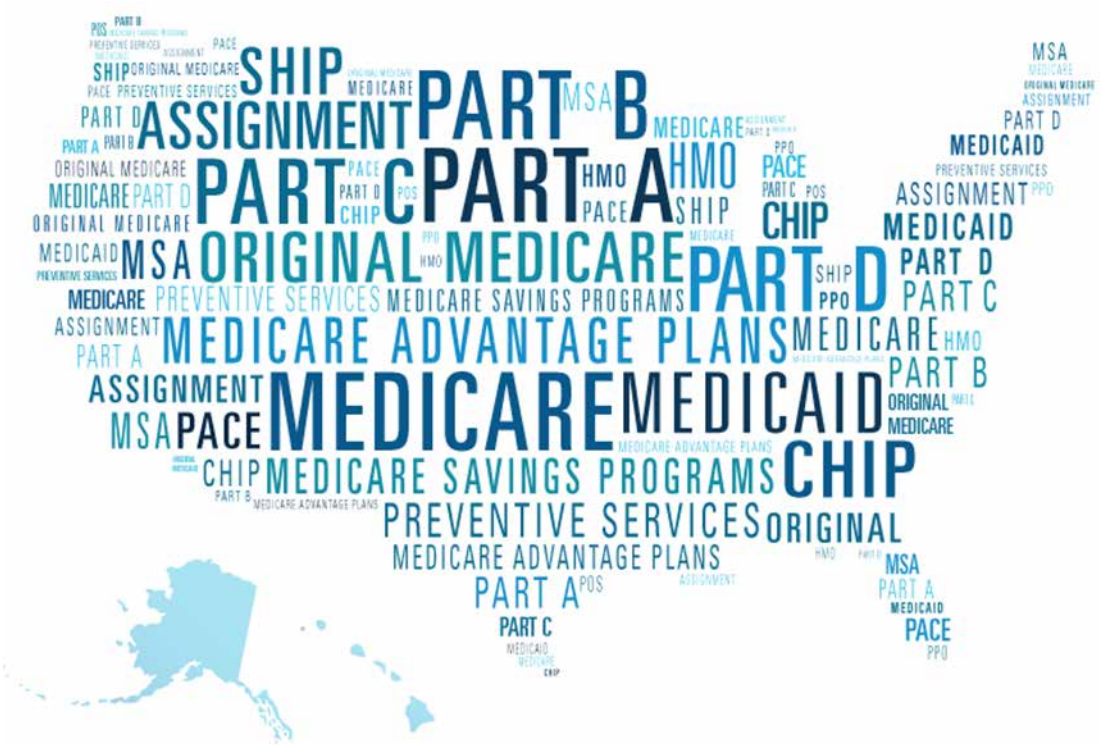
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2015 National Training Program

50 MEDICARE 1965-2015 MEDICAID ANNIVERSARY



Module 9

Medicare Part D Prescription Drug Coverage

Session Objectives

§ This session should help you

- Differentiate 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
- Prescription drug coverage under
  - Medicare Part A (Hospital Insurance)
  - Medicare Part B (Medical Insurance)

The 4 Parts of Medicare

Part A Hospital Insurance

Part B Medical Insurance

Part C Medicare Advantage Plans (like HMOs/PPOs)
Includes Part A, Part B, and sometimes Part D coverage

Part D Medicare Prescription Drug Coverage

Medicare Prescription Drug Coverage

- Prescription drug coverage under 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
- This information applies if you have Original Medicare

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
- 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
  - Flu shot
  - Pneumococcal shot (to prevent 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

Prescription drugs may be covered by which of the following?

a. Part A

b. Part B

c. Part D

d. All of the above

Check Your Knowledge—Question 2

Part A covers all drugs for people receiving Medicare-covered hospice care.

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
- You must join a plan to get coverage
- There are 2 ways to get coverage
  1. Medicare Prescription Drug Plans
  2. Medicare Health Plans with prescription drug coverage

Medicare Drug Plans

- 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 levels
  - Deductible
  - 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 2015, most people will pay
  - A monthly premium
  - A yearly deductible (if applicable)
  - Copayments or coinsurance
  - 45% for covered brand-name drugs in the coverage gap
  - 65% for covered generic drugs in the coverage gap
  - Very little after spending $4,700 out of pocket

Standard Structure in 2015

Ms. Smith joins a prescription drug plan. Her coverage begins on January 1, 2015. 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 $320 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 $2,960.	Once Ms. Smith and her plan have spent $2,960 for covered drugs, she's in the coverage gap. In 2015, she pays 45% of the plan's cost for her covered brand-name prescription drugs and 65% of the plan's cost for covered generic drugs. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap.	Once Ms. Smith has spent $4,700 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
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

True Out-of-Pocket (TrOOP) Costs

- Expenses that count toward your out-of-pocket threshold ($4,700 in 2015)
- 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)
- 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 manufacturers providing discounts under the Medicare coverage gap discount 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)
- Over-the-counter drugs or most vitamins (even if they're required by the plan as part of step therapy)

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

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 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)

Your Yearly Income in 2013 Filing an Individual Tax Return	Your Yearly Income in 2013 Filing a Joint Tax Return	In 2015 You Pay Monthly
$85,000 or less	$170,000 or less	Your Plan Premium (YPP)
Above $85,000 Up to $107,000	Above $170,000 Up to $214,000	YPP + $12.30*
Above $107,000 Up to $160,000	Above $214,000 Up to $320,000	YPP + $31.80*
Above $160,000 Up to $214,000	Above $320,000 Up to $428,000	YPP + $51.30*
Above $214,000	Above $428,000	YPP + $70.80*

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

Check Your Knowledge—Question 3

When the coverage gap improvements are reached in 2020, you'll pay the following percent for covered generic and brand-name drugs.

a. Brand-name 30%, Generic 37%

b. Brand-name 20%, Generic 20%

c. Brand-name 25%, Generic 25%

d. Brand-name 35%, Generic 44%

Check Your Knowledge—Question 4

Part A covers flu vaccines.

a. True

b. False

Lesson 3—Medicare Part D Drug Coverage

- Covered and non-covered drugs
- Access to covered drugs
- Medication Therapy Management

Part D Covered Drugs

- Prescription brand-name and generic drugs
  - Approved by the U.S. Food and Drug Administration
  - Used and sold in United States
  - 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
  1. Cancer medications
  2. HIV/AIDS treatments
  3. Antidepressants
  4. Antipsychotic medications
  5. Anticonvulsive treatments
  6. Immunosuppressants
- All commercially available vaccines
  - Except those covered under Part B (e.g., 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
- Non-prescription 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
- Plan usually must notify you 60 days before changes
  - You may be able to use drug 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	§ Doctor must contact plan for prior approval and show medical necessity for drug before drug will be covered
Step Therapy	§ Must first try similar, less expensive drug § Doctor 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 § Doctor may request an exception if additional amount is medically necessary

Requirement for Prescribers

NEW!

§ CY 2015 final rule issued May 23, 2014 requires prescribers of Part D drugs

- Be enrolled in an approved status, or
- Have a valid opt-out affidavit on file for their prescriptions to be covered under Part D

§ The May 1, 2015, interim final rule changed enforcement date to January 1, 2016

If Your Prescription Changes

- Get up-to-date formulary information from your plan's
  - Website
  - Customer service center
- Give your doctor a copy of plan's formulary
- If the new drug isn't on the plan's formulary
  - Can request an exemption from the plan
  - May have to pay full price if plan still won't cover

Medicare Therapy Management

- A pharmacist or other health professional does a comprehensive review of all your medications and talks with you about
  - How to get the most benefits from the drugs you take
  - Any concerns you have, like medication costs and drug reactions
  - How best to take your medications
  - Any questions or problems you have about your prescription and over-the-counter medication
- Your drug plan may enroll you if you meet all of these conditions:
  1. You have more than one chronic health condition
  2. You take several different medications
  3. Your medications have a combined cost of more than $3,017 per year

Check Your Knowledge—Question 5

Prescribers must _____ or _____ to prescribe Part D drugs starting December 1, 2015.

a. Enroll in Medicare and be in good standing
b. Enroll in Medicaid and be in good standing
c. Opt out of Medicare
d. a and c

Check Your Knowledge—Question 6

Which of the following is NOT a condition for a Part D plan to enroll you in Medication Therapy Management?

a. You have more than one chronic health condition

b. You live alone

c. You take several different medications

d. Your medications have a combined cost of more than $3,017 per year

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
- You must have Medicare Part A and Part B to join a Medicare Advantage Plan with drug coverage
- 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 U.S.
  - You can't live outside the United States
- You must join a plan to get drug coverage

Effective 1/1/2016

Creditable Drug Coverage

- Current or past prescription drug coverage
  - For example, employer group health plans, retiree plans, Veterans Affairs, TRICARE, the Indian Health Service, and the Federal Employee Health Benefits 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	First day of the month after month you apply

When You Can Join or Switch Plans

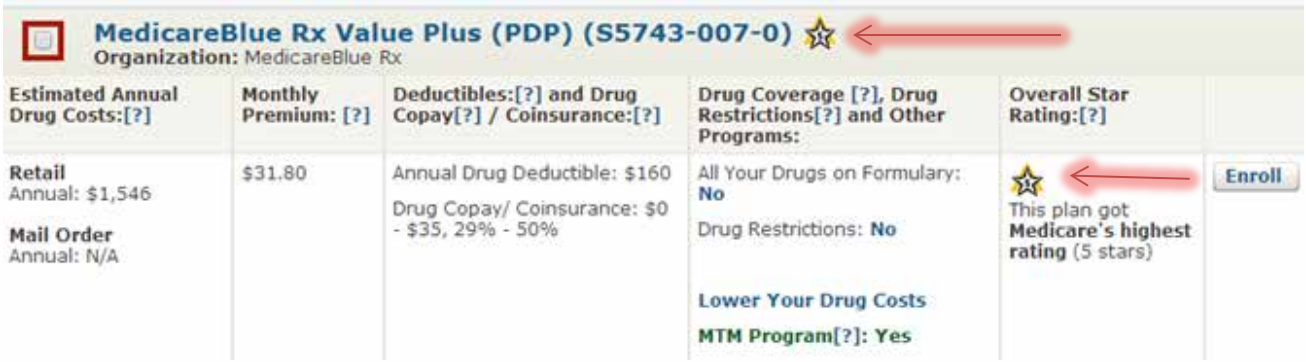
- Medicare's Open Enrollment Period is October 15–December 7 each year, coverage starts January 1
- You can leave a Medicare Advantage Plan and switch to Original Medicare from January 1–February 14 each year
  - You have until February 14 to also join a Part D plan
- If you don't have Medicare Part A coverage, and enroll in Part B during the General Enrollment Period (January 1–March 31), you can sign up for a Medicare Prescription Drug Plan 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
  - You belong to a State Pharmaceutical Assistance Program
  - 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, assigned in October of the past year
- Use 5-star SEP to switch to any 5-star plan one time
  - December 8–November 30 of following year
  - Coverage starts first day of month after enrolled
  - Be careful not to switch from a Medicare Advantage (MA) Plan with drug coverage to an MA Plan with **no** Part D coverage



Low Performing Plan

- 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 Performance 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 ($33.13 in 2015)
    - For each full month eligible and not enrolled
  - Amount changes every year

Part D Penalty Example

Ann didn't join when she was first eligible—by June 2012, and she has no drug coverage from any other source. She joined a Medicare drug plan during the 2014 Open Enrollment Period. Her coverage began on January 1, 2015.

She was without creditable prescription drug coverage from July 2012–December 2014. Her penalty in 2015 is 30% (1% for each of the 30 months) of $33.13 (the national base beneficiary premium for 2015), which is $9.93. The monthly penalty is rounded to the nearest $.10, so she'll be charged $9.90 each month in addition to her plan's monthly premium in 2015.

Here's the math:

.30 (30% penalty) × **$33.13** (2015 base beneficiary premium) = **$9.93**

$9.93 (rounded to the nearest $0.10) = **$9.90**

$9.90 = **Ann's monthly late enrollment penalty for 2015**

Check Your Knowledge—Question 7

Life events that allow a Special Enrollment Period ***don't*** include

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

b. You lose other creditable prescription coverage

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

d. You enter, live at, or leave a hospice facility

Lesson 5—Extra Help With Part D Drug Costs

- What is Extra Help?
- How to qualify
- Enrollment
- Continuing eligibility

What Is Extra Help?

- Program to help people pay for Medicare prescription drug costs
  - Also called the Low-income Subsidy
- 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

2015 Extra Help Income and Resource Limits

§ Income limits
- Below 150% of the federal poverty level
  - $1,471.25* per month for an individual or $1,991.25* per month for a family size of 2
- Based on family size

§ Resources limits
- Up to $13,640* for an individual, or $27,250* for a married couple
  - Includes $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
  - Help from Medicaid paying your Part B premium (Medicare Savings Program)
- All others must apply
  - Online at socialsecurity.gov/medicare/prescriptionhelp/
  - Call Social Security (SSA) 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

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	

2015 Extra Help Copayments

Institutionalized	$0
Receiving Home and Community-Based Services	$0
Up to or at 100% Federal Poverty Level (FPL)	$1.20/$3.60
Full Extra Help – up to 135% FPL	$2.65/$6.60
Partial Extra Help (Deductible/Cost-Sharing)	$66/15%

(Generic/Brand Name)

Reassignment Notices

§ People reassigned notified by CMS early November (BLUE paper)

- Three versions of notice
  - People whose plans are leaving Medicare program
    - CMS product No. 11208 (MA-PD)
    - 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
  1. Initial
  2. Cyclical or recurring
  3. Subsidy-changing event (SCE)
  4. Other event (change other than SCE)

Medicare's Limited Income Newly Eligible Transition (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 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 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 Limited Income NET Program at the pharmacy counter (point-of-sale).

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.

Check Your Knowledge—Question 8

You automatically qualify for Extra Help if you get

a. Full Medicaid coverage

b. Supplemental Security Income

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

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 coverage?
- 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 Join

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/questions/home.aspx
    - Plan's website
  - Enroll by phone
    - 1-800-MEDICARE (1-800-633-4227)
      - TTY users should call 1-877-486-2048
    - Call 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 exception if no acceptable alternative drug is on the list

Annual Notice of Change (ANOC)

- All Medicare drug plans must send an ANOC to members by September 30
  - May be sent with Evidence of Coverage (EOC)
- 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

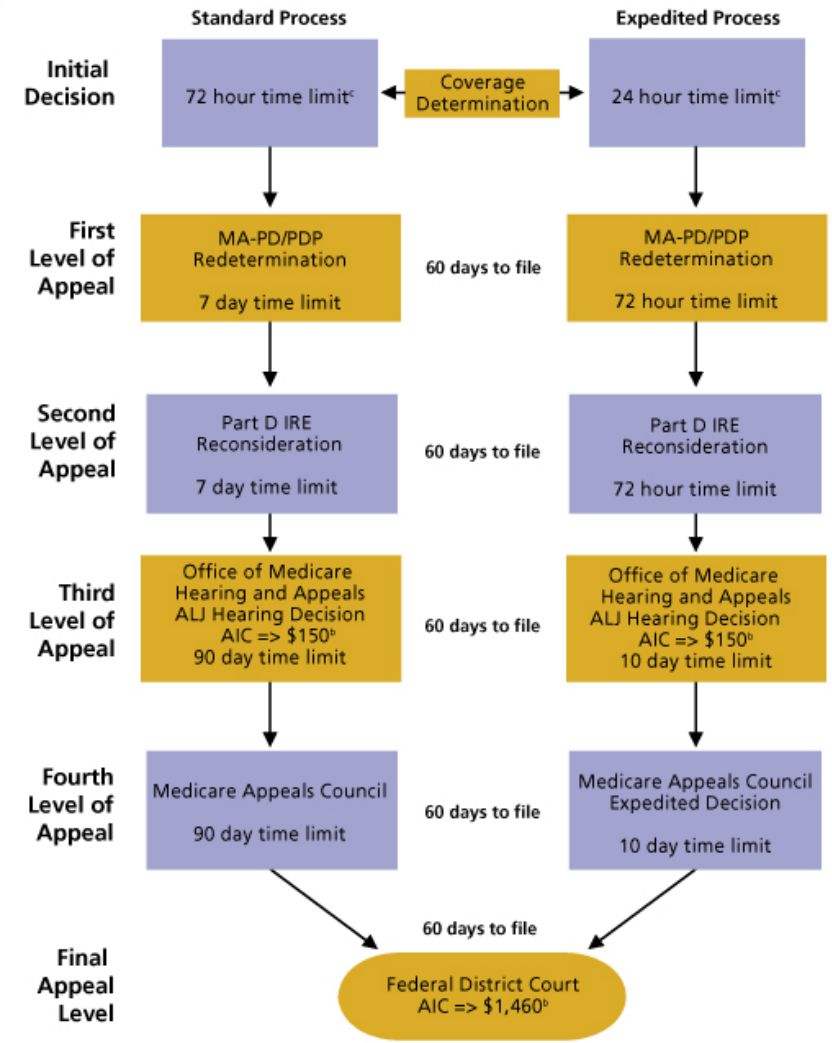
Exception Requests

- Two types of exceptions
  1. Formulary exceptions
     - Drug not on plan's formulary, or
     - Access requirements (for example, step therapy)
  2. 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

Appendix A: Part D Appeals



Appeals Flow Chart Foot Note

a: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days

b: The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index.

c: A request for a coverage determination includes a request for a tiering exception or a formulary exception

AIC = Amount in Controversy

ALJ = Administrative Law Judge

MA-PD = Medicare Advantage Prescription Drug

A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, Prescription Drug Plan (**PDP**) or the enrollee's physician.

The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves as exception request, the adjudication time frame begins when the plan sponsor gets the physician's supporting statement.

IRE = Independent Review Entity

This chart reflects the **CY 2015 AIC** amounts.

Key Points to Remember

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

Medicare Prescription Drug Coverage Resource Guide

Resources

Websites:
Centers for Medicare & Medicaid Services (CMS) CMS.gov

RxAssist - A directory of Patient Assistance Programs
rxassist.org

Medicare Part D Appeals MedicarePartDAppeals.com

Contacts:
Medicare.gov
1-800-MEDICARE (1-800-633-4227)
1-877-486-2048 (TTY)

Social Security
1-800-772-1213
socialsecurity.gov

Local State Health Insurance Programs Medicare.gov/contacts

Limited Income NET Program (HUMANA)
1-800-783-1307 or 711 (TRS)
Email: linetoutreach@humana.com

Manuals/Guidance
"Prescription Drug Benefit Manual"
CMS.gov/Medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html

"PDP Enrollment and Disenrollment Guidance"
CMS.gov/Medicare/eligibility-and-enrollment/medicarepresdrugeligenrol/index.html

Manuals/Guidance (continued)
"Medicare Premiums: Rules For Higher-Income Beneficiaries"
SSA.gov/pubs/EN-05-10536.pdf

"2014/2015 Guide to Mailings from CMS, Social Security, and Plans" CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/downloads/2014Mailings.pdf

National Training Program – Partner Job Aids
Visit the Training Library at CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram

CMS Publications
"Your Guide to Medicare Prescription Drug Coverage" (CMS Product No. 11109)

"Things to Think About When You Compare Medicare Drug Coverage" (CMS Product No. 11163)

"4 Ways to Help Lower Your Medicare Prescription Drug Costs" (CMS Product No. 11417)

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