DIVISION OF HEALTH POLICY AND FINANCE
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MEMORANDUM

TO:	SRS/EES Regional Office Staff HealthWave Eligibility Clearinghouse Staff	DATE:	November 7, 2005 End dated: 12/05/2011
FROM:	Scott Brunner, Medicaid Director Bobbi Mariani, EES Director	RE:	Implementation of Medicare Part D and the Medicare Part D Subsidy

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established the Medicare Prescription Drug program by adding Part D to the Medicare benefit. The program goes into effect January 1, 2006. This memo provides initial instructions for implementation of the new benefit as well as Medicare D Subsidy, as provided in KEESM Revision 26.

I. MEDICARE PART D INFORMATION

A. General Information

Medicare prescription drug coverage will be available to anyone entitled to Medicare. All current Medicare beneficiaries have been notified of the new program benefits through a series of special mailings from CMS, including the 'Medicare and You 2006' handbook. New Medicare beneficiaries will be notified of Part D options when they are notified of general Medicare entitlement prior to the initial enrollment period.

Coverage is provided through private companies who have been approved by CMS to provide coverage. The Medicare beneficiary chooses which plan they wish to enroll with. There are two basic types of plans to choose from:

1. **Prescription Drug Plan (PDP) -** A stand-alone prescription drug insurance plan offered through private companies.

2. **Medicare Advantage Prescription Drug Plan (MA PDP) -** A plan which provides coverage under Medicare Parts A and B as well as prescription drug coverage. Medicare Advantage plans provide coverage through a contracted or preferred provider network. People who are enrolled in a MA plan must receive Part D coverage through the same plan.

Note: Persons in a PACE plan will receive prescription drug coverage through the PACE provider and payment will be part of the capitated rate.

In Kansas, 15 companies offer 40 PDP plans. There are a total of 9 companies offering 25 MA PDP options, but most are regionalized and are available in specific areas only. See the 'Medicare and You 2006' handbook for a complete list of coverage options.

B. **Benefits**

The Medicare beneficiary will receive comprehensive prescription drug coverage through Medicare Part D. Each plan will operate with a formulary, or a list of preferred drugs that are covered for all members. Other drugs may be covered if medically necessary and each plan must have an appeal process. The formulary will vary by plan. Plans must contract with pharmacies to become a participant in their preferred network. Each plan will soon publish it's preferred formulary and list of preferred pharmacies or providers.

C. **Costs**

Persons electing Medicare Part D coverage will be subject to the following costs for coverage:

1. **Premiums -** A monthly premium will be charged to each enrollee. Premium charges range from about $10.00/month to over $125.00/month for some MA-PDP plans. The beneficiary can elect to have the premium withheld from his Social Security benefit or can pay it directly to the company.

   The Basic Premium: Beneficiaries may elect to join plans with additional benefits, such as a broader provider network or more extensive preferred drug list. CMS calls these enhanced alternative plans. Carriers will charge more for these enhanced plans. This will be most important for dual eligibles and other subsidy recipients because the subsidy premium benefit is limited.

   Note: Unlike Medicare Parts A and B, coverage and premium information for Part D will not be available on EATSS.

2. **Deductibles -** The amount of expense the beneficiary must incur before coverage begins. The standard annual deductible for a Medicare Part D plan is $250. However, some plans offer coverage with lower or no deductible.

3. **Copayments and Coinsurance -** Cost sharing applicable after the deductible has been met, usually applied to each service or drug received. These may be a percentage of the total cost or a set amount for each prescription received. Generally, the beneficiary will have a 25% coinsurance charge for each prescription filled. However, this can vary by plan and by the type of prescription that has been filled.

D. **Medicare Part D Entitlement Date**

Persons who are entitled to Medicare Part A or Medicare Part B are also entitled to Medicare Part D. The date of entitlement to Medicare Part D is critical, as it is the entitlement date which triggers the Medicaid payment exclusion addressed in item (3) below and not the enrollment date. The following rules apply when determining the Medicare Part D date of entitlement:

1. **Current Beneficiaries -** Entitlement to Part D is effective January 1, 2006 for all persons entitled to Medicare on or before that date.

   Example: Benji has been a Medicare beneficiary since 01-1977. His Medicare Part D entitlement date is 01-2006.

2. **New Beneficiaries Prospectively Entitled to Medicare B -** For persons prospectively entitled to Medicare, the Medicare Part D effective date is the earliest of entitlement to Part A or B.

   Example: In 02-2006 Sam reports his Medicare will begin 04-2006. 04-2006 is the Medicare Part D entitlement date. If Sam doesn't enroll in a plan until 08-2006, the Medicare entitlement date is still 04-2006.

3. **New Medicare Beneficiaries Retroactively Entitled to Medicare Part B -** For persons determined retrospectively entitled to Medicare Parts A or B, Medicare Part D entitlement is effective the month of notification of Medicare entitlement. This essentially means that Parts A and B may be effective prior to Part D. The Medicaid payment exclusion does not apply in this situation and Medicaid can pay drugs up through the month of Medicare entitlement notification.

   Example: Jennifer's disability application with SSA has been pending since 2003 and is approved in 06-2006. Later that month, she is notified her Medicare entitlement begins 02-01-2006. However, because Medicare Part D entitlement is not retroactive in these situations, Medicare Part D begins 06-01-06. Medicare Parts A and B are effective 02-01-2006. If Jennifer is a Medicaid recipient, her prescription expenses are covered until the date of Medicare Part D entitlement, or 06-2006.

E. **Source of Entitlement Information**

An automated source of Medicare Part D enrollment or entitlement information is not available to DHPF or SRS staff prior to case approval. Unlike Part A or B information, which is available on EATSS, Part D information is not included on another automated data source. The best source of enrollment information is the applicant. Although having the information available may be helpful, providing proof of Medicare Part D is not an eligibility requirement unless there are other issues to warrant the need for the information, such as a retroactive entitlement.

For Medicaid purposes, the entitlement date is determined based on the rules described above. The date determined by KAECSES is assumed to be correct

unless the worker receives verification of a different Part D entitlement date. If it is determined the entitlement date on KAECSES is not correct, it is important to ensure the correct date is entered on both KAECSES and MMIS.

Once the case is approved and information is sent to the MMIS, the beneficiary will be included on the MMA file (addressed below). Each month, we will receive a response to the MMA file list which provides the actual entitlement date and any enrollment information. This is considered our primary verification source of Part D entitlement. If the entitlement date is different from the entitlement date originally determined by the MMIS, the case will be researched and the case worker notified if any action is necessary.

F. **Enrollment**

Enrollment refers to joining a prescription drug plan. The effective date of enrollment is the date the plan becomes responsible for providing the beneficiary's prescription drug coverage. To enroll with a plan, the beneficiary must complete an enrollment form. The plan is responsible for verifying certain information with CMS, such as their eligibility to enroll with a drug plan. Persons who live outside the plans coverage area or are in jail cannot enroll. Enrollment into the plan is effective the month following the month the completed enrollment request is received.

Medicare beneficiaries can enroll in a new plan only at certain times, called enrollment periods. There are three types of enrollment periods:

1. **Initial Enrollment Period (IEP) -** The first opportunity to enroll in a Medicare prescription drug plan.

   For current Medicare beneficiaries, the period begins 11-15-05 and runs through 05-16-06.

   Example: Beth in an ongoing beneficiary. She fills out an accepted enrollment form in 11-2005. Enrollment is effective 01-2006. Seth is also an ongoing beneficiary. He fills an enrollment form out in 02-2006. Enrollment is effective the month following the month the request is received or 03-2006.

   For new Medicare beneficiaries, the IEP is the same as the existing 7-moth period for Part B. IT begins three months prior to the month the person is eligible and runs three months past the month of eligibility. Requests received prior to the month of eligibility are effective the first day of eligibility. Those received later are effective the month following the month of receipt.

   Example: Jack turns 65 in 05-2006 so his IEP runs from 02-01-2006 through 08-31-2006. If his enrollment request is received prior to 05-01-2006, coverage in the plan begins 05-01-2006. If it is received after that date, but still within the IEP timeframe, it is effective the first day of the

following month. If Jack's request is received on 06-15-2006, enrollment is effective 07-01-2006.

2. **Annual Enrollment Period (AEP) -** An open enrollment period for all Medicare beneficiaries to change plans. Each year, the AEP begins on 11-15 and ends on 12-31. Enrollment in the new plan is effective 01-01 of the following year.

3. Special Enrollment Periods (SEP) - Special period where the Medicare beneficiary is allowed to change plans because of his situation. For most enrollment changes, coverage is effective the month following the month the request is received, but there are exceptions. The following events are examples of situations causing an SEP:

    a. The individual is full dual eligible or a partial dual eligible. The SEP for a dual eligible begins the first month of Medicaid or MSP eligibility and ends 3 months following the month of termination. This essentially means that a dual eligible may change plans each month. The new plan choice is effective the month following the month the enrollment application is received by the PDP. This same benefit is not available to a subsidy eligible individual or a persons with only a Medically Needy unmet spend down. The request will be effective the month after the month the PDP receives the enrollment request.

    b. An individual moves outside of the plan's service area. The effective date is driven by the date the beneficiary moves and the date reported.

    c. The beneficiary moves into, resides in, or moves out of an institution. The request is effective the month following the month the PDP receives the enrollment request.

    d. The beneficiary is currently covered under an alternate creditable plan (see item J below) which stops providing creditable coverage.

    e. The PDP is in violates certain terms of the CMS contract which impact the individual beneficiary.
    f. The PDP stops providing coverage.

G. **Late Enrollment Penalty**

Persons who do not enroll in a Medicare Part D plan during the initial enrollment period may only do so during the annual enrollment period or a special enrollment period. Except where creditable coverage exists, there will be a penalty for late enrollment if the beneficiary doesn't enroll during the initial period. The fee is 1% of per month for every month enrollment is delayed. It is not waived if the beneficiary later enrolls during an open enrollment period.

The fee is assessed based on the base Medicare D premium for the calendar year. In 2006 the base premium is $32.20. A person who waits to enroll for 3

months past the initial enrollment period will pay a 3% monthly penalty, about $.96. Since the premium is computed on the base premium for the calendar year, it will be adjusted every year.

Example: Iris has been a Medicare beneficiary since 1995. She doesn't enroll with a plan until October 2006 when she enters a nursing facility. Enrollment is effective November 1. There is a 5 month penalty applied, or about $1.60, to her monthly premium.

H. **Auto Enrollment in a Medicare Part D Plan**

As stated in information previously in the the Auto Enrollment of Medicaid Beneficiaries Memo, 10-31-2005, all full duals, partial duals and subsidy eligibles who fail to enroll in a Medicare Part D plan on their own will be automatically enrolled into a Medicare Part D Plan. Information on the auto enrollment process for the initial group of full dual eligibles was outlined in the memo. The partial dual eligibles will be auto enrolled in a similar batch process in May, 2006 to be effective June, 2006. DHPF should receive the assignment information for the partial duals in late April, 2006. All full dual eligibles who were not in the original file, but have been approved prior to the MMA file deadline of 12-15-05 will be auto enrolled for January, 2006. CMS has since reported those beneficiaries whose benefits are approved between 11-15-2005 and 12-15-2005 may experience delays in notifications of their auto enrollment.

For enrollments after 2005, the effective date of auto enrollment is dependent upon Medicaid status at the point of Medicare entitlement.

1. **Medicaid First - Medicare Later-** For persons who are Medicaid eligible first and then become entitled to Medicare, the effective date of auto enrollment is the first day of Part D entitlement. CMS has indicated they will attempt to accomplish the enrollment prior to the effective date of Part D entitlement. If the Medicaid application is received on or before the month of Medicare entitlement, Medicare enrollment may be retroactive. This is one of the few situations where enrollment may be retroactive.

   Example: Sam is a Medicaid recipient on the Working Healthy program. On 04-10-2006 he tells the worker his Medicare entitlement begins 06-01-2006. If Sam doesn't pick a plan, he will be auto enrolled prior to 06-01-2006 if CMS knows he is a Medicaid beneficiary. If CMS doesn't identify his Medicaid status until a later date, coverage may be retroactive.

2. **Medicare First - Medicaid Later -** For persons with Medicare who later become Medicaid eligible, auto enrollment is effective the second month following the month the individual is recognized on the MMA file. This is applicable to both partial and full duals. Upon receipt of the MMA file, CMS determines the individual hasn't signed up for a plan and will flag the individual as a person to be auto enrolled. CMS will send a notice to the client the following month as notification of the pending auto enrollment. In order to give the individual time to pick a plan on their own, the assignment

will not be effective until the first day of the second month following the notice.

Example: Terry, an ongoing Medicare beneficiary who didn't sign up for a Medicare prescription drug plan, applied for Medicaid on 05-21-2006 and was approved on 06-12-2006. Her status as a full dual eligible will be indicated on the June 2006 MMA file. CMS will target the individual for assignment to a PDP and will include Terry on the July auto enrollment run. She will receive notice from CMS in late July. Terry may choose to change plans until the enrollment effective date of September 1, 2006.

Example: John began receiving Medicare in 05-2006 and applied for Medicaid in 08-2006. His application was approved with an unmet spenddown for the period 08-2006 through 02-2007. He is not eligible for subsidy or a Medicare Savings Plan. On October 17, 2006 he brings in an expense incurred by his ineligible wife, which meets the spenddown. John is now a full dual. On October 20, the case is authorized for August - November. Because John didn't pick a plan, he is subject to auto enrollment. John's name is sent to CMS as a full dual on the November MMA file and will be notified in December. John will be auto enrolled two months later, or 02-01-2007.

3. **Medicare to Subsidy D only -** For persons with Medicare who become eligible for Part D subsidy only, auto enrollment is effective the first day of the month following the expiration of the beneficiary's next open enrollment period.

   Example: Joyce is approved for Part D subsidy in 07-2006. However, she didn't enroll with a PDP. She will be auto enrolled following her next open enrollment period. Unless there is another change prompting a special enrollment period for Joyce, she will be eligible to enroll in a Part D plan in the open enrollment period running November 15, 2006 through December 31,2006. If she doesn't enroll in a plan during the open enrollment period, she will be auto enrolled effective the first day of the next month, or January 1, 2007.

I. **Affirmatively Decline**

Beneficiaries who do not want to be auto enrolled into a Medicare Part D plan must make a specific request to stop the process. All dual eligible and subsidy eligibles will be subject to auto enrollment. A beneficiary may "affirmatively decline" auto enrollment by contacting Medicare directly or the PDP to which the individual has been prospectively auto enrolled. CMS will place a special indicator on the beneficiary's file to indicate refusal of Part D coverage.

Persons may choose to affirmatively decline if they have alternate, creditable coverage that they want to preserve. However, persons may also decline for other reasons. Regardless of why, there is no Medicaid penalty for affirmatively declining. However, Medicaid will not pay prescription drugs as long as the beneficiary is entitled to Medicare Part D. If the beneficiary later decides he

wants to be auto enrolled, he can request to have the indicator removed from his record.

J. **Creditable Coverage**

A Medicare beneficiary may continue to be offered drug coverage through a private company or employer. The MMA provides special funding to those employers or companies who offer an alternative to Medicare Part D if the coverage is considered creditable. For MMA purposes, creditable coverage is coverage which is actuarially better or equal to coverage offered under Medicare Part D. Beneficiaries who choose to sign up for a creditable plan can delay enrollment into Medicare Part D without incurring a late enrollment penalty. The company or entity offering the alternative plan is responsible for determining if the coverage is creditable and for notification of the beneficiary.

Although it is possible for prescription drug coverage offered through a Medicare supplemental plan to be creditable, CMS has stated they believe no standard supplemental plan H or plan I or plan J will meet the creditable coverage definition (see Kansas Insurance Department website).

K. **Impact on Medicaid Coverage**

Beginning with the date of Part D entitlement, Medicaid will no longer cover most prescription drugs for Medicare beneficiaries. This is different than the supplemental coverage Medicaid and QMB provide for services covered under Medicare Parts A and B. The MMA strictly prohibits the state Medicaid program from claiming federal matching funds for any prescription drugs included in a covered therapeutic class. This is true regardless of whether the actual drug the beneficiary receives is covered by the plan.

Example: David has both Medicare and Medicaid coverage. On 01-05-2006 his doctor prescribes a pain killer, oxycodone, which has been covered by Medicaid in the past. However, his new Medicare plan does not cover this drug on it's basic formulary and covers other pain killers such as codine or morphine. David appeals the plan's decision to deny coverage, but David doesn't win the appeal. Since he still has a Medicaid card, he asks his caseworker about getting Medicaid to cover the drug because they cover other services Medicare denies. However, Medicaid will NOT cover the drug. Even though it is not covered by his Medicare PDP, Medicaid is not a secondary payer to Medicare pharmacy coverage. David must choose to pay for the drug himself or use another pain killer.

Current full dual eligible lose drug coverage through Medicaid on 12-31-05 and Medicare Part D coverage begins on 01-01-2006. Persons who become full dual eligible in the future will not have drug coverage under Medicaid beginning the date of Medicare Part D entitlement.

Exceptions to coverage rules - There are two primary exceptions to the prescription drug exclusion.

1. **Excluded Drugs -** Certain drug classes were specifically excluded from Medicare Part D coverage. Medicaid is allowed to cover these drugs. Kansas Medicaid has elected to continue to cover those drugs listed below, at current coverage levels available to non-Medicare beneficiaries. The following is a full list of excluded drugs and current Medicaid coverage rules (for up-to-date coverage information, please see the KMAP web site):

    a. **Drugs for anorexia, weight loss or weight gain -** Medicaid provides coverage of some weight loss medications. Others are not covered.

    b. **Drugs used to treat fertility -** Medicaid does not cover.

    c. **Drugs for cosmetic or hair growth purposes -** Medicaid does not cover.

    d. **Prescription vitamins and minerals, except prenatal and fluoride -** Medicaid covers prenatal and fluoride as well. Coverage of other vitamins is very limited.

    e. **Over the counter medication -** Covered by Medicaid in specific instances only (e.g., Kan-Be-Healthy and certain NF beneficiaries).

    f. **Drugs used for the systematic relief of cough and colds -** Medicaid does not cover.

    g. **Barbiturates -** Covered by Medicaid.

    h. **Benzodiazepines -** Covered by Medicaid.

    Although not covered under general Medicare Part D plans, a PDP can offer them in the coverage package of a supplemental benefit to an upgraded plan.

2. **Drugs covered under Medicare Parts A or B -** Medicare currently provides coverage of some drugs under parts A and B. This coverage will continue at current levels. Full Medicaid as well as QMB will continue to provide secondary coverage for these expenses.

    a. Part A provides coverage of drugs as part of the inpatient rate paid during hospital and nursing facility stays. Part A also provides coverage of drugs related to pain relief and symptom control under the hospice benefit.

    b. Part B covers a broader range of drugs, the most common Part B covered drugs are the following:
        i. Drugs given through and injection or infusion that are not usually self-administered. Examples are chemotherapy treatments given in a physicians office and respiratory drugs,

supplied by a DME provider, and given through a nebulizer;

ii. Drugs provided during out patient treatment;

iii. Certain drugs related to the treatment of End Stage Renal Disease;

iv. Immunosuppressive Drugs, or those used for transplant therapy, if Medicare paid for the transplant;

v. Certain vaccines, such as the Pneumococcal, Hepatitis B and Influenza vaccines; and

vi. Some oral medications, such as chemotherapy and anti-nausea drugs for cancer treatment and hemophilia clotting factors.

Many of these drugs listed above are covered only for specific medical conditions. If the drugs is used for other purposes, the drug may be covered under the Part D plan.

II. MEDICARE PART D SUBSIDY

Assistance with Medicare Part D costs is available for people with limited income and resources, including those who receive Medicaid. The new benefit, the Medicare Part D Subsidy, provides coverage through two avenues: those deemed eligible due to eligibility for another Medicaid program and those determined eligible through a separate program determination. CMS is responsible for provision of benefits under either determination. DHPF/SRS provide only the eligibility determination.

Because CMS is responsible for maintaining information on the subsidy, eligibility determinations completed by Kansas Medicaid must be communicated to them. This is done through a monthly file transfer. This file is sent to CMS on the 15th of each month. Limited information on the monthly file transfer is available, see the Auto Enrollment of Medicaid Beneficiaries Memo dated 10-31-2005. More information will be made available at a later date.

Persons approved for subsidy through either the deemed or determined process receive the subsidy benefit through 12-31-2006 regardless of changes. Persons deemed eligible in 2005 are eligible for the calendar year 2006. Those deemed or determined eligible in 2006 are eligible for the remainder of the calendar year 2006. More information will be provided on eligibility periods past 2006. It now appears that CMS will not reduce the level of subsidy for a person in the calendar year 2006 and will only react to changes which will reduce the beneficiaries cost sharing. More information on these rules and rules for eligibility periods past 2006 will be provided when available from CMS.

A. DEEMED ELIGIBLES

Persons approved for Medicaid under any category, including Medically Needy with a met spenddown or a Medicare Savings Plan are deemed eligible for the Medicare Part D subsidy. A separate application is not needed nor is a separate determination required for the months of deemed coverage.

1. **Effective Date -** Subsidy is effective the first month of mutual eligibility under one of the deemed groups and entitlement to Medicare Part D. A person is considered deemed regardless of whether enrollment into a plan has taken place. CMS will attempt to identify current Medicaid recipients prior to the effective date of Medicare in order to ensure subsidy is in place on the first day of Medicare entitlement

   Example: Bill is an ongoing Medicaid eligible who becomes entitled to Medicare beginning 06-01-2006. Bill is deemed eligible for subsidy beginning 06-01-2006.

   Example: Betty is a Medicare beneficiary who is approved for a prior Medically Needy spenddown period of 03/2006 though 05/2006 and a current base period of 06/2006 through 11/2006. She chooses to use a due and owing bill to meet her prior spenddown. Betty is deemed eligible for the subsidy beginning 03/2006.

2. **Benefits of the Subsidy -** The subsidy provides help with Medicare cost sharing. Individuals deemed subsidy eligible receive the following benefits:

   a. **Basic Premium Coverage -** The subsidy will provide coverage of the lowest premium a plan offers, up to the basic premium level for the state. A beneficiary receiving the subsidy may elect an enhanced or higher cost plan, but he is responsible for the difference. The current benchmark premium cost for Kansas is $33.44.

      Example: Benny wants to join plan X, which offers the following premiums:
      Basic Premium - $25.00
      Enhancement - $35.00 (an additional $10.00)
      If approved for subsidy, the lower of the benchmark premiums for the state or the cost of the basic premium will be covered. Additional costs will not be covered. For Benny, the subsidy would only cover $25.00 (since it is lower than the benchmark). If he wants the enhancement, he must pay the full $10.00/month extra.

      Example: Bunny wants to join plan Y, which offers the following premiums:
      Basic Premium - $37.00
      Enhancement - $5.00
      If approved for subsidy, the lower of the benchmark premium and basic premium for the plan will be covered. For Bunny, the benchmark is lower, so $33.44 of the premium will be covered. If Bunny still wants to enroll in Play Y, she must pay $3.56 for the basic or an extra $8.56 ($3.56 = $5.00) for the enhanced plan.

Late Enrollment Penalty: Persons approved for Medicare Part D subsidy will receive be relieved of a portion of the penalty for the first 5 years. Persons who are deemed eligible for the subsidy will pay 20% of the penalty.

Example: Iris, from the example in item I (F) above, is approved for Medicaid in November, 2006. She will be responsible for 20% of the penalty, or about 32 cents each month.

Beneficiaries determined eligible for the subsidy will not receive the 20% exemption and must pay the full premium penalty.

b. **Deductible -** The subsidy will cover the standard $250.00 annual deductible. Please note that some plans to do not charge a deductible.

c. **Copayments/Coinsurance - Beneficiaries deemed eligible for subsidy will have a standard copayment** for each covered prescription. The copayment is based on Medicaid status:

   1. **Persons eligible for QMB, LMB or Expanded LMB only -** $2.00 per generic or preferred brand and $5.00 prescription for all others.

   2. **Persons eligible for full Medicaid coverage, including a met spenddown under the Medically Needy program, and income is at or below 100% of FPL -** $1.00 per generic or preferred brand and $3.00 for other prescriptions.

   3. **Persons eligible for full Medicaid coverage, including a met spenddown under the Medically Needy program, and income is above 100% of FPL -** $2.00 per generic or preferred brand and $5.00 for other prescriptions.

   4. **Persons eligible for full Medicaid coverage and a resident of an approved institutional living arrangement (Nursing Facility, State Hospital, ICF-MR, Swing Bed, Head Injury-Rehab or other recognized Medicaid approved institution -** For persons in the institution at least 30 days, no copayments will be charged for covered prescriptions. HCBS recipients are not considered institutional residents and will be charged a copayment

The Medicaid status which determines the level of copayment is indicated on the monthly MMA file each month. The file reports the information as it comes to the MMIS from KAECSES. For MS programs, the income level will be determined by the countable income entered on KAECSES. Where income isn't enterable on KAECSES (such as the MA CM and SI programs) the person will be assumed to have income less than 100% FPL. Information on the LOC screen in the MMIS, which comes from the

KAECSES LOTC screen, will be used to determine the institutional indicator.

B. **Determined Eligibles**

DHPF and SRS, as the Medicaid agency, and Social Security have been given authority to process subsidy applications. Information on the SSA process is available in Policy Memo 05-05-02. Since the formal application period for the subsidy benefit began in July, we have relied on Social Security to process all applications. To meet federal requirements, SRS will begin processing applications for this benefit on January 1, 2006.

Because Social Security continues to encourage applicants through it's system, referrals to Social Security for subsidy determination continue to be appropriate. If an individual indicates the only benefit he is interested in is Medicare Part D subsidy, a referral to Social Security is appropriate. The worker, or other SRS staff person, may assist with the application process.

If the client submits an application for medical coverage, Medicare Part D subsidy is another program option and shall be processed for persons who are not determined eligible under a deemed group. If an individual applies for full Medicaid or a Medicare Savings Program, but is denied, a subsidy determination shall then be completed. These applications are not to be referred to Social Security, unless the person makes a specific request to have the application processed by SSA. SRS, including state staff at the Clearinghouse, shall process the subsidy application for persons also seeking another benefit plan that does not offer a deemed subsidy status, such as Medically Needy with an unmet spenddown or TB.

Note: Beneficiaries determined eligible for the subsidy will not receive the 20% exemption for a late enrollment and must pay the full premium penalty.

1. **Medicare D Subsidy Eligibility Requirements -** The non-financial and financial rules of the MS program are used to determine subsidy eligibility, except for the following:

    a. **Number in Subsidy Household -** Although the assistance planning rules of KEESM 4300 apply in the subsidy determination, a new element is also considered in the determination. Certain relatives who live with the applicant/recipient are considered members of the subsidy household. For this purpose a relative is defined as any person who is related by blood, marriage or adoption, who is living with the applicant and spouse and who is dependent on the applicant or spouse for at least one half of his/her financial support. The subsidy household size is used only to determine the poverty level for the determination. For example, a subsidy household size of 3, the 3 person poverty level standard applies. The income and resources belonging to members of the subsidy household who are not included in the assistance plan are exempt. Verification of

relationship is not required and they should not be registered on the MS program.

Example: George and Martha, married Medicare beneficiaries, apply for subsidy. They report their two grandchildren, Robert and Ulysses, live with them. Because they are married and living together, George and Martha are the only members of the assistance plan and their income and resources are used in the determination. Because the grandchildren live with them, the subsidy household size is 4. However, income and resources belonging to Robert and Ulysses are not considered. The 4 person poverty level standard is applicable in the determination.

Example: Polly is a 32-year old Medicare beneficiary applying for a Medicare Savings Plan. Her income is $1500/ month. She is over the income limit for Expanded LMB, so a subsidy determination is necessary. She indicates on her application that her sister and two nieces were currently living with her. She is the only one with income right now. For the subsidy determination, the household size is 4. Polly is at 93% of FPL for the Subsidy. She is eligible for Subsidy at Level D.

Note regarding the application forms - Although the new ES-3100.8 has been designed to capture information on other household members, persons who apply using other application forms (e.g., the ES-3100.4 or the ES-3100) will not be asked to report this information. Separate contact with the individual will be needed to capture the information.

b. **SSA COLA Exception -** The COLA exemption applicable to the Medicare Savings Programs until the new poverty levels are implemented [KEESM 6410 (52)] is not applicable to subsidy determinations.

c. **Processing Guidelines -** There is no prior eligibility for subsidy. Eligibility is determined effective the first day of the month of application. Eligibility for the subsidy is determined regardless of Part D enrollment status. If there is a delay in sending approval information to CMS, a reimbursement may be due from the PDP or other carrier.

d. For QMB Approvals - Because eligibility under the QMB program is not effective until the month following the month of processing, there is a potential gap in subsidy coverage. Therefore, for any QMB approval, a Subsidy application must be processed for each of the months beginning in the month of application through the month in which QMB is approved. These applications are the responsibility of SRS and are not referred to SSA.

Example: Johnny applies for Medicaid on 04-29-2005. His application is approved for QMB coverage on 06-03-06, so coverage is effective 07-01-2005. A subsidy determination must be completed for 04/05, 05/05 and 06/05.

e. **Income/Resource Limits -** There are five distinct levels of Medicare Subsidy. Eligibility under each of the levels is based on countable income and resources.

Level D: Incomes at or below 135 % FPL and resources at or below $6,000 for a single or $9,000 for a couple.

Benefits: Coverage of the basic premium charge and the $250 annual deductible. Copayments of $2.00 per preferred or generic prescription and $5.00 for other covered prescriptions.

Level D1: Incomes at or below 135% FPL and resources at or below $10,000 for a single or $20,000 for a couple.

Benefits: Coverage of the basic premium charge. A $50.00 annual deductible is applicable and copayments of 15% per prescription up to the catastrophic level. $2.00/$5.00 per prescription after the catastrophic level is reached.

Level D2: Incomes greater than 135% and at or below 140% FPL; resources at or below $10,000 for a single or $20,000 for a couple.

Benefits: Coverage of 75% of the basic premium charge. A $50.00 annual deductible is applicable and copayments of 15% per prescription up to the catastrophic level. $2.00/$5.00 per prescription after the catastrophic level is reached.

Level D3: Incomes greater than 140% and at or below 145% FPL; resources at or below $10,000 for a single or $20,000 for a couple.

Benefits: Coverage of 50% of the basic premium charge. A $50.00 annual deductible is applicable and copayments of 15% per prescription up to the catastrophic level. $2.00/$5.00 per prescription after the catastrophic level is reached.

Level D4: Incomes greater than 145% and below 150% FPL; resources at or below $10,000 for a single or $20,000 for a couple.

Benefits: Coverage of 25% of the basic premium charge. A $50.00 annual deductible is applicable and copayments of 15% per prescription up to the catastrophic level. $2.00/$5.00 per prescription after the catastrophic level is reached.

C. **The MD PICK Code**

A new special medical indicator, or PICK code, has been created to use for subsidy only cases. The MD PICK code is mandatory on all subsidy-only cases. The code is necessary for two reasons:

1. The MMIS reads most MS records coming from KAECSES as spenddown records unless there is another indicator on the case telling the MMIS that other coverage exists. The CC override for LTC cases, the LO and QO medical program subtypes and other PICK codes are examples of coverage indicators.

   For a person seeking only subsidy, the MD PICK code will distinguish the case as a subsidy only case from other MS cases and tell the MMIS to provide only the subsidy benefit. Note that the full authorization through the new SUDD screen also must be completed to authorize a subsidy record, this is explained in Section IV (Automated System Changes) below.

   However, for persons who are also seeking coverage under a Medically Needy spenddown, the PICK code is not appropriate. Subsidy eligibility is authorized through SUDD for these cases and using the PICK code will prevent the spenddown from being read by the MMIS.

2. The PICK code will override the resource limit tied to the MS program for a subsidy determination. For example, a beneficiary with countable resources of $5000 is not eligible for regular medical or an MSP, but is potentially eligible for subsidy. Using the MD PICK code will allow authorization of the subsidy benefit regardless of the resource limit.

Please be cautioned, there is no resource limit built into the subsidy determination. The eligibility worker must pay careful attention to the countable resources listed on the SUDD screen and limits tied to the specific subsidy level.

D. **Denied Applications**

As part of the MMA file transfer, information on all denied subsidy applications is being captured and sent to the MMIS. CMS will retain this information for coordination with Social Security subsidy applicants. Therefore, it is extremely important that accurate denial codes are entered on the SUDD screen (see Section IV below). CMS will allow reporting of only certain codes, so the codes are limited by federal design. One of the following must be entered on the new SUDD screen when an application is denied:

1. **NM - Not enrolled in Medicare A or B.** For use with beneficiaries who apply for subsidy but are not entitled to Medicare D;

2. **US -** Not residing in the United States, currently incarcerated or deceased;

3. **CO -** Failure to cooperate;

4. **XR - Excess Resources.** Use if countable resources exceed $10,000 for a single or $20,000 for a couple;

5. **XI - Excess Income.** Use if countable income exceeds 150% of the FPL;

6. **FR - Failed Review.** Use if manually closing the program or case for no review; and

7. **DM - Deemed Eligible.** Use if the subsidy case is closing because the person is now a deemed eligible (e.g., moving from subsidy to QMB).

III. Treatment of Medicare Part D Expenses For Other Medicaid Programs

Although Medicare Part D is considered comprehensive coverage, the beneficiary will incur some out of pocket expenses that may be allowable against a Medically Needy spenddown, patient liability or HCBS client obligation. These expenses may also be considered when determining Impairment Related Work Expense (IRWE) or Blind Work Expense (BWE) deductions.

A. Premiums

Premiums which are not subject to reimbursement by the subsidy are allowable, including the following:

1. The basic premium charge incurred in months the individual is not eligible for subsidy;

2. Additional charges for enhanced plans above the basic plan covered by the subsidy;

3. Late enrollment fees added to the premium which are not subject to reimbursement by the subsidy; and

4. Premiums paid for creditable prescription drug coverage taken as an alternative to Medicare Part D.

As with all health insurance premiums, for Medically Needy or SOBRA spenddown cases these expenses are recorded on the KAECSES MEEX screen.

B. Deductibles/Copayments

All cost sharing expenses which are not subject to reimbursement by the subsidy are allowable, including applicable $1.00 - $5.00 copayment charged for persons receiving the subsidy.

1. For Medically Needy or SOBRA spenddown cases, providers are encouraged to continue to bill these expenses through the MMIS. However, pharmacy billing practices may not permit direct bill of a copayment amount. In these situations, the copayment is entered on a Beneficiary Billed Claim Form by the eligibility worker. Expenses used

toward the Medicare Part D deductible are also allowable using the Beneficiary Billed process if the claim may not be filed electronically.

2. For long term care cases, the copayments are allowable on the KAECSES MEEX screen. However, no deductible is applicable in the first month of Medicaid eligibility as the individual is deemed eligible for subsidy.

C. **Non-Covered Prescription Drugs**

Prescription drugs which are not covered by the Part D or other prescription drug plan are allowable.

1. Drugs which are not on the plan's formulary which have been denied through an appeal. Proof of the denial from the company as well as proof of the appeal finding are required. The actual cost to the beneficiary is allowable.

   For Medically Needy or SOBRA Spenddown cases, the provider may electronically bill these claims or they are allowed as Bene Billed claims. For LTC situations, they are entered on the KAECSES MEEX screen.

2. Expenses incurred prior to enrollment in a Part D plan are allowable for persons entitled to Medicare Part D, even though Medicaid will not pay these expenses. Extreme caution is to be used before using these expenses. The actual enrollment date into the plan must be verified prior to considering the expenses. If the beneficiary fails to enroll in a plan, the effective date through the auto enrollment process must be considered. Documentation is required.

3. Over-The-Counter Medication. Medicare Part D does not provide coverage of over-the-counter drugs. Costs for these items are potentially allowable if medically necessary. Follow the medical necessity guidance in Appendix Item P1 to determine medical necessity.

4. Drugs purchased through an out of network pharmacy. The MMA requires reimbursement to the dual eligible beneficiary who utilizes an out of network pharmacy. It is unknown how this process will work. Documentation from the PDP is required prior to allowing expense in which the beneficiary is claiming non-coverage due to out-of-network provider.

IV. Automated System Changes

To support both Medicare Part D coverage and the Medicare Part D subsidy, several changes were made to both the KAECSES AE system and the MMIS.

A. **KAECSES Changes -** The system changes described below are effective Monday, January 9, 2006. With the exception of the MEIN screen, copies of the modified screens will be available in the training material provided to eligibility staff in November and December. A copy of the revised MEIN screen is included in this material.

1. **PROGRAM -** Medicare Part D Subsidy must be processed under the MS program.

2. **MERE -** Medicare Part D and SubdD fields have been added to this screen. Information on this screen is necessary in order to authorize the subsidy benefit. Note the following rules:

    a. The Part D field is blank, but requires a 'Y' or 'N' entry by the eligibility worker for the MS program.

    b. Medicare Part D Subsidy cannot be approved on the new Subsidy D screen (SUDD) unless there is a 'Y' in the Medicare Part D field.

    c. The value in the new SubD field defaults to 'N'. The 'N' should be changed to a 'Y' when a consumer is requesting a Medicare Part D Subsidy eligibility determination.

    d. The MD special medical indicator cannot be enter on PICK for an individual unless that person has a 'Y' in the SubdD field.

3. **MEIN -** Minor screen layout changes were made to allow room for new Medicare Part D entitlement and end date fields and a new Part D Allow Auto Update field.

    a. The MEIN Part D entitlement and end dates are not enterable. Only the 'Allow Auto Update' field is enterable.

    b. Part D entitlement and end dates will be calculated by the system anytime a user enters initial Part A or B entitlement and/or end dates on the MEIN screen. The dates will also be recalculated by the system anytime receipt of a BENDEX or WPTQY record causes a change to either a Part A or B entitlement or end date. Note: if the worker enters the Part A and or B dates, they would have to leave then return to the MEIN screen to see the newly calculated Part D dates.

    c. Like the Part A and B Allow Auto Update field, the Part D Allow Auto Update field will default to Y. The Y can be changed to an N in situations where it is determined automated processes can not correctly determine the Part D entitlement or end dates.

    d. Since the Part D entitlement and end date field are not enterable, any necessary change to either will require SRS help desk participation.

    e. Unlike Part A and B, Part D information on MEIN does not cause a Y to be entered in the Part D field on MERE.

f. Unlike Part A and B, Part D information is not sent to the MMIS from KAECSES. The MMIS will calculate Part D entitlement dates based on Part A and B entitlement information it receives from MEIN and from CMS.

g. A copy of a portion of the modified MEIN screen is displayed below, with changes highlighted:

MEIN MEDICARE INFORMATION 110605 13:43
CASE NAME: BOND JAMES CASE NUMBER: 11111111 CHRIS

POA: 01 BID: 0000000001
NAME: BOND JAMES DOB: 02021900 SEX: M SSN: 000000011

NAME: BOND JAMES DOB: 02021900 SEX: M SOURCE: BEND
MEDICARE CLAIM #: 000000011A RAILROAD MEDICARE (PARTB)? N MEDICARE HMO: N
ENTITLEMENT START DT END DT COVERAGE IN EFFECT? Z99 DT ALLOW
PART A: 12011996 Y AUTO UPDATE
PART B: 12011996 Y Y
PART D: 01012006 Y

4. **MSID -** Two changes have been made:

a. Allows the MS program to be authorized if there are excess resources when the 'MD' code is entered in the Special Medical Indicator field on PICK.

b. Added a new field, 'Go to Subsidy D' field?' 'N' is the default value for this field, but a worker can change to 'Y' to access the Subsidy D (SUDD) screen.

5. **SUDD (Subsidy D Determination) -** This new screen captures Medicare Part D Subsidy entitlement. SUDD is a multiple part screen.

a. The top part calculates and displays the number in the medical unit, household size, the household's net income, countable resources and federal poverty level percent. The household size defaults to the same number as the number in the medical unit, but can be changed by the eligibility worker. After you change the household size number, push enter so the system can recalculate and display the new federal poverty level percent.

b. The bottom two-thirds of SUDD is for Medicare Part D Subsidy approval, change, denial or closure actions. It functions much like the CHSE and LOTC screens in that it requires entry of the POA (position on app) number(s) before the rest of the fields open for

entry or display existing data.

c. The eligibility worker can enter any of the four action types (AP for approval/changes; CL for closures; DE for denials; and DL for deletes).

d. Based on the Action type, other fields open on the screen so required information can be entered by the eligibility worker.

e. Each action requires the eligibility worker to authorize by entering their PIN. Once an action type is entered, it will not display the next time the screen is accessed.

f. The Closure/Denial Date is protected and populated by the system. Closure dates are the last day of a month and denial dates are the calendar day the denial action is taken. These dates do not display until the worker leaves the screen and returns to SUDD.

g. SUDD is a month specific screen and can also be accessed by using the 'Next' function. Like other screens, to next to SUDD, the system requires the case number, benefit month and budgeting method.

h. As with other programs, to close Subsidy D for an individual, the MS program must be in the month after the effective date of closure. For example, to close Subsidy D effective 02/28/06, you must be in the benefit month of 03/06.

i. Medicare Part D Subsidy denials and closures will be transmitted to the MMIS fiscal agent when SUDD is authorized. Subsidy D approvals/changes (types) are sent to the MMIS fiscal agent on the current daily and monthly benefit files.

j. The SUDD Help Screen lists the Action types, Subsidy D types and Denial/Closure Reasons. Additional information about the SUDD screen is in KAECSES Code Card revision and KAECSES AE User Manual Volume I, Section 335D.

6. SPEN - Additional edits have been added to this screen so you cannot authorize an MS case that has a MD special medical indicator unless there is an approved Medicare Part D Subsidy type on SUDD.

7. MEBH - The Medicare Part D Subsidy type will display on MEBH for each entitled individual. You can send a changed Subsidy D record to MMIS by reworking MSID, SUDD and SPEN.

8. Closures - Several rules exist for subsidy closures:

   i. When the system closes the MS program because of no review, all open Medicare Part D Subsidy coverage will also close.

ii. All subsidy records on the SUDD screen must be closed before you can close the MS program. You will receive an error message forcing you to close these records on SUDD. You cannot close an MS case with open Subsidy D coverage until you close the Subsidy D on SUDD.

iii. All unpaid Subsidy records for a month must be closed or denied prior to changing a participation code on SEPA for that month. The system will not allow a Subsidy record to be altered for anyone unless they are coded "IN" on SEPA. Remember to close/deny the unpaid Subsidy record on SUDD before changing a participation code on SEPA.

iv. Subsidy eligibility prior to QMB. See item II.B.1.d. above. A QMB eligible must have subsidy determined from the month of application through the month prior to QMB approval. The subsidy record must be closed for the month prior to QMB. Following the subsidy approval, the following steps provide may be followed to close the subsidy record:

i. Roll your case into the first month of QMB eligibility (month after the month of processing).

ii. Next to PICK and remove the 'MD' code (if used).

iii. Next to MSID, put a "Y' in the AUTHORIZE QMB and GO to SUBSIDY D fields to go to SUDD.

iv. Enter your POA and press ENTER.

v. Enter CL in the ACTION field and press ENTER.

vi. Enter DM code in the Reason field and press ENTER to go to SPEN.

vii. Authorize on SPEN.

viii. Check MEBH to be sure no subsidy types display in the first QMB month and any future months.

If you go back into the SUDD screen, the last day of the previous month will display in the Denial/Closure Date field. Your SUDD records are now closed and QMB may be processed.

B. Future System Changes for Medicare Part D and Subsidy occurring after January's implementation are as follows:

1. Display Subsidy D indicator on CAP2 and Active Case Listing (CR300/300A).

2. Display MD code on Review Labels so staff can easily identify Medicare Part D Subsidy only cases.

Further information to staff will be made available through SRSTSC upon implementation of these changes.

C. **Notices -** To support changes related to Medicare Part D, several new notices are being created. Several existing notices are also being changed to provide information about Medicare Part D and the subsidy benefit.

Notices for Persons Deemed Eligible for the Subsidy - Current approval notices will be updated to provide information on subsidy eligibility as part of the Medicaid approval. Proposed language is included in the attachment. Separate notices are being written for Medical Savings Plan/Subsidy determinations.

Notices for Determined Subsidy Eligibles - Approval, denial, closure and review notices are being developed for subsidy determinations.

SRSTSC will provide information on availability of individual notices.

D. **MMIS Changes -** Several changes are also being made to the MMIS. The fiscal agent, EDS, will provide additional information on these changes prior to implementation. Please note the following:

1. A new window will capture Part D entitlement information. This will not be displayed on the Medicare Coverage window.

2. Part D entitlement on the MMIS is DETERMINED from the Part A and Part B effective dates sent from MEIN. As indicated earlier, the Part D MEIN date is not sent to the MMIS. The logic used to determine the Part D entitlement date in both systems is the same. However, if an entitlement date must be changed in the MMIS, this is caused by changing the A or B dates on MEIN.

3. The Part D entitlement date will drive claims edits to stop payment of pharmacy claims.

4. PDP information, sent from CMS on the MMA Response file, will be available for display in the MMIS. This will provide current information on the beneficiary's current PDP or MA PDP assignment.
5. Subsidy eligibility information will be displayed on the MMIS in a new window. It will not be displayed on the general eligibility windows.

V. Conclusion

The implementation of Medicare Part D has proven to be a multi step process, with more information yet to come. Several items have been noted in this memo for additional informational releases in the future. In addition to those targeted, a separate

implementation memo for the new Medicare Savings Plan/Medicare Part D Subsidy application, the ES-3100.8, and the Review Extension are in development. Policies are still being developed for the relationship of Medicare D with other medical benefits, such as the AIDS Drug Assistance Program. Once these decisions are made, information critical to field operations will be shared with you and your staff.

The hard work and dedication to our Medicaid beneficiaries is much appreciated. Any questions about system issues may be addressed to SRSTSC. Other questions about the information may be directed to Jeanine Schieferecke (jzs@srskansas.org) or (785) 296-8866.