

IMPORTANT INFORMATION About The NEW Medicare Drug Coverage

*Ensuring Continuity Of Care
For Dual Eligibles:*

**A GUIDE TO TRANSITION FROM
MEDICAID TO MEDICARE'S
PRESCRIPTION DRUG COVERAGE**



A Partnership of The Arc & United Cerebral Palsy

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Who are Dual Eligibles?

People who receive Medicare and Medicaid benefits are called “dual eligibles.” As a result of federal legislation, all dual eligibles will have their Medicaid drug benefit end on December 31, 2005. It is being replaced by the new Medicare drug benefit, which begins on January 1, 2006.

Individuals, families, caregivers, and advocates need to learn the important aspects of the new Medicare drug coverage and how it impacts people with disabilities.

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KEY FACTS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

What are the most important things that people with developmental disabilities and their caregivers need to know about the new Medicare prescription drug coverage?

- *Medicaid* prescription drug coverage for all dual eligibles will end on December 31, 2005. It is being replaced by the new *Medicare* prescription drug coverage, which begins on January 1, 2006. Private prescription drug plans (known as PDPs) will provide this coverage.
- The Medicare drug benefit may not provide the same drug coverage provided by many state Medicaid programs. In addition, there is a complicated set of rules and procedures that govern the new Medicare prescription drug coverage.
- If a person with a developmental disability is only receiving Medicaid he or she is not affected by these changes.

DUAL ELIGIBLES

Who is a dual eligible?

A dual eligible is an individual who receives both Medicare and Medicaid benefits. Dually eligible people with disabilities usually receive Social Security and Medicare benefits and Supplemental Security Income (SSI) and Medicaid benefits. (The Social Security benefits are usually Disability Insurance benefits or Disabled Adult Child benefits received due to the retirement, death, or disability of a parent). Receiving both Medicare and Medicaid is why we refer to these individuals as dual eligibles. Of the 6.4 million dual eligibles, an estimated 500,000 are people with developmental disabilities.

MEDICARE PRESCRIPTION DRUG COVERAGE

Is Medicare prescription drug coverage voluntary? Can a dual eligible decide not to participate in it?

The MMA law does not require Medicare beneficiaries to participate in the new Part D prescription drug coverage. However, since Medicaid drug coverage is ending on December 31, 2005, ***if a dual eligible disenrolls from the Medicare prescription drug coverage, he/she won't have any drug coverage at all.*** Medicare will auto-assign people who are dual eligibles to a prescription drug plan (PDP) prior to January 1, 2006. Dual eligibles are permitted to switch from their auto-assigned prescription drug plan by enrolling in another PDP. However, if they disenroll from one drug plan without, at the same time enrolling in another drug plan, they will not have government sponsored coverage for prescription medications.

Note: There will be articles in the newspapers and news reports on television and radio that refer to Medicare prescription drug coverage as “voluntary.” However, the news coverage will be referring to the general Medicare beneficiaries, not to the dual eligibles.

Will there be just one Medicare PDP or many different ones?

There will be many plans. It is anticipated that 10 or more will be available nationally and there will be several additional plans in each state. The Centers for Medicare and Medicaid Services (CMS) Web site (www.medicare.gov) will have information about the plans.

DIFFERENCES FROM MEDICAID PRESCRIPTION DRUG COVERAGE

What are the key differences between Medicaid prescription drug coverage and the new Medicare Prescription Drug Plans (PDPs)?

- The private PDPs may have limited formularies or may place other restrictions on access to the medications a beneficiary needs.
- Cost sharing likely will be higher (except for individuals who live in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)).
- Unlike Medicaid, there is no requirement to dispense an emergency supply of medications pending an appeal in a case where a plan seeks to deny coverage for a specific drug.
- Unlike Medicaid, pharmacists are permitted to deny medications if beneficiaries are unable to pay the co-pays.
- Current Medicaid rules limit these potentially harmful actions that can disrupt treatments and put the health of dual eligibles at-risk, but the Medicaid rules will not apply to dual eligibles when they transition to Medicare prescription drug coverage.

CHOOSING A MEDICARE PRESCRIPTION DRUG PLAN

What should a dual eligible do to ensure that they have access to Medicare prescription drug coverage that meets their needs?

Dual eligibles, their families, providers and/or advocates must select and enroll in a plan that meets their needs. No one should assume that the PDP to which a dual eligible is randomly auto-assigned will meet their needs.

What are the key things to think about when choosing a PDP?

- Individuals or their caregivers will need to evaluate the drug formularies of the various plans to see if the formulary includes all the drugs they need, and to see if there are any restrictions on access to those drugs.
- If the plans do not cover all their prescription drugs, a medical consultation may be necessary to see if their doctor will work with the person to appeal the decision or if the individual can safely be switched to other medications.
- Individuals or their caregivers will need to look at the pharmacy network to make sure the pharmacy they use is part of the PDP's network.
- Individuals and their caregivers need to be aware that Medicare will reimburse only for premiums that are at or below a certain cost level, so choosing another plan may result in higher costs to the individual.

Be aware that different rules apply for individuals who reside in nursing facilities or ICFs/MR versus other group homes, at home or in supported living arrangements (see cost sharing discussion below).

Who is authorized to enroll in a Medicare PDP on behalf of a dual eligible with a cognitive or intellectual disability?

The federal Centers for Medicare and Medicaid Services (CMS) has stated that each state will decide who is considered a legally authorized representative for selecting and enrolling a person with a cognitive disability in a PDP. Families and caregivers are urged to contact their State Medicaid agencies or check www.ucp.org or www.thearc.org for updates on this issue.

AUTO-ASSIGNMENT

When will dual eligibles receive information about their new Medicare PDP?

In late October to November 2005, CMS will randomly auto-assign all dual eligibles to a PDP. CMS will send a letter to all dual eligibles (or to their representative payee, if the individual has a representative payee) notifying them of the PDP to which they have been assigned. From mid-October to early November 2005, dual eligibles, their caregivers, and representative payees should be checking their mail for this important notice from CMS.

What happens if a dual eligible does not enroll in a PDP?

If the dual eligible (or their legally authorized representative) does not enroll in a PDP of their choice, then the auto-assigned drug plan named in the letter from CMS will become the plan that is responsible for the prescription drugs for that individual.

After receiving the CMS auto-assignment letter (see above), when will the dual eligibles be able to change to a different prescription drug plan (PDP)?

Starting on November 15, 2005, dual eligibles can switch from the CMS auto-assigned drug plan another PDP. Dual eligibles can switch plans up until Dec. 31, to ensure that they have their choice of Medicare prescription drug coverage on January 1, 2006.

To switch to another PDP, it is advisable to make the change as soon as it is known which plan will meet the individual's needs. Given that there is likely to be processing time involved in making the changes enrolling early to ensure continued prescription drug coverage is advised.

What happens if a dual eligible is auto-assigned to a prescription drug plan (PDP) that does NOT include the pharmacy that he/she has been using?

There are two ways to handle this situation. Either the dual eligible needs to switch to another PDP, one which includes the pharmacy that he/she has been using, or the dual eligible needs to use a different pharmacy, one included in the current PDP's network.

DRUG FORMULARIES

What is a drug formulary?

A drug formulary is a list of prescription medications that a drug plan *will* pay for. When medications are not listed on a PDP's formulary, then the drug plan will not pay for them unless an exception is granted (see discussion below).

Will there be just one drug formulary or many different ones?

Many different ones will be provided. Each PDP providing Medicare prescription drug coverage will have its own formulary. To determine which drug plan's formulary meets the needs of each dual eligible, it may be necessary to examine all of the formularies.

Will any medications be available on all of the different formularies?

Yes. CMS has designated six drug classes in which Medicare beneficiaries need *uninterrupted access* to all or substantially all of the drugs in that class. However, CMS does not require that extended release products be included or that all dosages be included.

Those medication classes are:

- Antidepressants (e.g., Prozac, Effexor, Zoloft) used for treating depression;
- Antipsychotics (e.g., Risperdal, Zyprexa, Seroquel) used for treating psychiatric disorders such as schizophrenia;
- Anticonvulsants (e.g., Depakote, Tegretol, Lamictal) used for preventing or reducing seizures;
- Antiretrovirals used for the treatment of HIV and AIDS;
- Antineoplastics used for the treatment of cancers; and
- Immunosuppressants used to prevent the rejection of transplants and may be used for the treatment of multiple sclerosis, lupus and some types of rheumatoid arthritis.

What about other drug classes?

A PDP must include at least two drugs in every class.

Can a PDP change its formulary?

Yes, the PDP can change its formulary. However, the PDP must send a written notice of a formulary change, including a change in the cost sharing to those enrollees who use an affected drug. The notice must be sent at least 60 days in advance of the change.

How will dual eligibles, their caregivers, and staff know whether the individual's medications are on the formulary of their PDP?

The easiest way to compare the formularies of the different PDPs will be on the Internet. *Starting in mid-October, 2005*, www.medicare.gov will include a method for comparing all of the PDPs near where people live. Another family member, such as a sibling, may be able to do the Internet comparison. Another alternative is to call the CMS toll free number, 1-800-MEDICARE (1-800-633-4227), starting in mid-October, and ask for assistance in comparing the drug plan formularies.

What if a dual eligible cannot find a PDP whose formulary includes all the drugs he/she needs?

PDPs must have a transition process that describes how each PDP will handle the situation where an individual who is stabilized on a drug regime enrolls in a plan that does not include the person's medication. Information on all PDPs' transition plans will be available on the CMS Medicare Prescription Drug Plan Finder (which can be accessed after October 13, 2005 at www.medicare.gov). Dual eligibles should also consult with their doctor ASAP to determine if the doctor is willing to assist with seeking an exception and/or to see if they can be safely switched to another medication.

OTHER LIMITS ON ACCESS TO MEDICATIONS

Can PDPs require that prior authorization be obtained before certain medications are prescribed?

Yes, PDPs may require that a doctor wishing to prescribe certain drugs receives permission from the plan before prescribing the medication. This is commonly referred to as prior authorization.

Can PDPs use step-therapy and fail first requirements?

Yes, PDPs may require that some drugs be tried first before a beneficiary can be prescribed more expensive medication. This is commonly referred to as step-therapy.

Can PDPs use other cost control methods to limit access to medications?

Yes, PDPs may place limits on the use of off-label medications (see discussion below). State Medicaid programs already use some of these tools, but it is not yet known how extensively Medicare prescription drug plans will use cost controls to limit access to specific drugs. Some state Medicaid programs limit the number of prescriptions that can be filled each month. According to CMS, PDPs will not place limitations on the number of prescriptions allowed each month.

EXCLUDED MEDICATIONS

Are there medications that the Medicare prescription drug coverage won't pay for?

Yes, the list of excluded drugs includes a number of medications that may be used by people with developmental disabilities:

- Barbiturates
- Benzodiazepines
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparation)
- Non prescription drugs
- Medications used for anorexia, weight loss or weight gain
- Medications used for cosmetic purposes and hair growth

Will states cover any of the medications excluded from the Medicare prescription coverage?

Maybe, many states cover benzodiazepines and barbiturates in their state Medicaid program. CMS has said that if a state covers these drugs for other Medicaid beneficiaries, the state should cover them for dual eligibles. Check with the state's Medicaid office to learn whether it will pay for the dual eligibles to receive the medications that are excluded from Medicare prescription drug coverage.

What are the specific medications in the benzodiazepine class that are excluded from Medicare prescription drug coverage?

Many people do not know the categories of the prescription medications they are taking. It is helpful to check this list of benzodiazepines because if a dual eligible is taking any of the following medications, they will not be listed on the drug plan formularies:

Alprazolam	Midazolam HCL
Alprazolam Intensol	Niravam
Ativan	Oxazepam
Chlordiazepoxide HCL	Prosom
Clonazepam	Restoril
Clorazepate Dipotassium	Serax
Dalmane	Temazepam
Diazepam	Tranxene T-Tab
Estazolam	Triazolam
Flurazepam HCL	Xanax
Halcion	Xanax XR
Klonopin	
Librium	
Lorazepam	
Lorazepam Intensol	

What are the specific medications in the barbiturate class that are excluded from Medicare prescription drug coverage?

Bellaspas
 Bel-Tabs
 Butisol Sodium
 Eperbel-S
 Ergocaff-PB
 Mebaral
 Meridia
 Phenobarbital
 Phenobarbital Sodium
 Seconal Sodium
 Spastrin

OFF-LABEL MEDICATIONS

What is an off-label medication?

A drug is used off-label when the doctor prescribes that drug for a medical use other than the one that received Food and Drug Administration (FDA) approval. Off-label prescribing is a commonly used and accepted medical practice. These drugs *do* have FDA approval – but for a different use. For example, doctors frequently prescribe FDA-approved anticonvulsant medications for persons who do not have seizures, but who need a mood stabilizer. When an anticonvulsant medication is prescribed for use as a mood stabilizer, that is considered an off-label use.

How will the PDPs respond to prescriptions for medications that are off-label?

Every PDP will be permitted to develop its own procedures for off-label medications. Some PDPs may allow the pharmacists in their network to fill these prescriptions just as they would for any other

prescription drug. But other PDPs may require prior authorization or other procedures that may greatly delay the consumer's receipt of the medication and may be time-consuming and burdensome for the physicians. The answer to this question will not be available until the names of the PDPs are released by CMS and each PDP's formulary and procedures are available on the CMS website at www.medicare.gov.

PHARMACIES

Will every pharmacy be included in every PDP?

No, each PDP will establish its own network of pharmacies. It is expected that the PDP will include many pharmacies in its networks. A dual eligible will be able to receive prescription medication *only* from a pharmacy that is participating in that PDP's network. This is also true for individuals who live in ICFs/MR; these individuals will need to ensure that the long term care pharmacy's facility is a network pharmacy. When dual eligibles receive their auto-assignment letter from CMS, the dual eligible can find out whether their pharmacy is included in their auto-assigned PDP's network by asking their pharmacist if the pharmacy is participating in their PDP, by calling 1-800-MEDICARE (1-800-633-4227); or by checking the website, www.medicare.gov.

What if a dual eligible is away from home and needs to fill a prescription?

Each PDP must have provisions for how to deal with the occasional or unavoidable need to use an out-of-network pharmacy. These protections cannot be used for routine out-of-network access.

COST SHARING

Is a dual eligible required to pay a monthly premium for Medicare prescription drug coverage?

No, Medicare will cover the premium cost up to the average premium level for each state as determined by CMS.

How will I know if a PDP's premium is at or below the average for my state?

This information will be available at the CMS/Medicare website (www.medicare.gov).

What happens if the PDP that the person wants to switch to has a premium above the average?

If a dual eligible selects a plan with a higher than average premium, he or she will have to pay the entire amount over the average premium. In some states, state funding may be available to pay for the difference in premium cost.

Will dual eligibles be required to pay an annual deductible for their Medicare prescription drug coverage?

No, dual eligibles will not be required to pay an annual deductible.

Will dual eligibles be required to pay a co-pay?

- A dual eligible residing in an ICFs/MR or nursing facility (see discussion below) will not be required to pay co-pays.
- If the dual eligible's income is under 100 percent of the federal poverty level (\$9,570 annually for an individual) he or she must pay \$1 for preferred (usually generic) medications or \$3 for non-preferred (usually brand name) medications as described by the PDP.

- If the individual's annual income is above 100 percent of the federal poverty level (\$9,570 annually) then the co-pay is \$2 for the preferred medication and \$5 for the non-preferred.

Are States providing additional coverage to fill in the gaps for dual eligibles?

The MMA prohibits states from using *federal* Medicaid funds to fill in the gaps (e.g. co-pays). However states can use *state* funds to fill in any gaps. Some states may use their State Pharmacy Prescription Assistance Program to supplement coverage. Others states have passed separate legislation (sometimes using *state* Medicaid funds) to wrap around Medicare prescription drug coverage so that dual eligibles will not have to pay co-pays.

LONG TERM CARE FACILITIES

What is the CMS definition of long term care facilities?

Long term care facilities include nursing facilities, Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), inpatient psychiatric hospitals and other medical institutions that receive Medicaid payments for institutionalized individuals. Specifically not included are individuals who are supported by Home and Community Based Waivers. The definition of long term care facilities also excludes other types of residential settings such as assisted living homes and other group homes that are regulated by the state.

Why is it important to know whether an individual lives in a long term care facility?

- Individuals who reside in long term care facilities do not have to pay co-pays.
- Dual eligibles receiving waiver services, living with their families, living in group homes that are not ICFs/MR, and other residential services *will* have to pay co-pays (see discussion above).
- Emergency supplies of medications are available to individuals who reside in long term care facilities during transition periods but are not guaranteed in other settings.
- PDPs are required to provide convenient access to network long term care pharmacies, which means that the PDP will pay for the services that long term care pharmacies typically provide.
- PDPs are encouraged - but not required - to pay for these services when they are offered to non ICFs/MR or other residential providers. Individuals will need to check their PDPs to ensure that their residential provider uses their plan's long term care pharmacy.

EXCEPTIONS AND APPEALS

What if the needed medication is not on the Medicare PDP's formulary?

Dual eligibles have the right to request that their PDP covers a medically necessary drug not on the plan's formulary when:

- the drug is removed from the PDP's formulary for reasons other than safety, and
- the doctor prescribes a drug that is not on the PDP's formulary, but believes the drugs available on the PDP formulary will not meet a dual eligible's needs.

Who can request an exception?

A dual eligible, their legally authorized representative, or their prescribing physician can request an exception by contacting the plan. The pharmacist who tells you that your medication is not covered by your plan does not affect a coverage determination which can only be made by the plan. Network pharmacists will post or distribute general notices to tell beneficiaries to contact their PDP for a coverage determination or to request an exception.

How is a request for an exception to the PDP formulary made?

Once it is realized that a drug is not covered, it is important to contact the PDP to request an exception. An oral or written supporting statement from a doctor demonstrating the drug's need is necessary. Generally, PDPs must grant these exception requests when making a determination that it is medically appropriate. PDPs must respond to requests within 72 hours.

What if medication is needed sooner than 72 hours?

A faster response (an expedited request) can be made when "life, health or ability to regain maximum function" is in jeopardy. PDPs must respond to expedited requests within 24 hours. If a PDP denies an exception request, an appeal of its decision can be made.

Will a request for an exception be necessary every time a medication refill is made?

No, if a PDP grants a request, the exception must continue to cover refills as long as: 1) the doctor continues to prescribe that drug; 2) the drug continues to be safe, and 3) the calendar year has not expired.

Can an exception for excluded drugs be requested?

No, exceptions for drugs specifically excluded from Medicare prescription drug coverage, such as a benzodiazepine (see discussion above), cannot be requested.

What if the exception request is denied?

An appeal can be made. The appeals process includes a second review by the plan, a review by an independent review entity, an administrative law judge review and, finally, consideration by the Medicare Appeals Council.

SWITCHING TO ANOTHER PRESCRIPTION DRUG PLAN

Why would a dual eligible switch from one plan to another?

A PDP may take a drug off its formulary or a dual eligible may be required to take a new drug that is not on the PDP's formulary.

What happens if a dual eligible wants to switch to another prescription drug plan (PDP) after January 1, 2006?

Dual eligibles are permitted to change to another PDP at any time. However, changes in a PDP will go into effect *only* on the first day of each month. For example, if the parents of a dual eligible decide on January 2 that their child would be better served by a different PDP, the parents can call to make the switch on January 2 by calling 1-800-MEDICARE (1-800-633-4227). However, the change will not go into effect until February 1.

What is the best way to switch PDPs?

Switching PDPs can be done by either enrolling in the new drug plan or by disenrolling from the current drug plan and then enrolling into the new PDP. It is strongly recommended that whenever dual eligibles want to switch from one drug plan to another, they **simply enroll in the new PDP** – without doing a separate disenrollment. By enrolling in the new PDP, there will be an automatic disenrollment from the previous plan.

COMPARISON BETWEEN COVERAGES

What are some of the most significant differences between Medicare's prescription drug coverage rules governing dual eligibles and the rules for the other Medicare beneficiaries?

- Dual eligibles will be auto-assigned to a Medicare PDP, which will take effect on January 1, 2006. Other Medicare beneficiaries will not be auto-assigned.
- Because dual eligibles are auto-assigned in a PDP they will not be subject to any late enrollment penalties. General Medicare beneficiaries may be required to pay if not enrolled during the specified enrollment period.
- Dual eligibles will not have to pay a monthly premium (if they retain their auto-assigned plan or choose a plan at or below the average). Other Medicare beneficiaries will pay approximately \$32.
- Dual eligibles will not have any deductibles. Other Medicare beneficiaries will have a \$250 deductible.
- Dual eligibles will not have a gap in coverage. For other Medicare beneficiaries the coverage gap refers to the annual drug spending from \$2,250 to \$5,100. In this period, PDPs provide no coverage, and individuals must pay 100 percent of their drug costs.
- Dual eligibles can switch prescription drug plans at any time. Other Medicare beneficiaries can switch only once a year.

Can a person with a developmental disability who receives Medicare but does NOT receive Medicaid benefits receive extra help in paying for their prescription drugs?

If a Medicare beneficiary's resources are limited (annual income below \$14,355 a year for individuals and \$19,245 a year for couples in 2005) and their assets are low (less than \$11,500 for individuals and \$23,000 for couples) he or she may be eligible for extra help paying for their Medicare drug costs (premiums, deductible and co-pays).

Medicare beneficiaries must **apply** for this extra help through the Social Security Administration (SSA) by using either the SSA's paper or online application (available at www.ssa.gov). Beneficiaries may also call SSA at 1-800-772-1213 or visit their local SSA office. After the SSA determines eligibility for extra help in paying for Medicare's prescription drug costs, beneficiaries must choose and enroll in a Medicare prescription drug plan (PDP). Visit www.medicare.gov or call 1-800-Medicare (1-800-633-4227) for more information.

GETTING HELP IN CHOOSING A PLAN

In addition to 1-800-Medicare, are there other resources to help dual eligibles, their families, caregivers, and staff select a PDP that meets their needs?

CMS is developing an innovative Internet tool called the “Medicare Prescription Drug Plan Finder” to assist individuals with information and enrollment in the plans (www.medicare.gov). Other information resources include:

- State Health Insurance Assistance Programs (SHIPs) - providing volunteers to assist beneficiaries in choosing PDPs. A list of the SHIPs is available at <http://www.medicare.gov/contacts/static/allStateContacts.asp>;
- Regional CMS offices - <http://www.cms.hhs.gov/about/regions/consumers.asp>;
- Medicaid case workers; and
- Area Agencies on Aging - <http://www.n4a.org/>.

Additional resources can be found in Appendix B of this brochure.

IMPORTANT DATES

What are the most important dates for dual eligibles and their caregivers to remember?

October 13, 2005: CMS’ Prescription Drug Plan Finder tool will be available on the Internet at www.Medicare.gov.

Mid-October – early November 2005: A letter will arrive from CMS notifying each dual eligible or their representative payee of the prescription drug plan (PDP) to which he/she has been auto-assigned.

October 15 – December 31, 2005. CMS is engaged in their beneficiary education campaign including the release of the updated “Medicare and You” handbook.

November 15, 2005: Starting on this date, dual eligibles (or their legally authorized representatives) will be able to switch from the dual eligible’s assigned drug plan to another prescription drug plan.

December 31, 2005: Medicaid prescription drug coverage ends for people who receive both Medicaid and Medicare. These dual eligibles will still be covered by Medicaid, but their medications will be provided under the rules established for the new *Medicare* drug coverage.

January 1, 2006: Medicare prescription drug coverage begins. Dual eligibles must follow the rules of this new system to receive their prescription drugs.

APPENDIX A: KEY TERMS

Antidepressants: Drugs used to prevent depression.

Antipsychotics: Drugs that counteract or alleviate the symptoms of a psychiatric disorder such as schizophrenia.

Anticonvulsants: Drugs for preventing or reducing the incidence of seizures.

Antiretrovirals: Drugs used in the treatment of HIV and AIDS.

Antineoplastics: Drugs used to prevent or slow the growth of cancers.

Auto-Assignment: For individuals who receive both Medicare and Medicaid benefits, the Centers for Medicare and Medicaid will randomly assign the person to a prescription drug plan effective January 1, 2006.

Co-Pay: A fee that the individual pays each time they purchase a drug. The co-pays for individuals who are dually eligible for Medicaid and Medicare are established in the law.

Cost Tiers: A system that drug plans use to price medications. Generic drugs are generally on the first and least expensive tier, followed by brand-name drugs, and then specialty drugs, with each subsequent tier requiring higher out-of-pocket costs.

Centers for Medicare and Medicaid Services (CMS): The federal agency with responsibility for implementing the Medicare Modernization Act, issuing regulations, approving the drug plans, providing technical assistance to the public, etc.

Deductible: An amount the individual must pay before Medicare will begin paying for drugs. Dual eligibles are not required to pay deductibles.

Drug Formulary: A list of prescription medications that a drug plan *will* pay for. When medications are not listed on a drug plan's formulary, then the drug plan will not pay for them.

Dual eligible: An individual who receives both Medicare and Medicaid benefits.

Excluded Drug: There are certain drugs, or uses of drugs, that the law excluded from the definition of a Medicare Part D drug. This means that they cannot be provided as part of basic coverage.

Exception: The Prescription Drug Plans must have an exceptions process for enrollees to request that their plan cover a medically necessary drug not on its formulary.

Extra Help: Subsidies that are available to low income individuals to help pay the costs of the prescription drug coverage. Individuals who are dually eligible for Medicare and Medicaid will automatically receive the extra help; others must apply for the assistance.

Immunosuppressants: Drugs used to prevent the rejection of transplanted organs and may be used for the treatment of multiple sclerosis, lupus and some types of rheumatoid arthritis.

Legally Authorized Representative: An individual who can select and enroll in a Medicare prescription drug plan on behalf of a person with a cognitive disability. CMS has stated that each state will decide who is considered a legally authorized representative for this purpose. Families and caregivers are urged to contact their State Medicaid agencies or check www.ucp.org or www.thearc.org for updates on this issue.

Long Term Care Facility: Long term care facilities include nursing facilities, Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) and other medical institutions that receive Medicaid payments for institutionalized individuals. Specifically not included are individuals who are supported by Home and Community Based Waivers and other types of residential settings such as assisted living homes and other group homes that are regulated by the state.

Medicare Modernization Act (MMA) of 2003: The federal law that created the Medicare drug benefit and also resulted in all of the changes for dual eligibles that are discussed in this document.

Off-label use: When a drug is prescribed for a reason other than the FDA approved use.

Part D: This section of the MMA establishes the new Medicare prescription drug coverage.

Pharmacy Network: The list of pharmacies that are contracting with a prescription drug plan (PDP).

Premium: Monthly fees that a plan charges for the prescription drug coverage.

Prescription drug plan (PDP): A company to which every dual eligible will be automatically assigned. Each PDP will have its own formulary, pharmacy network and its own procedures.

Prior Authorization: A requirement by the PDP that a doctor must get approval from the plan before prescribing selected medications.

Step-Therapy: A requirement by the PDP that a person must try one medication before the doctor may prescribe another, more expensive one.

Transition Plan: The transition plan describes how each PDP will handle the situation where an individual who is stabilized on a drug regime enrolls in a plan that does not include the person's medication.

APPENDIX B: RESOURCES

Federal government:

www.medicare.gov (Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services)

Toll-free assistance: 1-800-MEDICARE (1-800-633-4227)

www.cms.hhs.gov/about/regions/consumers.asp (Your regional CMS office)

www.aoa.gov (U.S. Administration on Aging)

State resources:

<http://www.medicare.gov/contacts/static/allStateContacts.asp> (The State Health Insurance Assistance Program (SHIP) has counselors in every State and several Territories that are available to provide free one-on-one help with your Medicare questions or problems)

Non-profit organizations:

www.thearc.org (The Arc of the United States)

www.ucp.org (United Cerebral Palsy)

www.thedesk.info (Medicaid Reference Desk – information about Medicaid for people with cognitive disabilities)

www.thearclink.org (TheArcLink)

www.maprx.info (MedicareRx-Connect provides quick links to a wide variety of information and tools to answer beneficiaries' most frequently asked questions about the Medicare Prescription Drug Coverage. It is designed for individuals in position to assist Medicare beneficiaries with special needs as they learn more about the benefit and compare and select their plan coverage)

www.accestobenefit.org (Access to Benefits Coalition – a Coalition of 104 national voluntary health care, disability and aging organizations, chaired by The National Council on the Aging, which supports 56 local coalitions in educating and enrolling low-income individuals in the Medicare drug benefit and other prescription drug coverage)

www.medicareadvocacy.org (The Center for Medicare Advocacy – a national non-partisan education and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare)

www.medicarerights.org (Medicare Rights Center - works to teach people with Medicare and those who counsel them--health care providers, social service workers, family members, and others--about Medicare benefits and rights)

**All the information in this guide is also available
online at the Medicaid Reference Desk
(www.TheDesk.info/PartD).**

**Visit this site for updates on
Medicare's New Prescription Drug Coverage that
will be published after this brochure is printed.**

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