

Medicare with Medicaid: Maximizing Health Coverage for Dual Eligibles Living with HIV

Client scenario (pre-training)

Mr. J, a 56-year old single individual, gets Social Security Disability (SSD). He also has Medicare and ADAP. His gross monthly SSD benefit (before Part B premium taken out) is \$1450. He comes to your office in a panic because beginning next month, his Medicare Part D plan will stop covering all of his medications because he will hit the “donut hole.” What can Mr. J do?

[See end of training material for suggested answer.]

Introduction

Medicare’s role in HIV care

- ❖ Medicare is now the single largest source of federal financing for HIV care, largely due to the implementation of the Medicare prescription drug benefit (Part D) in 2006.¹
- ❖ Growth in the size of the HIV-infected population and longer life spans for persons living with HIV have also contributed to the increase in Medicare spending.²

Importance of Medicare to Medicaid recipients

- ❖ Most Medicaid recipients will age into Medicare when they turn 65, and some Medicaid recipients qualify before age 65 based on disability.

¹ Kaiser Family Foundation’s February 2009 “HIV/AIDS Policy Fact Sheet”, available at http://www.kff.org/hiv/aids/upload/7171_04.pdf.

² Id.

People who receive Medicare and Medicaid together are often referred to as “dual eligibles.”

- ❖ Medicaid requires that recipients, including dual eligibles, utilize all available third party health insurance coverage.
- ❖ Enrollment in Medicare is a condition of eligibility for Medicaid. (MARG p. 344.1; 05 ADM-OMM 5)

The transition from Medicaid to Medicare

- ❖ Once Medicaid recipients enroll in Medicare, Medicare becomes primary and Medicaid is secondary.
- ❖ Medicare’s prescription drug coverage benefit is *radically different* from Medicaid’s. Other aspects of coverage will change, too, but less dramatically.
- ❖ Understanding how Medicare and Medicaid work together can be critical to ensuring that low-income beneficiaries retain access to the health care services they need.

Linking Medicare beneficiaries to Medicaid

- ❖ Medicaid can help low-income Medicare beneficiaries, including those living with HIV, cover their cost-sharing obligations under Medicare.
- ❖ Medicaid can also cover medical services that aren’t provided by Medicare.
- ❖ Many Medicare beneficiaries will need navigational assistance and advocacy to help them access Medicaid.

Background -- Medicare and Medicaid

What are the differences between Medicare and Medicaid?

- ❖ Both are health insurance programs established in 1965 through amendments to the Social Security Act.
- ❖ Medicare is in Title XVIII (“Health Insurance for the Aged and Disabled”); codified in 42 USC 1395-1395ccc. The regulations are at 42 CFR parts 400-424, 482-493, 498.
- ❖ Medicaid is in Title XIX (“Grants to States for Medical Assistance Programs”). 42 USC 1396-1396v; regs are in 42 CFR parts 402, 430-436, 440-442, 447, 455-456, 482-483, 485, 491, 493.

❖ **Medicare**

- Is a national, 100% federally funded program
- Serves the elderly, certain disabled individuals, and people with severe kidney disease
- Has no income or resource tests
- Provides less comprehensive coverage than Medicaid (ie, doesn't cover long-term care, routine dental & eye care, hearing aids)
- Has significant cost sharing components (deductibles, premiums, co-pays)

❖ **Medicaid**

- Is a joint state/federal program, administered at the state or county level. New York has a state-supervised, county-administered program; costs are shared by the federal, state & local governments
- Serves people of all ages
- Is means-tested (has income/resource limits)
- Generally provides a much more complete benefit package than Medicare
- Only cost-sharing component: co-pay

❖ **Medicare and Medicaid together**

- Many individuals are eligible to receive both Medicare and Medicaid.
- In New York State, 30% of all individuals enrolled in the Medicare Part D (prescription drug) benefit in 2008 – about 720,000 people -- also received some type of low-income assistance (Medicaid, Medicare Savings Program, Low-Income Subsidy).
- The Center for Medicare and Medicaid Services (CMS) estimates that an *additional* 120,000 New Yorkers, were eligible for, but not receiving, Part D or the Low Income Subsidy

Overview of Medicare for Medicaid recipients

What kinds of services does Medicare provide?

❖ Medicare has different components –

➤ Part A:

- Hospital Insurance
 - *Includes inpatient hospital care, skilled nursing facilities [short term], home health care, hospice*

➤ Part B:

- Medical Insurance
 - *Includes doctors' services, durable medical equipment, ambulance services, outpatient therapy, some preventive care*

- Parts A & B together are known as “original Medicare,” sometimes also called “fee for service” Medicare.
- Part C:
 - Another way to receive Part A & B services, through a private health plan
 - Part C is usually referred to as “Medicare Advantage.”
- Part D:
 - Prescription drug coverage, provided through a private health prescription drug plan (PDP)
- Medicaid recipients who become eligible for Medicare will need to enroll in Parts A, B & D. They have the option of joining a Medicare Advantage (Part C) plan.

Who can get Medicare?

- ❖ The elderly (people age 65 or older)
 - Elderly individuals generally qualify for Medicare once they turn 65 because they are “insured” (ie, through the Social Security/ Railroad Retirement system)
 - Those not insured can still get Medicare beginning at age 65, but they must
 - live in the U.S. AND
 - be U.S. citizens OR lawful permanent residents with 5 or more years of continuous residence in the U.S
- ❖ Certain disabled individuals
 - People receiving Social Security Disability (SSD)
 - There is a 24 month waiting period for Medicare.
 - SSD recipients qualify for Medicare once they’ve received SSD for 24 months. Medicare starts with the 25th month of SSD receipt.
 - *Exception:* there is no 24-month waiting period for individuals approved for SSD based on Amyotrophic Lateral Sclerosis (ALS). Medicare entitlement begins with the first month of SSD receipt.
 - People with End Stage Renal Disease (ESRD)³

³ This training outline does not address the special rules governing the Medicare ESRD program, including when coverage begins and ends, and how the coverage interacts with other health programs such as Medicaid or employer insurance. Navigating prescription drug access can be particularly challenging, particularly for individuals who have ESRD and other medical conditions such as HIV. You can get an overview of ESRD through CMS’ publication “**Medicare Coverage of Kidney Dialysis and Kidney Transplant Services**”, available at <http://www.medicare.gov/Publications/Pubs/pdf/10128.pdf>. If you are working with a client with ESRD and have questions, please feel free to contact Cathy Roberts at the Empire Justice Center at 1-800-635-0355 x 112.

- Must be insured through Social Security or Railroad Retirement system.
- No waiting period.
- Children with ESRD can qualify for Medicare if insured through a parent.

Where do I apply for Medicare?

- ❖ At the Social Security Administration
 - if you're applying for original Medicare (Part A and/or B)
- ❖ Through a private plan
 - for Part C and/or D.
- ❖ If you are getting Social Security benefits when you first become eligible for Medicare, SSA will automatically enroll you into original Medicare.
 - Everyone else must apply through SSA.
 - People aging into Medicare can sign up as early as 3 months prior to their 65th birthday.

How much does it cost to enroll?

- ❖ Part A is free (no monthly premiums) if you are insured.
 - Elderly individuals who are uninsured can buy Part A coverage. The Part A premium for 2010 is \$461 per month.
 - People with at least 30 quarters of coverage in the Social Security system ("partially insured") are eligible for a reduced monthly premium rate (\$254 in 2010).
- ❖ Part B charges monthly premiums.
 - The Part B monthly premium in 2010 will be \$96.40 for most individuals with annual incomes below \$80,000 -- the same amount as 2009.
 - This is because Social Security recipients didn't get a cost of living adjustment (COLA) increase for 2010 and therefore are protected from having to pay an increase in their Part B premium.
 - If you are new to Part B in 2010, or were already on Part B but not receiving Social Security, your monthly Part B premium for 2010 will be \$110.50.
 - Payment of Part B premiums
 - If you get Social Security benefits, SSA will automatically deduct the monthly Part B premium out of your monthly Social Security check, unless you affirmatively decline Part B coverage.
 - People who don't opt into Medicare when they first become eligible may be charged a "premium penalty" (resulting in a higher monthly premium) and face a waiting period before they can enroll.

- ❖ Medicare coverage (A & B) should be *free* for most Medicaid recipients.
 - The Medicare Savings Program (MSP) can pay for Part B premiums and help with other Medicare cost sharing.
 - There is no Part B late enrollment penalty or enrollment waiting period for MSP recipients.
- ❖ **What happens after I enroll?**
 - You get a red, white and blue Medicare card.
 - SSA forwards your Medicare enrollment information to the Centers for Medicare and Medicaid Services (CMS), who runs Medicare.
 - SSA can take an application for the Part D Low-Income Subsidy.

The Medicare Savings Program: Help with Part B premiums and more

What is the Medicare Savings Program?

- ❖ The Medicare Savings Program (MSP) is the generic “catch-all” term for three special Medicaid programs that
 - pick up the cost of the monthly Medicare Part B premiums for low income beneficiaries and
 - automatically qualify them for the Part D (prescription drug) low income subsidy (LIS).
- ❖ MSPs can assist individuals with incomes up to 135% of the federal poverty level (FPL).
- ❖ There is *no resource test* in New York State for any of the MSPs.
- ❖ One of the MSPs, the Qualified Medicare Beneficiary (QMB) program, also covers Part A and B coinsurance and deductibles.

1.) Qualified Medicare Beneficiary (QMB)

- Income limit: 100% FPL (federal poverty level).
- Pays Parts A & B premiums, deductibles and co-pays.
- Can receive QMB-only or QMB and Medicaid (with or without spenddown).
- Coverage becomes effective the month *after* application.

2.) Specified Low-Income Medicare Beneficiary (SLIMB)

- Income range: 100-120% FPL.
- Pays for Part B premium.
- Can receive SLIMB-only or SLIMB and Medicaid with a spenddown.
- Coverage can begin 3 months retroactive to application date.

3.) Qualified Individual-1 (QI-1)

- Income range: 120-135% FPL.
- Pays for Part B premium.
- Person must have Part A coverage.
- Cannot receive both QI-1 and Medicaid – must choose one or the other.
- Coverage can begin 3 months retroactive to application date.

Where can I obtain the current MSP income guidelines?

- ❖ The New York State Department of Health posts the MSP income guidelines on their website at http://www.health.state.ny.us/health_care/medicaid/program/update/savingsprogram/medicaresavingsprogram.htm

How do I apply for MSP if I don't already have Medicaid?

- ❖ Apply for MSP through your local Medicaid office.
 - Outside of NYC, at your local Department of Social Services (LDSS)
 - In NYC, at the Human Resources Administration (HRA)
- If you are applying for MSP only (not also Medicaid), you can use the simplified MSP application form (the DOH-4328).
- No interview is required – applications can be submitted by mail. 07 GIS MA 027
- Along with your application form, submit proof of income, copy of your Medicare card (front and back) and proof of residency/address.
- People applying for Medicaid should *automatically* be assessed for MSP, whether or not they specifically request it. (00 OMM/ADM-07; GIS 05 MA 033)
- ❖ *Starting in January 2010: you will be able to apply for MSP through SSA, by filing a Part D Low Income Subsidy (LIS) application.* [see p. 14 for more information about LIS]
 - The LIS application will also be treated as MSP application, unless you “opt out” of MSP.
 - SSA will electronically transmit MSP application data to NYS DOH and your local social services district, who will in turn determine your eligibility for MSP.

How long will I have to wait to get a decision?

- ❖ Application processing should take no more than 45 days (NYS DOH's Medical Assistance Resource Guide, p. 374)
 - SLMB & QI-1 can be authorized retroactively, as far back as 3 months prior to the date of application (just like regular Medicaid).
 - QI-1 retroactive coverage, though, is limited to the current calendar year. (GIS 07 MA 027)
 - QMB coverage is not retroactive.
 - It starts the month following the month of application. (GIS 07 MA 027)

What happens after my MSP application is approved?

- ❖ After the MSP approval (all)
 - MSP now responsible for paying Part B premiums
 - The local Department of Social Services transmits the MSP approval to the New York State Department of Health, who in turns shares the information with SSA and CMS.
 - SSA stops deducting the Part B premiums out of the beneficiary's Social Security check, and refunds any amounts owed to the recipient. (*This process can take a long time.*)
 - CMS "deems" the person eligible for the Part D Low Income Subsidy (LIS)

- ❖ After the MSP approval – QMBs
 - Card issuance
 - QMBs who don't already have a Medicaid Common Benefit Identification Card (CBIC) will be issued one by mail. The card is the mechanism for health care providers to bill Medicaid's QMB program for the Medicare deductibles and co-pays.
 - If the person already has a CBIC benefit card, QMB coverage will be activated on their existing card.
 - Billing
 - CMS has clarified that providers are not allowed to bill QMB recipients directly for Medicare co-payments, nor can they accept QMB recipients as "private pay" patients.
 - As a practical matter, only Medicaid-enrolled providers can bill the QMB program.
 - Check to see whether your providers accepts both Medicare and Medicaid
 - Be sure to provide both cards when you get medical care.
 - QMB will pick up all Medicare cost sharing, even for Medicare services that Medicaid does not cover (ie, chiropractic care).

How do I get into MSP if I already have Medicaid?

- ❖ Medicaid recipients who transition onto Medicare should be automatically evaluated for MSP eligibility at their next Medicaid recertification. 2000 OMM/ADM-7.
- ❖ Individuals can also affirmatively ask to be enrolled in MSP in between recertification periods.
- ❖ Some individuals may lose full Medicaid eligibility when they begin receiving Medicare (ie, because of new Social Security income).
 - If a Medicare recipient reports income that exceeds the Medicaid level, districts must evaluate the person's eligibility for MSP. 08 OHIP/ADM-4

I'm not enrolled in both Part A & Part B. How does MSP work for me?

- If you have Part A but not Part B coverage:
 - You can use the MSP application process to enroll in Part B and MSP at the same time.
 - DSS shouldn't require you to enroll in Part B first. 08 GIS MA 032
- If you have Part B but not Part A:
 - The QMB enrollment process can be used to get you into Part A and MSP at the same time.
- If you don't have Part A or Part B:
 - You may face special hurdles getting into both Medicare and MSP because:
 - You can't apply for MSP unless you already have either Part A or Part B
 - You may have trouble getting into Medicare if you try to apply outside of the normal enrollment period.
 - However, the conditional enrollment process can help get you get into both Medicare and MSP.
 - ◆ *This process can only be used for QMB eligibles – people with incomes at or below 100% FPL.*
 - ◆ The general concept is that SSA takes a “conditional” application for Parts A and B, based on the person's intent to apply for QMB.
 - If the QMB application is approved, SSA activates the enrollment into Parts A & B.
 - The Medicare Rights Center has developed a great toolkit about the conditional enrollment process! Here is the link:
<http://www.medicarerights.org/pdf/PartABuy-InPacket.pdf>

Can Medicaid pay for my Part B premium if I'm not eligible for MSP?

- ❖ Possibly. There is an “original” Medicare buy-in program for certain categories of Medicaid recipients not otherwise eligible for MSP. (See NYS Medical Assistance Resource Guide p. 41-7)
- ❖ The original buy-in program covers:
 - SSI cash recipients (ie, individuals in congregate care facilities)
 - “Pickle” eligibles⁴
 - Disabled Adult Children who qualify for full Medicaid (95 ADM-11)
 - Those who lose SSI cash benefits because of earnings

⁴ Individuals who lost SSI eligibility due to an increase in their Social Security benefits.

Using original Medicare and Medicaid together

How can I make sure my original Medicare and Medicaid coverage are working together the way they should?

- ❖ Dual eligibles should see providers who accept both Medicare and Medicaid.
- ❖ Remember that QMB (or Medicaid if you don't have QMB) should "wrap" around your Medicare coverage and cover all your Medicare cost sharing.
- ❖ Medicaid can pay for services that aren't covered by Medicare, like dental and long term care.
- ❖ The only costs dual eligibles should be assessed are the regular Medicaid co-pays.
- ❖ *Reminder:* If you have a Medicaid spenddown, ADAP can be used to meet the spenddown and activate your Medicaid coverage. (See more details on p. 14.)

Part C – Medicare Advantage

- ❖ We'll skip over this for now ... will cover after Part D.

Part D – Prescription Drug Benefit

❖ **Background**

- Part D, the Medicare Prescription Drug benefit, is relatively new. Congress passed the Medicare Modernization Act (MMA) in 2003 and Part D went into effect in January 2006.
- Before the implementation of Part D, Medicare did not cover outpatient prescription drugs (with some very limited exceptions).
- Part D works much differently from the original Medicare mode – you don't simply use your Medicare card to pay for drugs at the pharmacy.
- Instead, you sign up for Part D by enrolling in a private health insurance plan that offers Part D prescription drug coverage.
- CMS oversees the Part D plans.
- The Part D Low Income Subsidy ("LIS," also known as "Extra Help") can pick up most of the cost sharing for low income Part D beneficiaries.
- SSA administers the LIS program.

❖ **How does Part D change the way Medicaid recipients get the prescription drugs they need?**

- Medicaid will no longer pay for most prescriptions (there are some limited exceptions).
- You have to choose a private Part D plan or be auto-enrolled into one by CMS.
- It may become harder to obtain certain medically necessary drugs
 - ie, if your plan denies coverage altogether or requires certain "hoops" before the drug is covered

- Your co-pay obligation will increase.
- You may be mistakenly charged the wrong co-pay amount.
- You may be reassigned, or need to switch plans, year after year.
- You'll be blitzed with notices, other mailings, and advertisements related to Part D (aka "beneficiary vertigo").

Overview

- Part D coverage is optional. However, if you don't enroll when you are first eligible, you may face penalty premiums and a waiting period when you try to enroll later on.
- Medicaid recipients cannot opt out of Part D unless they have other creditable coverage (ie, employer or other prescription drug coverage which is comparable to or better than Part D).
- Individuals who have "creditable coverage" or are receiving the Low Income Subsidy (LIS) are generally protected from the late enrollment penalty/waiting period provision.

How does the enrollment process work?

- Sign up for Part D by enrolling in a private plan that offers Part D coverage.
- Dual eligibles who don't sign up for a Part D plan on their own during their initial enrollment period will be randomly assigned to one by CMS.
- All Part D recipients can switch plans during the annual open enrollment period, November 15-December 31.
- LIS beneficiaries have a continuous special enrollment period, meaning that they can switch plans at any time.

How do I choose a plan?

- The easiest way to view plan options is through Medicare's website (www.medicare.gov). There you can
 - get a detailed listing of all plans available in your service area with links to the plan websites
 - use the "formulary finder" function to find a plan that most closely matches a beneficiary's drug needs
 - enroll directly in a plan. You can also enroll by contacting the plan directly.
 - This website can also be a great resource for other Part D issues (ie, trying to track down specific plan information for a particular enrollee)

How much does Part D cost?

- Part D plans generally charge a yearly deductible, monthly premiums and co-pays for each prescription.
 - The amounts vary widely from plan to plan.
 - Beneficiaries who are not enrolled in LIS may run into the Part D “donut hole” (coverage gap).⁵
 - There are very specific cost-sharing protections for LIS beneficiaries:
 - ◆ No deductible if enrolled in benchmark plan
 - ◆ No monthly premium if enrolled in benchmark plan
 - ◆ Minimal co-pays
 - ◆ No negative effects of the “donut hole”

What drugs are covered?

- Each Part D plans must have a formulary (a list of drugs it will cover) that includes at least two drugs for every drug class and category.
- Each covered drug is assigned a tier level which governs its co-pay amount. (Tier 1 = lowest; Tier 4/5 = highest.)
- Plans can impose restrictions called “utilization management” on their formulary drugs, including prior authorization, step therapy, and quantity limits.
- Plans must make their formularies publicly available

What can I do if my plan isn't covering the drugs I need?

- Beneficiaries have appeal rights to challenge a plan's decisions regarding coverage of a specific drug. (see more info starting on page below)

❖ Does Part D cover all prescription drugs?

- No. These are among the types of drugs not covered under Part D:
 - Barbiturates*
 - Benzodiazepines*
 - Drugs covered under Parts A & B
 - Drugs to treat anorexia, weight loss or weight gain
 - Fertility drugs
 - “Off-label” drugs unless listed in Medicare-approved compendia
 - Cancer drugs under Part D should be evaluated under same criteria as under Part B
 - Over the counter medications

⁵ You can hit the donut hole (“coverage gap”) if your drug costs for the year hit a certain threshold amount, at which point you become responsible for 100% of the cost of your Part D drugs until your out-of-pocket costs reach the “catastrophic coverage” limit.” Once you hit the catastrophic limit, the plan resumes coverage and you pay a minimal co-pay (no higher than 5%).

- Prescription vitamins and minerals*
*Asterisked drugs may be covered by Medicaid.

Where can I get help paying for drugs if Part D doesn't meet my needs (drugs are too expensive or not covered at all)?

- The Low Income Subsidy (see next section)
- Medicaid
 - For non-Part D drugs:
 - ◆ Ie, barbiturates; benzodiazepines; prescription vitamins and minerals.
 - Part D “wrap” coverage is available for these drugs, if rejected by the Part D plan:
 - 1) atypical antipsychotics,
 - 2) antidepressants,
 - 3) antiretrovirals used in the treatment of HIV/AIDS, and
 - 4) immunosuppressants used in the treatment of tissue and organ transplants.
- ADAP
 - covers HIV-related drugs if rejected by the Part D plan.
- EPIC (Elderly Pharmaceutical Insurance Coverage program)
 - pays for drugs not covered by the Part D plan.
 - ◆ In order to qualify for EPIC, you must be
 - At least 65 years old AND
 - Not in receipt of full Medicaid coverage
 - Medicaid spenddown recipients are eligible
 - So are MSP-only recipients.
 - EPIC income limits:
 - \$35,000/year (single person) or \$50,000 (couple).
 - No asset test.
 - No citizenship or immigration requirements, but you must be a New York State resident.
 - ◆ To learn more about EPIC, including how to apply, go to: http://www.health.state.ny.us/health_care/epic/
- New York Prescription Saver Card
 - Provides discounts on generic and brand name drugs.
 - Must be age 50-64 OR disabled.
 - Same income criteria as EPIC.
 - For more information, including how to apply, go to <https://nyprescriptionsaver.fhsc.com/>
- Patient assistance programs
 - Usually administered through drug manufacturers
 - Can access through websites like pparx.org or needymeds.org

How can I get help paying for Part D-covered drugs?

- The Low Income Subsidy (LIS) helps with Part D cost-sharing. LIS is also known as “Extra Help.”
- SSA determines LIS eligibility. (You can’t apply through your Part D plan.)
- The LIS income limit is 150% FPL; there are also resource limits.
- You can get the most recent LIS income/resource guidelines from SSA’s publication [Getting Help With Medicare Prescription Drug Plan Costs: Income And Resource Limits](http://www.ssa.gov/pubs/10115.html), available at <http://www.ssa.gov/pubs/10115.html>
- Medicaid and MSP recipients are automatically “deemed” eligible for LIS – they don’t have to file an application at SSA.
- Receiving Medicaid for just one month (ie, on spenddown) guarantees LIS coverage for at least the remainder of the calendar year. If the spenddown month falls between July – December, LIS coverage lasts through the end of the following calendar year.

How can ADAP help me get into Extra Help?

- ADAP can help you meet your Medicaid spenddown and get into LIS.
 - Medicaid allows costs that ADAP pays on a beneficiary’s behalf to count toward the Medicaid spenddown.
 - If an ADAP recipient with Part D isn’t enrolled in LIS:
 - ◆ ADAP (instead of Part D) can be billed as primary payor for their HIV meds.
 - ◆ Get a printout or receipt from the pharmacy confirming the amount that ADAP paid.
 - ◆ Bring the pharmacy printout to the local Medicaid office and ask your worker to activate your Medicaid coverage. (If you don’t have an open Medicaid case, you’ll need to apply for Medicaid and submit the ADAP receipt to show that you’ve met your spenddown.)
 - ◆ Once the Medicaid case has been opened, *even for just one month*, you have “deemed” LIS status.
 - ◆ To speed up the LIS activation process (so that your Part D plan recognizes your low income status and adjusts your co-pays to the lowest amount), contact your plan directly and let them know you’ve been approved for Medicaid.
 - ◆ Your plan should then be able to adjust your co-pays right away, instead of waiting to get confirmation of your LIS status from CMS, which can take several weeks. **(see more about data sharing issues on p. 17)**
 - ◆ Once you have LIS, Part D will be your primary payor for all your medications and ADAP will be secondary. ADAP can pick up any HIV related medications that aren’t covered by your Part D plan.

- ◆ DOH has a handy fact sheet about Medicare Part D and ADAP at <http://www.health.state.ny.us/diseases/aids/resources/adap/medicarefaqs.htm>

How much do I pay for drugs once I'm in the Extra Help program?

- ❖ First, figure out if you're in a benchmark plan
 - A plan is considered "benchmark" if it offers basic Part D coverage with premiums equal to or lower than a certain amount (the "regional benchmark amount," which varies from year to year).
 - In 2010, the benchmark amount in New York State is \$33.32.
 - An LIS beneficiary not already enrolled in a Part D plan will be auto-enrolled into a benchmark plan by CMS.
 - The LIS beneficiary can opt out of the auto-assignment and choose another plan.
 - Dual eligibles who choose their own plan will not have to pay any monthly premium if they enroll in a benchmark plan.
 - Auto-assigned enrollees whose plan loses benchmark status the following year will be reassigned to a new benchmark plan.

- ❖ Next, figure out what type of Extra Help coverage you have.
 - Cost sharing obligations depend on whether the person is a "full" or "partial" dual eligible.
 - Dual eligible for Part D purposes = any LIS recipient.
 - Full dual eligibles include:
 - ◆ LIS recipients with incomes at/below 135% FPL
 - ◆ Medicaid recipients (with or without spenddown)
 - ◆ MSP recipients.
 - Partial dual eligibles are
 - ◆ LIS recipients with incomes between 135-150% FPL who are not receiving Medicaid or MSP.

 - Here are the cost sharing amounts for full dual eligibles:
 - ◆ Deductible:
 - None.
 - ◆ Monthly premium:
 - None if in benchmark plan.
 - If plan is above the benchmark, the person is responsible for the difference between the plan's premium and the benchmark amount.
 - ◆ Co-pays – see chart below

2010 levels for full dual eligibles*	Brand name drugs: co-pay maximums	Generic drugs: co-pay maximums
On Medicaid, below 100% FPL	\$ 3.30	\$ 1.10
On Medicaid, above 100% FPL	\$ 6.30	\$ 2.50
Not receiving Medicaid	\$6.00	\$ 2.50
On Medicaid, in nursing home	\$0	\$0

**Co-pay obligation ends when catastrophic level reached (total annual drug costs are \$6,440 in 2010).*

- Here are the cost sharing amounts for partial dual eligibles:
 - Deductible:
 - \$60 maximum for 2010.
 - ◆ Monthly premium:
 - Set on sliding scale (assumes enrollment in benchmark plan).
 - 135-140% FPL: 25% of benchmark
 - 140-145% FPL: 50% of benchmark
 - 145-150% FPL: 75% of benchmark
 - ◆ Co-pays – see chart below

2010 co-pays for partial dual eligibles	Brand name drugs	Generic drugs
Before catastrophic limit reached (Catastrophic limit = total annual drug costs reach \$6,440 in 2010)	15% of drug cost (or less, if plan's normal co-pay amount is less than 15% of drug cost)	15% of drug cost (or less, if plan's normal co-pay amount is less than 15% of drug cost)
After catastrophic limit reached	\$ 6.30	\$ 2.50

Aren't Medicaid recipients protected by the Medicaid co-pay cap limit?

- ❖ Unfortunately, no. Part D drugs are not Medicaid-covered services. This means Medicaid recipients are worse off under Part D, because:
 - Medicaid does not cover Part D co-pays
 - Part D co-pays cannot be applied toward the annual Medicaid recipient co-pay limit of \$200
 - Pharmacists are not obligated to provide the drug if the person can't afford their Part D co-pay.
- ❖ The lack of co-pay protections for duals makes it especially critical that beneficiaries enroll in the best possible Part D plan for their individual circumstances, with the lowest overall cost sharing.

How long does Extra Help coverage last?

- For deemed LIS eligibles (Medicaid and MSP recipients):
 - LIS eligibility continues *at least* until the end of the current calendar year.
 - People deemed eligible between July-December will remain LIS eligible until the end of the following calendar year, *even if they lose eligibility for Medicaid/MSP.*
- For non-deemed LIS recipients (those who apply at SSA):
 - SSA may perform redetermination annually or on periodic basis.
 - Changes in income, resources and/or living arrangements may affect eligibility.
 - LIS recipients have no reporting obligations in between application/redetermination periods.

- This means that LIS recipients do not have to report changes in income, resources and/or living arrangements unless they choose to, or unless they receive a redetermination request from SSA.

❖ **How do I transition to a new plan?**

- LIS recipients have a continuous special enrollment period, meaning that they can switch plans at any time. If they switch plans, the change becomes effective the month *after* the month of enrollment.
- You don't have to disenroll in your old plan before signing up for a new plan. Signing up for a new plan should result in automatic disenrollment from your old plan.
- If a plan loses its benchmark status at the end of a calendar year (because its monthly premium for the next year is higher than the new benchmark amount), beneficiaries who had been auto-enrolled will be reassigned into a new benchmark plan.
- Plans must have a transition policy for new enrollees. The policy must include a temporary (30 day) supply of medication for drugs not on the new plan's formulary or which have utilization requirements.

What other kinds of problems might come up after I enroll in Extra Help?

- ❖ The most common issues usually involve data sharing delays or errors.
 - Part D-related data matching occurs between
 - a MINIMUM of 3 different entities (plan, CMS, pharmacy) and
 - as many as 6 or more different entities (DSS, NYSDOH, SSA, CMS, plan, pharmacy) for low-income beneficiaries.
 - This can create problems when data is not shared on a timely basis or if there is a mistake in the data entered into one or more agency's computer system.
 - CMS has a special policy governing new dual eligibles for whom the pharmacist cannot confirm proof of enrollment in a Part D plan.
 - Pharmacists should follow the "Point of Sale Facilitated Enrollment (POS FE)" process so that the beneficiaries can get their prescriptions filled immediately.
 - Similarly, for dual eligibles already enrolled in a Part D plan, if the data matching does not accurately reflect the client's LIS status at the pharmacy, plans are supposed to follow CMS' "best available evidence" guidance to allow LIS beneficiaries to get their drugs at the proper co-pay level.
 - CMS' best available evidence policy is posted at http://www.cms.hhs.gov/PrescriptionDrugCovContra/17_Best_Available_Evidence_Policy.asp
 - Although multiple agencies share data concerning beneficiaries' enrollment and low-income status, do NOT assume that all data (including address changes and/or changes in income) are shared among agencies.

- A change of address reported to SSA will likely NOT be shared with the local Medicaid office.

How does the appeals process work?

- ❖ The Part D appeals process is contained in 42 CFR part 435.560 et seq.
 - Denials of services, which occur at the pharmacy counter, do not trigger notice and appeal rights.
 - In order to trigger these rights, beneficiaries must ask for a written coverage determination from their plan.
 - “Exception requests” are probably the most common type of coverage determination requests – asking that the plan make an exception from their formulary requirements.
 - Plans have 72 hours to act on a coverage determination request, unless there is emergency situation (serious jeopardy to health/well-being), in which case the plan must act within 24 hours (called an “expedited determination”).
 - These are the next levels of appeal, if the plan denies the coverage determination request:
 - ◆ Redetermination (at plan level)
 - ◆ Reconsideration (Independent Review Entity – Maximus)
 - ◆ ALJ hearing
 - ◆ Medicare Appeals Council
 - ◆ Federal district court (if amount at issue is at least \$1,180).
 - Appeal issues can include:
 - Drug not on formulary
 - Drug is on formulary but has utilization management requirement (prior authorization, step therapy, quantity limits)
 - Tier level assigned to drug is too high
 - Plan not following transition supply policy
 - Client’s LIS status not being recognized (amount of co-pay is too high).

❖ Recap -- Part D principles for dual eligibles:

- Enroll in, or switch to, a plan that covers as many of their drugs as possible, with the least number of restrictions.
- If there are restrictions or coverage limitations:
 - understand what those restrictions are
 - enlist the help of the person’s doctor to get the necessary paperwork completed
 - use the appeals process if the plan still denies coverage
- Make sure they’re paying as little as possible for their prescriptions – meaning that:
 - they’re receiving the Low Income Subsidy,
 - their plan recognizes their low-income status and

- they're being charged the proper co-pay.
- Make sure they know where to go for help if something goes wrong (often the first time people run into problems is at the pharmacy counter to pick up their prescriptions ...)
- Report address changes to SSA and the Medicaid office, so that you will continue to receive important notices.

❖ **Additional reminder for persons with HIV:**

- Remember that ADAP can be used in conjunction with Medicaid to get into the Extra Help program.
- Either ADAP or Medicaid can pay for HIV-related drugs if they are denied by the Part D plan.

Back to Part C – Medicare Advantage

- ❖ Medicare Advantage (Part C) is an optional way of receiving Part A & B (original Medicare) services, through private health insurance plans.
- ❖ Medicare Advantage plans must provide
 - the same services as provided through original Medicare,
 - but they don't have to follow the same cost-sharing structure.
 - They can offer additional services not provided under original Medicare.
 - But they can also impose restrictions on how or where services are provided – restrictions that are not part of original Medicare.
 - For example, a Medicare Advantage plan may require you to go to a network provider or hospital
- ❖ Medicare Advantage may cause unwanted headaches for Medicaid and QMB recipients.
 - However, they have the right to enroll if they choose.
 - If they do, their providers can bill all the Medicare Advantage co-pays/co-insurance to Medicaid.
 - Dual eligibles enrolled in Medicare Advantage should make sure their providers accept Medicaid in order for Medicaid to pick up the “wrap around” cost sharing.
 - Additionally, Medicaid recipients can use their Medicaid card for services not provided by the Medicare Advantage plan, including “out of network” services. (09 OMM/INF-1)
 - *Medicaid Advantage* plans are Medicare Advantage plans which also provide Medicaid services through the plan. Participants must generally

- receive all their services through the plan, unless there is a Medicaid-covered service that the plan doesn't provide.
- Just like in Part D, LIS beneficiaries can opt in or opt out of Medicare Advantage at any time.
 - The change becomes effective the month after the opt-in or opt-out.
- ❖ Watch out for Medicare Advantage marketing abuses
- There have been widespread problems with the marketing of Medicare Advantage and, to a lesser extent, Part D, plans – ie, insurance agents/brokers misleading or coercing individuals into signing up for plans they don't understand, want and/or need.
 - CMS has clamped down on marketing abuses but complaints continue to surface. A victim of marketing abuse may be eligible to retroactively (and prospectively) disenroll from their Medicare Advantage plan by complaining to the CMS regional office in New York City.
 - Dual eligibles, who can enroll in Medicare Advantage throughout the entire year, are particularly vulnerable to marketing abuses. Marketing abuse complaints should be made to both CMS and to the NYS Insurance Department. (The Insurance Department licenses insurance agents and brokers).

Client scenario (post-training)

Mr. J, a 56-year old single individual, gets Social Security Disability (SSD). He also has Medicare and ADAP. His gross monthly SSD benefit (before Part B premium taken out) is \$1450. He comes to your office in a panic because beginning next month, his Medicare Part D plan will stop covering all of his medications because he will hit the "donut hole." He doesn't have the money to pay for his medications himself. What can Mr. J do?

Suggested answer: Apply for Medicaid ASAP, and use ADAP to meet Mr. J's Medicaid spenddown. This will get him out of the donut hole by getting him into the Part D low-income subsidy (Extra Help), and will reduce his Part D co-pays to a minimal amount.

Additional resources

www.nyhealthaccess.org – a health care resource webpage for legal advocates, focusing on access and eligibility to public health insurance programs available to New Yorkers, including Medicare and Medicaid.

www.empirejustice.org – webpage of the Empire Justice Center

www.medicarerights.org – webpage of the Medicare Rights Center

www.medicare.gov or **1-800-MEDICARE** – Medicare’s own webpage and toll-free number

www.health.state.ny.us – NYS Department of Health (DOH) website: contains Medical Assistance Resource Guide (MARG) and DOH policy directives

HIICAP Hotline Number - 1-800-701-0501: for a referral to a local Medicare counseling agency in New York State.