Benefit) will not get Part D unless someone pays the premium.
- IHS will not pay Part D premiums without specific authorizing legislation.
- Tribes who choose to pay premiums have a number of local policy and procedure decisions to make before enrollment can occur. These include: who is eligible for premium payment; what funds will be used for premiums; which staff will manage the program; will CHS policies form the basis of guidelines; will the tribe pay the premium directly to the PDP or will they reimburse tribal members (if deducted from SS check).
- Premiums will be billed by and paid to the PDP, unless premium payment is made by an automatic Social Security check deduction.
- Tribes will have to individually negotiate with each PDP how premium payments will work.
- Because this is a new program still in the implementation phase, there currently is no central source for tribes about the premium group payer function. Each tribe will need to develop their own system and share information through tribal forums like the National Indian Health Board's Medicare and Medicaid Policy Committee.

Troop (True Out Of Pocket)

- Troop is important to I/T/Us because it determines the “catastrophic coverage” or the point where the Part D benefit starts to cover more costs.
- Troop is technically the amount of “out of pocket” money a person spends for their drugs. In the case of AI/AN, who may rely on an I/T/U to cover their drugs, the I/T/U would pay any Troop.
- From the perspective of the I/T/U, it is beneficial for as much as possible to be counted as Troop, especially for patients with high drug costs.
- The catastrophic coverage limit is based on the cost of the drugs, not what a person pays out of pocket.
- The catastrophic coverage limit for all Part D is the same === \$5,100 in drugs.
- If a person cannot get their drugs counted toward Troop, they will never be able to “climb out of the coverage gap”.
- CMS guidance suggests that the cost of prescription drugs provided by an I/T/U facility or paid for by CHS will count toward the Part D deductible (\$50 for Low Income Subsidy; \$250 for Standard) but not toward the Troop (or catastrophic coverage) unless certain conditions are met.
- These conditions have been expressed by CMS in several ways:
 - “Even if a charity is not a bona fide charity for purposes of Federal fraud and abuse law, any drug payments it makes on behalf of Part D enrollees would count toward True out-of-pocket costs (TrOOP) unless otherwise excluded”
 - “Any cost sharing reimbursed or paid for by insurance or otherwise does not count toward TrOOP. “Insurance or otherwise” includes any government-funded program whose principal activity is the direct provision of health care to individuals. Since the principal

activity of the Indian Health Service is the direct provision of health care, any cost-sharing the Indian Health Service subsidizes on behalf of enrollees cannot count toward the true out-of-pocket costs, regardless of its status as payer of last resort.”

- “We (CMS) note that in certain areas, Tribal organizations using tribal-only money may qualify as TrOOP-eligible payers.”
- More work needs to be done to advise tribes how they might set up their Medicare Part D programs to ensure that their funding counts toward AI/AN patients’ Troop.

Creditable Coverage

- Creditable coverage is a concept that protects insurance companies from adverse risk. It means that a person has some type of coverage that is at least as good as the insurance coverage they are changing to.
- AI/AN who use I/T/Us are identified as having creditable coverage for Medicare Part D.
- The implication is that AI/AN who use I/T/Us can enroll in Medicare Part D at a date later than July, 2006 and not have to pay a late enrollment penalty.
- I/T/Us should let their Medicare patients know that they have creditable coverage so they do not feel rushed into signing up for Part D by outside media and mailings.
- August, 2006 is the earliest that an AI/AN patient would need any documentation from an I/T/U certifying that they have creditable coverage. This would be required by a PDP if the AI/AN decided to enroll on their own. Because more immediate implementation issues need to be dealt with first, guidance on this documentation will likely appear next year.

The Low Income Subsidy (Extra Help) Application Form

- The Social Security Administration (not CMS) is responsible for the Low Income Subsidy application and determination process.
- Application can be completed on-line at: www.socialsecurity.gov or by completing a paper application (must be original SSA-1020 not Xeroxed form) and returning to SSA.
- SSA has CDs available explaining the application form.
- Successful application will result in two significant benefits: a lower premium and a higher level of Rx coverage.

The Part D Enrollment Form

- Part D enrollment actually occurs when a person signs up for a PDP (on line, paper form or telephone call), so to enroll in Part D (except for full dual eligibles) you must first decide which PDP you want.
- Answer “No” to “Will you have prescription drug coverage in addition to PDP?”. A “Yes” answer will trigger a coordination of benefits form that is not intended for Indian Health.
- If a premium is required, the I/T/U must decide if it will pay it or not. If the I/T/U does pay the premium, decide if the I/T/U will reimburse the patient or if the I/T/U will directly pay the PDP. “Plan Premium Payment Option” must indicate which payment option is being used (monthly SSA check deduction similar to Part B or direct bill).
- If the I/T/U will pay the premium to the PDP, use the proper I/T/U address as the billing address. Because the premium invoices and other important notices will come to the billing address, it’s important that the address be correct and that staff receiving this mail know what it is and what to do with it.

| 2006 low-income premium subsidy amounts | | | |
|--|----------------------------|----------|---|
| PDP Region | State(s) | Subsidy | # Organizations with Auto Enrollment for Dual Eligibles |
| 1 | NH, ME | \$ 36.09 | 10 |
| 2 | CT, MA, RI, VT | \$ 30.27 | 7 |
| 3 | NY | \$ 29.83 | 10 |
| 4 | NJ | \$ 31.37 | 9 |
| 5 | DE, DC, MD | \$ 33.46 | 13 |
| 6 | PA, WV | \$ 32.59 | 13 |
| 7 | VA | \$ 34.42 | 13 |
| 8 | NC | \$ 36.30 | 10 |
| 9 | SC | \$ 34.88 | 13 |
| 10 | GA | \$ 33.15 | 12 |
| 11 | FL | \$ 29.07 | 5 |
| 12 | AL, TN | \$ 32.33 | 7 |
| 13 | MI | \$ 33.22 | 12 |
| 14 | OH | \$ 30.69 | 8 |
| 15 | IN, KY | \$ 35.69 | 11 |
| 16 | WI | \$ 31.27 | 12 |
| 17 | IL | \$ 31.60 | 11 |
| 18 | MO | \$ 31.37 | 8 |
| 19 | AR | \$ 35.45 | 11 |
| 20 | MS | \$ 36.39 | 10 |
| 21 | LA | \$ 34.14 | 9 |
| 22 | TX | \$ 31.68 | 13 |
| 23 | OK | \$ 35.13 | 9 |
| 24 | KS | \$ 33.44 | 9 |
| 25 | IA, MN, MT, ND, NE, SD, WY | \$ 33.11 | 10 |
| 26 | NM | \$ 25.95 | 7 |
| 27 | CO | \$ 28.92 | 9 |
| 28 | AZ | \$ 24.62 | 5 |
| 29 | NV | \$ 23.46 | 6 |
| 30 | OR, WA | \$ 30.60 | 11 |
| 31 | ID, UT | \$ 33.62 | 11 |
| 32 | CA | \$ 23.25 | 7 |
| 34 | AK | \$ 34.66 | 6 |

Go to: www.cms.hhs.gov/map/map.asp for specific information about the names of organizations and plans by State or Region.

STATE CONTACT INFORMATION FOR PDPs

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