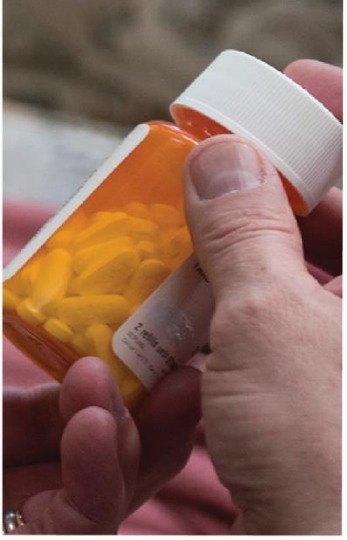


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS
NTP
NATIONAL
TRAINING PROGRAM
MODULE 9

Medicare Prescription Drug Coverage

Content

Session Objectives

This session should help you

- Differentiate between Medicare Part A, Part B, and Part D drug coverage
- Summarize Part D eligibility and enrollment requirements
- Compare and choose drug plans
- Describe Extra Help with drug plan costs
- Explain coverage determinations and the appeals process

Lesson 1—The Basics

- The 4 parts of Medicare
  - Part A (Hospital Insurance)
  - Part B (Medical Insurance)
  - Part C (Medicare Advantage (MA))
  - Part D (Medicare prescription drug coverage)
- Prescription drug coverage under
  - Medicare Part A (Hospital Insurance)
  - Medicare Part B (Medical Insurance)

The 4 Parts of Medicare

Throughout this training, these icons are used to identify the part of Medicare being discussed.

Original Medicare

Part A
Hospital Insurance

Part B
Medical Insurance

Medicare Advantage (Part C)

Part A

Part B

Part D
(Usually)

Medicare Prescription Drug Coverage

Part D
Medicare prescription drug coverage

Medicare Prescription Drug Coverage

- Prescription drug coverage under Original Medicare Part A, Part B, or Part D depends on
  - Medical necessity
  - Health care setting
  - Medical indication (why you need it, like for cancer)
  - Any special drug coverage requirements
    - Such as immunosuppressive drugs following a transplant

Part A Prescription Drug Coverage

- Part A generally pays for
  - All drugs during a covered inpatient stay received as part of treatment in a hospital or skilled nursing facility (SNF)
  - Drugs used in hospice care for symptom control and pain relief only

Part B Prescription Drug Coverage

- Part B covers limited outpatient drugs
  - Most injectable and infusible drugs given as part of a doctor's service
  - Drugs and biologicals
    - Used for the treatment of End-Stage Renal Disease (ESRD)
  - Drugs used at home with some types of Part B covered durable medical equipment (DME)
    - Such as nebulizers and infusion pumps
  - Some oral drugs with special coverage requirements like
    - Certain oral anti-cancer and antiemetic drugs
    - Immunosuppressive drugs, under certain circumstances

Part B Immunization Coverage

- Part B covers certain immunizations as part of Medicare-covered preventive services
  - Influenza virus vaccine (flu shot)
  - Pneumococcal shot (to prevent certain types of pneumonia)
  - Hepatitis B shot
- Part B may cover certain vaccines after exposure to a disease or after an injury
  - Tetanus shot

Self-administered Drugs in Hospital Outpatient Settings

- Part B doesn't cover self-administered drugs in a hospital outpatient setting
  - Unless needed for hospital services
- If enrolled in Part D, drugs may be covered
  - If not admitted to hospital
  - May have to pay and submit for reimbursement

Check Your Knowledge—Question 1

Which part of Medicare pays for drugs used only in hospice care for symptom control and pain relief?

a. Part A

b. Part B

c. Part D

d. None of the above

Check Your Knowledge—Question 2

Medicare Part D doesn't cover the cost of the flu shot, a preventive service immunization.

a. True

b. False

Lesson 2—Medicare Part D Benefits and Costs

- Medicare prescription drug coverage
- Medicare drug plan benefits and costs

Part D Medicare Prescription Drug Coverage

- Medicare drug plans
  - Approved by Medicare
  - Run by private companies
  - Available to everyone with Medicare
- In most cases, you must join a plan to get coverage
- There are 2 ways to get coverage
  - Medicare Prescription Drug Plans (PDP)
  - Medicare Health Plans with prescription drug coverage

Part D Medicare Prescription Drug Plans (PDPs)

- Can be flexible in benefit design
- Must offer at least a standard level of coverage
- Vary in costs and drugs covered
  - Different tier and/or copayment/coinsurance levels
  - Enhanced ("extra") coverage for drugs not typically covered by Part D
- Benefits and costs may change each year

Medicare Drug Plan Costs

- Costs vary by plan
- In 2018, most people will pay
  - A monthly premium
  - A yearly deductible (if applicable)
  - Copayments or coinsurance
  - 35% for covered brand-name drugs in the coverage gap
  - 44% for covered generic drugs in the coverage gap
  - Very little after spending $5,000 out-of-pocket—automatically get catastrophic coverage

Standard Structure in 2018

Ms. Smith joins a prescription drug plan. Her coverage begins on January 1. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year.

1. Yearly deductible	2. Copayment or coinsurance (what you pay at the pharmacy)	3. Coverage gap	4. Catastrophic coverage
Ms. Smith pays the first $405 of her drug costs before her plan starts to pay its share.	**Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches $3,750.**	**Once Ms. Smith and her plan have spent $3,750 for covered drugs, she's in the coverage gap. In 2018, she gets a 50% discount from the drug manufacturer on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. For 2018, she gets an additional 15% coverage from her plan on covered brand-name drugs and 56% coverage on covered generic drugs while in the coverage gap.**	**Once Ms. Smith has spent $5,000 out-of-pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.**

Improved Coverage in the Coverage Gap

Year	What You Pay for Covered Brand-Name Drugs in the Coverage Gap	What You Pay for Covered Generic Drugs in the Coverage Gap
2018	35%	44%
2019	25%	37%
2020	25%	25%

True Out-of-Pocket (TrOOP) Costs

- Expenses that count toward your out-of-pocket threshold ($5,000 in 2018)
- After threshold you get catastrophic coverage
  - You pay only small copayment or coinsurance for covered drugs
- Explanation of Benefits (EOB) shows TrOOP costs to date
- TrOOP transfers if you switch plans mid-year

What Payments Count Toward TrOOP?

- **Payments made by**
  - You (including payments from your Medical Savings Account (MSA), Health Savings Account (HSA), or Flexible Spending Account (FSA) (if applicable))
  - Family members or friends
  - Qualified State Pharmacy Assistance Programs (SPAPs)
  - Medicare's Extra Help (Low-income subsidy (LIS))
  - Indian Health Service (IHS)
  - Most charities (unless they're established, run, or controlled by the person's current or former employer or union or by a drug manufacturer's Patient Assistance Program operating outside Part D)
  - Drug manufacturer discounts on brand-name/generic drugs under the Medicare coverage gap program
  - AIDS Drug Assistance Programs (ADAPs)

What Payments Don't Count Toward TrOOP?

- The amount paid by a Medicare drug plan
- The monthly drug plan premium
- Drugs purchased outside the U.S. and its territories
- Drugs not covered by the plan
- Drugs excluded from the definition of Part D drug, even in cases where the plan chooses to cover them as a supplemental benefit (like drugs for hair growth)
- Payments made by, or reimbursed to you by
  - Group health or retiree coverage
  - Government-funded programs
  - Other third-party groups
  - Patient Assistance Programs operating outside the Part D benefit
  - Other types of insurance
- Over-the-counter drugs or most vitamins (even if they're required by the plan as part of step therapy)

Part D Monthly Premium and Income-Related Monthly Adjustment Amounts (IRMAA)

- Based on income above a certain limit
  - Fewer than 5% pay a higher premium
  - Uses same thresholds used to compute IRMAA for the Part B premium
  - Income as reported on your Internal Revenue Service (IRS) tax return from 2 years ago
- Required to pay if you have Part D coverage
  - Failure to pay will result in disenrollment

Income-Related Monthly Adjustment Amount (IRMAA)

Chart is based on your yearly income *in 2016* (for what you pay in 2018)

Filing an Individual Tax Return	Filing a Joint Tax Return	File Married & Separate Tax Return	In 2018 You Pay Monthly
$85,000 or less	$170,000 or less	$85,000 or less	Your Plan Premium (YPP)
Above $85,000 Up to $107,000	Above $170,000 Up to $214,000	Not applicable	YPP + $13.00*
Above $107,000 Up to $133,500	Above $214,000 Up to $267,000	Not applicable	YPP + $33.60*
Above $133,500 Up to $160,000	Above $267,000 Up to $320,000	Not applicable	YPP + $54.20*
Above $160,000	Above $320,000	Above $85,000	YPP + $74.80*

***IRMAA is adjusted each year, as it's calculated from the annual beneficiary base premium.**

Check Your Knowledge—Question 3

Which one of the following counts toward your True out-of-pocket (TrOOP) costs?

a. The amount you paid for your drugs covered under the plan

b. Your monthly drug plan premium

c. Over-the-counter drugs and most vitamins

d. The amount paid by your Medicare drug plan

Check Your Knowledge—Question 4

A small group of people will pay a higher monthly drug plan premium based on their income (as reported on their Internal Revenue Service tax return from 2 years ago).

a. True

b. False

Lesson 3—Medicare Part D Drug Coverage

- Covered and non-covered drugs
- Access to covered drugs
- Medication Therapy Management (MTM)

Part D Covered Drugs

- Prescription brand-name and generic drugs
  - Approved by the U.S. Food and Drug Administration (FDA)
  - Used and sold in United States (U.S.)
  - Used for medically-accepted indications
- Includes drugs, biological products, and insulin
  - And supplies associated with injection of insulin
- Plans must cover a range of drugs in each category
- Coverage and rules vary by plan

Required Coverage

- All drugs in 6 protected categories
  - Cancer drugs
  - HIV/AIDS drugs
  - Antidepressants
  - Antipsychotics
  - Anticonvulsants
  - Immunosuppressants
- All commercially available vaccines
  - Except those covered under Part B (flu shot)

Drugs Excluded by Law Under Part D

- Drugs for anorexia, weight loss, or weight gain
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products
- Over-the-counter drugs

Formulary

- A list of prescription drugs covered by the plan
- May have tiers that cost different amounts

Tier Structure Example

Tier	You Pay	Prescription Drugs Covered
1	Lowest copayment	Most generics
2	Medium copayment	Preferred, brand-name
3	High copayment	Non-preferred, brand-name
4 or Specialty	Highest copayment or coinsurance	Unique, very high cost

Formulary Changes

- Plans may only change categories and classes at the beginning of each plan year
  - May make maintenance changes during year
    - Such as replacing brand-name drug with new generic
- Plans usually notify you 60 days before changes
  - You may be able to continue to have your drug covered until end of calendar year
  - May ask for exception if other drugs don't work
- Plans may remove drugs withdrawn from the market by the FDA or the manufacturer without a 60-day notification

How Plans Manage Access to Drugs

Prior Authorization	▪ Prescriber must contact plan for prior approval and show medical necessity before drug will be covered
Step Therapy	▪ Must first try similar, less expensive drug ▪ Prescriber may request an exception if • Similar, less expensive drug didn't work, or • Step therapy drug is medically necessary
Quantity Limits	▪ Plan may limit drug quantities over a period of time for safety and/or cost ▪ Prescriber may request an exception if additional amount is medically necessary

How Plans Manage Unsafe Use of Opioids

Enhanced Drug Utilization Review	▪ If you use high amounts of opioids from several prescribers and pharmacies, your plan may communicate with your doctor(s) to understand if some or no opioid medications are appropriate and medically necessary ▪ You'll get a letter 30 days in advance if coverage of your opioid medications will be limited ▪ If you believe this is a mistake, you or your prescriber may contact the plan to request a coverage determination
Opioid Safety Edits	▪ An alert triggers at the pharmacy if your recent prescription(s) exceeds a high amount of opioids ("morphine equivalent dose") ▪ Some alerts can be overridden by the pharmacist while others may require a decision by the plan to override ▪ If your pharmacy can't fill a prescription, the pharmacist will issue a notice explaining that you or your prescriber can contact the plan to request a coverage determination

NEW Requirement for Prescribers

- New requirements for prescribers of Part D drugs will be in effect in 2019
- Prescribers must
  - Reject, or require a pharmacy benefit manager to reject a pharmacy claim for a Part D drug if the prescriber is included on the "preclusions list" (e.g., certain individuals and entities that are currently revoked from the Medicare Program)
  - Reject coverage of an MA service or item if the provider is on the "preclusions list"
- The Centers for Medicare & Medicaid Services (CMS) believes that a preclusion list requirement will reduce the burden on Part D prescribers and MA providers without compromising program integrity efforts

If Your Prescription Changes

- Get up-to-date formulary information from your plan's
  - Website
  - Customer service center
- Give your prescriber a copy of your plan's formulary if he or she doesn't prescribe electronically
- If the new drug isn't on the plan's formulary
  - You can request an exemption from the plan
  - You may have to pay full price if plan still won't cover
  - You may consider changing your Part D plan when permissible to one that does cover the drug

Medication Therapy Management (MTM)

A pharmacist or other health provider does a comprehensive review of all your medications and talks with you about

- How well your medications are working
- Whether your medications have side effects
- If there might be interactions between the drugs you're taking
- Whether your costs can be lowered
- Other problems you're having

Medication Therapy Management (MTM) Conditions

To qualify for MTM services, you need to meet all of these conditions

- You have more than one chronic health condition
- You take several different medications
- Your medications have a combined cost of more than $3,967 per year

Check Your Knowledge—Question 5

What year will new requirements for prescribers of Part D drugs go into effect?

a. 2018

b. 2019

c. 2020

d. 2021

Lesson 4—Part D Eligibility and Enrollment

- Eligibility requirements
- When you can join or switch plans
- Creditable coverage
- Late enrollment penalty

Part D Eligibility Requirements

- You must have Medicare Part A and/or Part B to join a Medicare Prescription Drug Plan (PDP)
- You must have Medicare Part A and Part B to join a Medicare Advantage (MA) Plan with drug coverage (MA-PD)
- You must have Medicare Part A and Part B or only Part B to join a Medicare Cost Plan with Part D coverage
- You must live in the plan's service area
  - You can't be incarcerated
  - You can't be unlawfully present in the United States (U.S.)
  - You can't live outside the U.S.
- You must join a plan to get drug coverage (in most cases)

Creditable Drug Coverage

- Current or past prescription drug coverage
  - For example, group health plans (GHP) like from an employer, retiree plans, Veterans Affairs (VA), TRICARE, the Indian Health Service (IHS), and the Federal Employee Health Benefits (FEHB) Program
- Creditable if it pays, on average, as much as Medicare's standard drug coverage
- Plans inform yearly about whether creditable
- With creditable coverage you may not have to pay a late enrollment penalty

Initial Enrollment Period (IEP)

- When you first become eligible to get Medicare
  - 7-month IEP for Part D

If You Join	Coverage Begins
During the 3 months before you turn 65	Date eligible for Medicare
During the month you turn 65	First day of the following month
During the 3 months after you turn 65	Delayed 2-3 months, Part A (if you have to buy it) and/or Part B

Other Enrollment Periods

- Medicare's yearly Open Enrollment Period (OEP) is October 15–December 7 each year, coverage starts January 1
- NEW January 1, 2019, new Medicare Advantage (MA) OEP
  - Can add or drop Part D when switching plans
  - Part D not guaranteed unless you were in an MA Plan on January 1
  - Can't switch from one standalone PDP to another standalone PDP
- If you don't have Medicare Part A coverage, and enroll in Part B during the General Enrollment Period (GEP) (January 1–March 31), you can sign up for a Medicare PDP from April 1–June 30 each year

Special Enrollment Period (SEP)

- Life events that allow an SEP include
  - You permanently move out of your plan's service area
  - You lose other creditable prescription coverage
  - You weren't properly told that your other coverage wasn't creditable, or your other coverage was reduced and is no longer creditable
  - You enter, live at, or leave a long-term care facility
  - You have a continuous SEP if you qualify for Extra Help
  - NEW
    - Special Enrollment Period change for 2019
  - You belong to a State Pharmaceutical Assistance Program (SPAP)
  - You join or switch to a plan that has a 5-star rating
  - Other exceptional circumstances

5-Star Special Enrollment Period (SEP)

- Use Medicare Plan Finder tool at Medicare.gov to see quality and performance ratings 
- Star ratings are given once a year in October for the past year

- Use 5-star SEP to switch to any plan with a 5-star overall rating one time
  - December 8–November 30 of following year
  - Coverage starts first day of month after enrolled
- Be careful not to switch from an MA Plan with drug coverage to an MA Plan without Part D coverage

Consistently Low Performing Plans

- Low performing star rating status
  - You may have a one-time option to switch to another Medicare drug plan with a rating of 3, 4, or 5 stars if your plan's summary rating was less than 3 stars for 3 years
  - Low Performing Icon (LPI) appears on Plan Finder 
  - Plans may not attempt to discredit their LPI status by showcasing a separate higher rating

Part D Late Enrollment Penalty

- Higher premium if you wait to enroll
  - Exceptions if you have
    - Creditable coverage
    - Extra Help
- Pay penalty for as long as you have coverage
  - 1% of base beneficiary premium ($35.02 in 2018)
    - For each full month eligible and without creditable prescription drug coverage
  - Amount changes every year

Part D Penalty Example—Ann

- Didn't join when she was first eligible—by May 31, 2014
  - Joined a Medicare drug plan during the 2016 OEP—coverage began on January 1, 2017
  - Without creditable prescription drug coverage from June 2014–December 2016 (31 months)
  - Penalty in 2017 was 31% (1% for each of the 31 months) of $35.63 (base beneficiary premium for 2017), which was $11.05
  - Monthly penalty was rounded to the nearest $.10, so she was charged $11.10 each month in addition to her plan's monthly premium in 2017

Part D Penalty Example—Ann (continued)

- Medicare recalculated Ann's penalty using the 2018 base beneficiary premium ($35.02)
  - Penalty is 31% (1% for each of the 31 months) of $35.02 (base beneficiary premium for 2018), which is $10.86
  - Monthly penalty is rounded to the nearest $.10, so she'll be charged $10.90 each month in addition to her plan's monthly premium in 2018

Here's the math:

.31 (31% penalty) × $35.02 (2018 base beneficiary premium) = $10.86

$10.86 (rounded to the nearest $0.10) = $10.90

$10.90 = Ann's monthly late enrollment penalty for 2018

Check Your Knowledge—Question 6

Life events that allow a Special Enrollment Period (SEP) don't include

a. You permanently move out of your plan's service area

b. You weren't properly told that your other coverage wasn't creditable, or your other coverage was reduced and is no longer creditable

c. You lose other creditable prescription coverage

d. You begin hospice care

Lesson 5—Extra Help With Part D Drug Costs

- What's Extra Help?
- How to qualify (income and resource limits)
- Enrollment
- Continuing eligibility

What's Extra Help?

- Program to help people pay for Medicare prescription drug costs
  - Also called the Low-income subsidy (LIS)
- For people with limited income and resources
  - Lowest income and resources
    - Pay no premiums or deductible and small or no copayments
  - Slightly higher income and resources
    - Pay a reduced deductible and a little more out-of-pocket
- No coverage gap or late enrollment penalty if you qualify
- Continuous Special Enrollment Period (SEP)
  - ➢ New in 2019 - Once per calendar quarter during first 9 months each year

2018 Extra Help Income and Resource Limits

- Income limits
  - Below 150% of the federal poverty level (FPL)
    - $18,210* per year for an individual, or $24,690* per year for a married couple
  - Based on family size
- Resource limits
  - Up to $14,100,* per year for an individual, or $28,150* per year for a married couple
    - Doesn't include $1,500/person for funeral or burial expenses
    - Counts savings and investments
    - Real estate (except your home)

***Higher amounts for Alaska and Hawaii**

Qualifying for Extra Help

- You automatically qualify for Extra Help if you get
  - Full Medicaid coverage
  - Supplemental Security Income (SSI)
  - Help from Medicaid paying your Part B premium (Medicare Savings Program (MSP))
- All others must apply
  - Online at socialsecurity.gov/benefits/medicare/prescriptionhelp
  - Call Social Security at 1-800-772-1213; TTY: 1-800-325-0778
    - Ask for "Application for Help With Medicare Prescription Drug Plan Costs" (SSA-1020)
  - Contact your state Medicaid agency
  - Work with a local organization, like a State Health Insurance Assistance Program (SHIP)

Automatic and Facilitated Enrollment

People With Medicare and…	Basis for Qualifying	Data Source	Enrollment
Full Medicaid benefits	Automatically qualify	State Medicaid agency	Automatic enrollment in Part D drug plan (unless already in a drug plan) ▪ Letter on YELLOW paper ▪ Coverage starts first month eligible for Medicare and Medicaid ▪ Continuous Special Enrollment Period (SEP)
Medicare Savings Program	Automatically qualify	State Medicaid agency	Facilitated enrollment in Part D drug plan ▪ Letter on GREEN paper ▪ Coverage starts 2 months after CMS receives notice of your eligibility ▪ Continuous SEP
Supplemental Security Income benefits	Automatically qualify	Social Security (SSA)	
Limited income and resources	Must apply and qualify	SSA (most) or state Medicaid agency	

2018 Extra Help Copayments

Extra Help Copayments	2018 Generic/Brand-name
Institutionalized (Level 3)	$0
Receiving Home and Community-Based Services (under waiver only) (Level 3)	$0
Up to or at 100% Federal Poverty Level (Level 2)	$1.25/$3.70
Full Extra Help (Level 1)	$3.35/$8.35
Partial Extra Help (Deductible/Cost-Sharing) (Level 4)	$83.00/15%

Medicare's Limited Income Newly Eligible Transition (LI NET) Program

- Designed to remove gaps in coverage for low-income individuals moving to Part D coverage
- Gives temporary drug coverage if you have Extra Help and no Medicare drug plan
- Coverage may be immediate, current, and/or retroactive
- Medicare's Limited Income Newly Eligible Transition (LI NET) Program
  - Has an open formulary
  - Doesn't require prior authorization
  - Includes standard safety and abuse edits to protect you from refilling too soon or therapy duplication
  - Has no network pharmacy restrictions
- Continuing Education credit webinars available
  - Run by Humana

How Do You Access Medicare's Limited Income Newly Eligible Transition (LI NET) Program?

Auto-enrollment by CMS	• CMS auto-enrolls you if you have Medicare and get either full Medicaid coverage or SSI benefits.
Point-of-Sale (POS) Use	• You may use Medicare's LI NET program at the pharmacy counter.
Submit a Receipt	• You may submit pharmacy receipts (not just a cashier's receipt) for prescriptions already paid for out-of-pocket during eligible periods.

Reassignment Notices

- People reassigned notified by CMS early November (BLUE paper)
  - Three versions of notice
    - People whose plans are leaving the Medicare Program
      - CMS product No. 11208 (Medicare Advantage (MA) Plan with prescription drug coverage)
      - CMS product No. 11443 (MA)
    - People whose premiums are increasing
      - CMS product No. 11209

Changes in Qualifying for Extra Help

- Medicare reestablishes eligibility each fall for next year
  - If you no longer automatically qualify
    - Medicare sends “Loss-of-Deemed-Status” notice in September (GRAY paper)
      - Includes Social Security application to reapply
  - If your status changes and you again automatically qualify
    - Medicare sends “Deemed Status” notice (PURPLE paper)
  - If you automatically qualify, but your copayment changed
    - Medicare sends “Change in Extra Help Co-payment” notice in early October (ORANGE paper)

Redetermination Process

- People who applied and qualified for Extra Help
  - Four types of redetermination processes
    - Initial
    - Cyclical or recurring
    - Subsidy-changing event (SCE)
    - Other event (change other than SCE)

Check Your Knowledge—Question 7

You automatically qualify for Extra Help if you get

a. Help from Medicaid paying your Part B premium (Medicare Savings Program)

b. Full Medicaid coverage

c. Supplemental Security Income

d. All of the above

Lesson 6—Comparing and Choosing Plans

- Things to consider
- Steps to choosing a Medicare drug plan
- What to expect

Things to Consider Before Joining a Plan

- Important questions to ask
  - Do you have other current health insurance?
  - Is any prescription drug coverage you might have as good as (creditable) Medicare drug coverage?
  - How does your current coverage work with Medicare?
  - Could joining a plan affect your current coverage or family member's coverage?

Steps to Choosing a Medicare Drug Plan

1. Prepare
2. Compare plans on the Medicare Plan Finder
3. Decide and enroll

Step 1: Prepare

- Prepare by getting your information together
  - Current prescription drug coverage
  - Prescription drugs, dosages, and quantities
  - Preferred pharmacies
  - Medicare card
  - ZIP code

Step 2: Compare Plans on Medicare Plan Finder

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on star ratings, benefits, costs, and more

Step 3: Decide and Join

- Decide which plan is best for you and enroll
  - Online enrollment
    - Medicare.gov/find-a-plan
    - Plan's website
  - Enroll by phone
    - Call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048
    - Call the plan
  - Mail or fax paper application to plan

What New Members Can Expect

- Your plan will send you
  - An enrollment letter
  - Membership materials, including card
  - Customer service contact information
- If your current drug isn't covered by plan
  - You can get a transition supply (generally 30 days)
  - Work with prescriber to find a drug that's covered
  - Request an exception if no acceptable alternative drug is on the list

NEW Annual Notice of Change (ANOC)

- All Medicare drug plans must send an ANOC to members 15 days before the annual OEP
  - Evidence of Coverage (EOC) to be delivered on the first day of OEP
- Will include information for upcoming year
  - Summary of Benefits
  - Formulary
  - Changes to monthly premium and/or cost sharing
- Read ANOC carefully and compare your plan with other plan options

Lesson 7—Coverage Determinations and Appeals

- Coverage determinations
- Exception requests
- Appeals

Coverage Determination Request

- Initial decision by plan
  - Which benefits you're entitled to get
  - How much you have to pay for a benefit
  - You, your prescriber, or your appointed representative can request it
- Time frames for coverage determination request
  - May be standard (decision within 72 hours)
  - May be expedited (decision within 24 hours) if life or health may be seriously jeopardized

Exception Requests

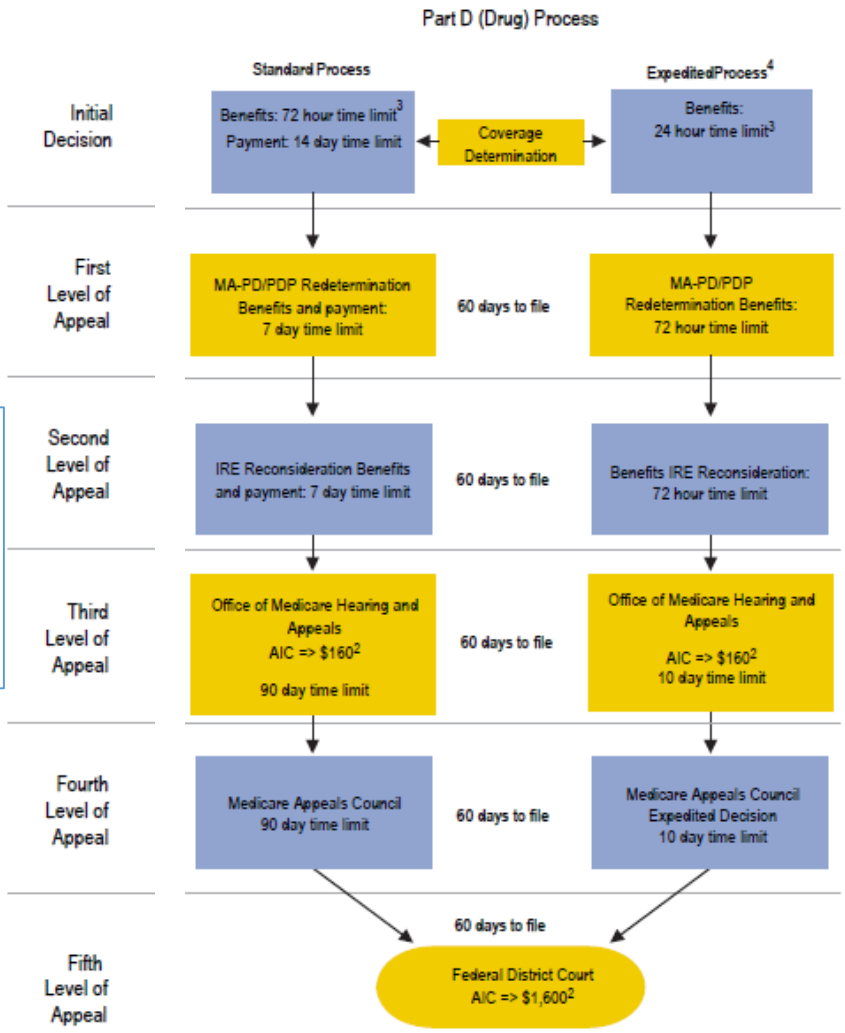
- Two types of exceptions
  - Formulary exceptions
    - Drug not on plan's formulary, or
    - Access requirements (for example, step therapy)
  - Tier exceptions
    - For example, getting a tier 4 drug at tier 3 cost
- Need supporting statement from prescriber
- You, your appointed representative, or prescriber can make requests
- Exception may be valid for rest of year

Requesting Appeals

- If your coverage determination or exception is denied, you can appeal the plan's decision
- In general, you must make your appeal requests in writing
  - Plans must accept oral (spoken) expedited requests
- An appeal can be requested by
  - You
  - Your doctor or other prescriber
  - Your appointed representative
- There are 5 levels of appeals

Part D Appeals and Flowchart Footnotes

- **AIC** = Amount in Controversy
- **IRE** = Independent Review Entity
- **MA-PD** = Medicare Advantage Prescription Drug
- **PDP** = Prescription Drug Plan



- 2: The AIC requirement for all appeals at the Office of Medicare Hearings and Appeals and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2018 AIC amounts.
- 3: A request for a coverage determination includes a request for a tiering exception or a formulary exception. The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.
- 4: Payment requests cannot be expedited.

Key Points to Remember

- Medicare Part D provides your Medicare prescription drug coverage
- You must take action to join a plan
- A delay in joining may result in a late enrollment penalty
- You have choices in how you get your coverage
- Extra Help is available to people with low income and resources

Medicare Prescription Drug Coverage Resource Guide

Centers for Medicare & Medicaid Services (CMS)	Call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048. Medicare.gov CMS.gov
Social Security	Call 1-800-772-1213; TTY: 1-800-325-0778. socialsecurity.gov
State Health Insurance Assistance Programs and State Insurance Departments	shiptacenter.org The SHIP National Technical Assistance Center ship state health insurance assistance programs Local Help for People with Medicare. SHIP
Limited Income NET Program (Humana)	Call 1-877-783-1307 or 711 (TRS) Humana.com/pharmacy/pharmacists/linet

Medicare Prescription Drug Coverage Resource Guide—Medicare Products

Prescription Drug Benefit Manual	CMS.gov/Medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html
Prescription Drug Plan Enrollment and Disenrollment Guidance for CY 2018	CMS.gov/Medicare/eligibility-and-enrollment/medicarepresdrugeligenrol/index.html
Medicare Premiums: Rules for Higher-Income Beneficiaries	socialsecurity.gov/pubs/EN-05-10536.pdf
2018/2019 Guide to Mailings From CMS, Social Security, and Plans	CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf
National Training Program – Partner Job Aids	CMSnationaltrainingprogram.cms.gov/?q=global-search&combine=job%20aids
"Your Guide to Medicare Prescription Drug Coverage"	Medicare.gov/Pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf
"Things to Think About When You Compare Medicare Drug Coverage"	Medicare.gov/Pubs/pdf/11163-Compare-Medicare-Drug-Coverage.pdf

Medicare Prescription Drug Coverage Resource Guide—Medicare Products (continued)

"4 Ways to Help Lower Your Medicare Prescription Drug Costs"	Medicare.gov/Pubs/pdf/11417-4-Ways-Lower-Prescription-Costs.pdf
"How Medicare Drug Plans Use Pharmacies, Formularies, and Common Coverage Rules"	Medicare.gov/pubs/pdf/11136-Pharmacies-Formularies-Coverage-Rules.pdf
"Medicare Drug Coverage Under Medicare Part A, B, & D"	CMS.gov/outreach-and-education/outreach/partnerships/downloads/11315-p.pdf
"Handling Medicare Part D Complaints"	CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11259-P.pdf
"How Retiree Coverage Works With Medicare Prescription Drug Coverage"	CMS.gov/Outreach-and-Education/Outreach/Partnerships/Publications-for-Partners-Items/CMS1221769.html?DLPage=1&DLEntries=10&DLFilter=ret&DLSort=2&DLSortDir=ascending

Medicare Prescription Drug Coverage Resource Guide—Ordering Medicare Products

"LI NET for People at Pharmacy Counter"	CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11328-P.pdf
"LI NET for People With Retroactive Medicaid & SSI Eligibility"	CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11401-P.pdf

To access other helpful products:

- View or download at Medicare.gov/Publications
- Order multiple copies (partners only) at Productordering.cms.hhs.gov.

You must register your organization.

Acronyms

AIC Amount in Controversy

ALJ Administrative Law Judge

ANOC Annual Notice of Change

BPH Benign Prostatic Hyperplasia

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

DME Durable Medical Equipment

EOB Explanation of Benefits

EOC Evidence of Coverage

ESRD End-Stage Renal Disease

FDA U.S. Food and Drug Administration

FPL Federal Poverty Level

IEP Initial Enrollment Period

IRE Independent Review Entity

IRMAA Income-Related Monthly Adjustment Amount

IRS Internal Revenue Service

LPI Low Performance Icon

MA Medicare Advantage

Acronyms (continued)

MAC Medicare Administrative Contractor

MA-PD Medicare Advantage Plans With Prescription Coverage

MSP Medicare Savings Program

MTM Medication Therapy Management

NET Newly Eligible Transition

NTP National Training Program

OEP Open Enrollment Period

PDP Prescription Drug Plan

PDE Prescription Drug Event

POS Point-of-Sale

RRB Railroad Retirement Board

SCE Subsidy-Changing Event

SEP Special Enrollment Period

SNF Skilled Nursing Facility

SSA Social Security

SSI Supplemental Security Income

TrOOP True Out-of-Pocket

TTY Teletypewriter

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