#06-21-04

Bulletin

May 25, 2006

Minnesota Department of Human Services □ P.O. Box 64941 □ St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Social Services Supervisors and Staff
- Mille Lacs Tribal TANF
- Financial Assistance Supervisors
- Financial Workers
- Senior Linkage Line®
- Area Agencies on Aging
- Disability Linkage Line
- MinnesotaCare Enrollment & Operations

ACTION/DUE DATE

Implement immediately.

EXPIRATION DATE

The policies in this bulletin are ineffective as of January 1, 2007. After that date, refer to the Health Care Programs Manual.

DHS Implements Policies and Procedures to help Minnesota Health Care Programs Enrollees Transition to Medicare Prescription Drug Coverage

TOPIC

Policies and procedures to help Minnesota Health Care Programs (MHCP) enrollees transition smoothly to Medicare Part D prescription drug coverage.

PURPOSE

Provide policy and procedures to help MHCP enrollees transition smoothly to Medicare Part D prescription drug coverage.

CONTACT

MinnesotaCare Operations, Counties and Tribal Agencies:
Submit questions to HealthQuest.
All others direct questions to:
Health Care Eligibility & Access
P.O. Box 64989, 540 Cedar St.
St. Paul, MN 55164-0989

SIGNED

BRIAN J. OSBERG
Assistant Commissioner
Health Care Administration

I. Background

Medicare Part D prescription drug coverage was enacted into law on December 8, 2003, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The Medicare Part D prescription drug benefit became available to Medicare beneficiaries beginning January 1, 2006.

The Department of Human Services (DHS) issued previous bulletins to help state and county staff, tribal agencies, and other partners learn about Medicare Part D, understand the impacts on Minnesota Health Care Programs enrollees who are Medicare beneficiaries, and apply changes in policy and process required by implementation of the new Medicare Part D benefit.

Previous bulletins issued include:

#05-21-03	DHS Provides Guidance Regarding New Medicare Prescription Drug Coverage	Issued July 1, 2005
http://www.dhs.state.mn.us/main/groups/publications/documents/pub/DHS_id_051470.pdf		
#05-56-07	DHS Issues Guidance to Counties About Providing Assistance with the Medicare Prescription Drug Benefit	Issued November 30, 2005
http://www.dhs.state.mn.us/main/groups/publications/documents/pub/DHS_id_054119.pdf		
#05-21-10	Changes to Cost-Effective Insurance Guidelines Due to Medicare Prescription Drug Coverage	Issued November 28, 2005
http://www.dhs.state.mn.us/main/groups/publications/documents/pub/DHS_id_053659.pdf		
#05-21-11	Minnesota's Prescription Drug Program (PDP) Ends on December 31, 2005	Issued December 7, 2005
http://www.dhs.state.mn.us/main/groups/publications/documents/pub/DHS_id_054150.pdf		

It may be helpful to review the bulletins listed above, as they provide background to much of the new information presented in this bulletin.

- See Attachment A for a brief summary of this bulletin.
- See Attachment B for a glossary of Medicare Part D terms used in this bulletin.

II. Introduction

This bulletin is being issued to augment the information provided in the earlier Medicare Part D bulletins. It provides state, county, and tribal workers with policy information and instructions to help ensure that Minnesota Health Care Programs (MHCP) enrollees who are or become Medicare beneficiaries transition to Medicare Part D prescription drug coverage timely and without undue disruption in benefits.

The information in this bulletin applies to Medicare beneficiaries who are applicants or enrollees of Medical Assistance (MA) and General Assistance Medical Care (GAMC). Section III (A) (4) applies to Medicare beneficiaries who are applicants and enrollees of MinnesotaCare.

For purposes of this bulletin, the term "Medicare Part D plan" is used to mean either a stand-alone Medicare prescription drug plan or a Medicare Advantage plan. Information about the specific plans available to Minnesota Medicare beneficiaries can be found online at: http://www.medicare.gov/medicarereform/map.asp.

III. Action Required

A. Medicare beneficiaries who subsequently enroll in MHCP

Medicare beneficiaries are not required to enroll in a Medicare Part D plan as a condition of their MHCP eligibility. However, MHCP are prohibited from paying for prescription drugs covered by Medicare Part D, for any enrollee eligible for Medicare Part D. A Medicare beneficiary who fails to enroll in a Medicare Part D plan will have no prescription drug coverage, other than the few categories of drugs that remain covered by MHCP. See Bulletin #05-21-03 issued July 1, 2005, for the list of drugs that Medical Assistance (MA) continues to cover for Medicare beneficiaries. This list also applies to state-funded MA and General Assistance Medical Care (GAMC).

Medicare beneficiaries who are not enrolled or do not enroll in a Part D plan because they have other health insurance that includes creditable drug coverage, can continue to receive their drug coverage through that other health insurance. MHCP cannot pay any prescription drug copays or other prescription drug cost sharing charged by the other health insurance. See Bulletin #05-21-10 issued November 28, 2005, for more information about cost effective premiums and the treatment of MA enrollees with other health insurance and Medicare. MHCP cannot pay for any prescription drugs included in the Medicare Part D benefit for any retroactive, current or future month, for Medicare beneficiaries.

MHCP applicants may be Medicare beneficiaries who are:

- Already enrolled in a Medicare Part D plan; or
- Not enrolled in a Medicare part D plan due to having other creditable drug coverage; or
- Not enrolled in a Medicare Part D plan because they failed to enroll during their initial enrollment period (IEP).

Medicare beneficiaries do not have to change their Medicare Part D plan, or the manner in which they receive their Medicare prescription drugs when they enroll in MHCP.

This section will provide information and instructions regarding Medicare beneficiaries who subsequently apply and are eligible for:

1. Federally-funded MA
2. State-funded MA and GAMC
3. MinnesotaCare

1. Federally-funded MA

Medicare beneficiaries become full benefit dual eligibles when they enroll in federally-funded MA. This means that they automatically qualify for the full Extra Help and they do not pay a monthly Medicare Part D plan premium if they are enrolled in a benchmark Medicare Part D plan. Cost sharing for full benefit dual eligibles is limited to per prescription copays of $1 - $5. See Bulletin #05-21-03 issued July 1, 2005, for information about full benefit dual eligibles and the Extra Help.

NOTE: New MA enrollees who are already enrolled in a Medicare Part D plan will have fully subsidized ($0) monthly Part D plan premiums **only** if they are enrolled in benchmark Medicare Part D plans. Enrollees who are in non-benchmark plans will continue to be charged premiums that may be reduced but not eliminated by the Extra Help subsidy. Enrollees in non-benchmark plans may use the portion of their monthly premium that they pay out-of-pocket toward a spenddown. See Attachment F.

New MA enrollees may want or need to switch to a benchmark Medicare prescription drug plan or an MSHO or MnDHO plan to avoid the monthly Part D plan premiums.

a. Monthly Medicare data file

DHS sends a data file to the Centers for Medicare and Medicaid Services (CMS) six working days prior to the last working day of each month. On this file, DHS identifies all federally-funded MA enrollees who have Medicare data in MMIS, as of the date of the file run. The data file includes records for the current month as well as changes that have been entered in MMIS for previous months, such as retroactive federally-funded MA coverage approved for a Medicare beneficiary. (At this time the data file cannot accommodate prospective MA or Medicare information.) DHS also identifies all Medicare Savings Program (MSP) enrollees on this data file. (MSP enrollees are those enrolled in the Qualified Medicare Beneficiary (QMB), Service-Limited Medicare Beneficiary (SLMB) and Qualified Individual-1 (QI-1) programs.)

CMS uses the monthly data file to deem new full benefit dual eligibles (enrollees who have both Medicare and Medicaid) and MSP enrollees as qualified for the Extra Help Paying Medicare Prescription Drug Plan Costs (Extra Help), the low-income subsidy that helps beneficiaries pay their monthly Part D plan premiums and other costs. CMS

communicates Extra Help eligibility information to the Medicare Part D plans, so they will collect the correct amount of cost sharing from the beneficiary. CMS also uses the data file to identify full benefit dual eligibles who are not enrolled in a Part D plan, for purposes of automatically and randomly enrolling them into benchmark plans. Benchmark plans are Part D plans that have been designated by Medicare to meet certain coverage requirements and that have a monthly premium which is fully subsidized by the Extra Help. See Attachment C for a list of benchmark plans available in Minnesota.

An enrollee will appear on the monthly data file when MMIS shows:

- An active federally-funded MA or MSP span on the RELG panel, and
- Medicare Part A or Part B (or both) for the eligibility month on the RMCR panel.

To be considered an active federally-funded MA enrollee for the data file, the enrollee must have no spenddown, or must have met their spenddown at the time the file is submitted. Program eligibility changes made in MMIS will result in retroactive records being generated to include those changes.

Example
Joanna is a Medicare beneficiary who applied for MHCP on May 10. Her application is processed, and federally-funded MA is approved in MAXIS and opened in MMIS on May 18, retroactive to April 1. Data from the STAT/MEDI panel in MAXIS is interfaced to the RCIP and RMCR panels in MMIS. DHS runs the monthly data file on May 23 and submits it to CMS. Joanna's May eligibility record is included on the data file because she appears as a federally-funded MA enrollee with active Medicare on May 23. A retro record for Joanna is also included on the data file, as she appears in MMIS to be a full benefit dual eligible for the month of April, but was not included on the April file. CMS processes the data file mid-June and communicates Joanna's status as a full benefit dual eligible and qualified for the Extra Help with $1 and $3 copays effective April 1 to her Part D plan. Joanna requests a refund from her Medicare Part D plan for monthly premiums and other cost sharing (in excess of the $1 and $3 Medicare copays) she paid for April, May and June.

Information about Medicare coverage or federally-funded MA coverage entered in MMIS after the file is submitted to CMS is reflected on the next month's data file.

Example
Suri is a Medicare beneficiary who applies for MHCP on May 15. Her application is processed and federally-funded MA is approved in MAXIS and opened in MMIS on May 28, with retroactive coverage approved beginning April 1. Data from the STAT/MEDI panel in MAXIS is interfaced to the RCIP and RMCR panels in MMIS. DHS ran the monthly data file and submitted it to CMS on May 23. Suri's record was not included on the May file, since her eligibility was not open on MMIS on that date. Suri's eligibility record is included on the next monthly data file, on June 23. The June data file includes retro records for Suri for the months of April and May. CMS is not aware of Suri's status as a full benefit dual eligible until CMS processes the June data file after June 23. Suri's Medicare Part D plan is not aware of her status as a full benefit dual eligible or her automatic eligibility for Extra Help until it is notified by CMS in mid-July. In July Suri requests a refund from her Medicare Part D plan, for monthly premiums and other cost sharing she paid in April through July (in excess of her $1 and $3 Medicare copays).

Because the monthly Medicare data file is submitted to CMS only once each month, new full benefit dual eligibles who sign up for a Part D plan to begin the month they become Medicare beneficiaries will experience a delay in being recognized by their Part D plan and by their pharmacy as eligible for the Extra Help. New full benefit dual eligibles whose MA coverage is approved late in a month, after DHS submits the data file, will experience an even greater delay in being recognized by the Part D plan as eligible for the Extra Help. CMS is working to resolve this problem. See Attachment D.

b. Medicare beneficiaries already enrolled in Medicare Part D plans when federally-funded MA begins.
Medicare beneficiaries who are enrolled in Medicare Part D plans, who then enroll in federally- funded MA, do not have to change their Medicare Part D plans. These Medicare beneficiaries can continue to get their Medicare Part D benefits from the plan they enrolled in prior to their MA coverage. As full benefit dual eligibles, they may choose to switch Medicare Part D plans at anytime, and are not subject to the limited opportunities for changing plans provided to other (non-full benefit dual eligible) Medicare beneficiaries. See Attachment E for a chart of Medicare Part D enrollment periods.

Medicare beneficiaries who enroll in federally-funded MA are automatically qualified for the Extra Help, beginning the first month in which they have concurrent Medicare Part D plan coverage and federally-funded MA. Part D plans are responsible for providing refunds for monthly premiums and other cost sharing, such as deductibles paid by beneficiaries who are then deemed eligible for the Extra Help retroactively. Refer enrollees to their Medicare Part D plan to request a refund.

c. MSHO and MnDHO

Full benefit dual eligibles age 65 and older may choose to enroll in a Minnesota Senior Health Options (MSHO) plan to obtain Part D coverage at any time. Enrollment in MSHO is voluntary and full benefit dual eligibles can change plans or choose a different Part D option on a monthly basis. MSHO plans are Medicare Special Needs Plans that specialize in serving full benefit dual eligibles and provide:

- All MA (Medicaid) benefits including Elderly Waiver services and some nursing home care;
- All Medicare benefits, including Part D prescription drug benefits and Medicare Part B drugs; and
- The remaining prescription and over-the-counter drugs that MA continues to cover for Medicare beneficiaries.

In addition to providing the same basic benefits as Medicare and Medical Assistance, MSHO plans offer the convenience of a care coordinator to help answer enrollees' questions, work with providers to ensure enrollees get the care they need, and facilitate information sharing between an enrollee's doctors and other providers. All MSHO plans are benchmark Medicare Part D plans with fully subsidized ($0) Part D premiums for full benefit dual eligibles. There are nine MSHO plans operating in various service areas throughout the state. The nine MSHO plans are sponsored by the same organizations that provide the Prepaid Medical Assistance Program (PMAP). A map of the health plan service areas for MSHO is available online at:
http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/DHS_id_052955.pdf

Full benefit dual eligibles can enroll in MSHO through the county managed care unit or by contacting the health plan directly. MSHO enrollment for MA enrollees age 65 and over is an alternative to mandatory managed care enrollment in PMAP. Additional information about MSHO is available online at:
http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_006271.hcsp

NOTE: Full benefit dual eligibles who choose to disenroll from MSHO or MnDHO **must** sign up for a new Medicare Part D plan before they disenroll, or they may have a gap in their Part D plan coverage. If they enroll in another Medicare Part D plan, (other than an MSHO or MnDHO plan) they will be automatically disenrolled from MSHO or MnDHO. Enrollees may also need to contact the county agency to re-establish home and community-based services managed through the county.

Minnesota Disability Health Options (MnDHO) is a Medicare Special Needs plan that specializes in serving full benefit dual eligibles who are between the ages of 18 and 64 and who have physical disabilities. MnDHO covers:

- All MA benefits including services under the Community Alternatives for Disabled Individuals (CADI) and Traumatic Brain Injury (TBI) waivers;
- All Medicare benefits, including Part D prescription drug benefits and Medicare Part B drugs; and
- The remaining prescription and over-the-counter drugs that MA continues to cover for Medicare beneficiaries.

MnDHO currently operates through one plan, UCare Minnesota, and serves enrollees in the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. MnDHO enrollment is done through the health plan. Additional information about MnDHO is available online at:
http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_006272.hcsp

Enrollment or disenrollment from MSHO or MnDHO will affect all Medicare and MA services for an enrollee including receipt of home and community-based services and Medicare Part D drugs.

d. Medicare beneficiaries <u>not</u> enrolled in Part D plans when federally-funded MA begins.
Medicare beneficiaries who are not enrolled in Medicare Part D plans, who enroll in federally-funded MA, may choose to continue their current form of drug coverage, or they may choose to enroll in a Part D plan.

CMS has contracted with a national point of sale contractor, Wellpoint (Anthem) to temporarily cover Medicare prescription drugs for full benefit dual eligibles not enrolled in Medicare Part D plans.

The Wellpoint point of sale plan is intended to provide coverage for:

- New full benefit dual eligibles who have not yet chosen a plan;
- New full benefit duals who have chosen a plan but it is not effective yet. (Including new federally-funded MA enrollees with Medicare who have signed up for MSHO or MnDHO, and are awaiting the effective date of that coverage.); and
- Any full benefit dual eligibles who are not currently enrolled in a Part D plan, although they may have been in the past or may be enrolled effective in a future month.

NOTE: Full benefit dual eligibles who want to switch Part D plans can avoid gaps in Part D plan coverage, and potential pharmacy problems with using the Wellpoint process, by enrolling in the new Part D plan but **not** disenrolling from the old Part D plan. Enrollment in the new plan will automatically trigger disenrollment from the old plan.

Medicare beneficiaries with federally-funded MA who are not enrolled in a Medicare Part D plan who present at the pharmacy with both their Minnesota Health Care Programs card and their Medicare card should be able to fill their prescriptions through the Wellpoint point of sale plan. The Wellpoint point of sale plan will cover all Medicare Part D prescription drugs. More information about this feature is available online at:

http://www.cms.hhs.gov/States/Downloads/Wellpoint4Steps.pdf and

http://www.cms.hhs.gov/hillnotifications/downloads/WellPointOnePager.pdf

According to CMS, full benefit dual eligibles who use the Wellpoint point of sale plan to get their Medicare prescription drugs, and who are not enrolled in or awaiting the effective date of a plan, will be subsequently enrolled in one Medicare prescription drug plan, the Unicare Medicare RX Rewards plan. However, the timing of enrollment in Unicare can vary, and some full benefit dual eligibles may need to use the Wellpoint point of sale plan for several months.

Like all other Medicare prescription drug plans, the Unicare plan has a specific formulary, which may or may not include all of the specific drugs needed by a beneficiary. Full benefit dual eligibles not yet enrolled in a Medicare Part D plan, who do not have current prescription needs and do not use the Wellpoint point of sale plan will be randomly autoenrolled in a Medicare prescription drug plan by CMS. However, the timing of when this autoenrollment will occur for any one beneficiary may vary.

►Encourage Medicare beneficiaries who become federally-funded MA enrollees to proactively enroll in a Medicare Part D plan and not wait for Unicare enrollment or random enrollment in a Part D plan.

►See Bulletin #05-56-07 issued November 30, 2005, for guidance about helping full benefit dual eligibles determine if they need assistance choosing or switching Medicare Part D plans.

►Refer beneficiaries seeking help with Medicare prescription drug coverage and with choosing a Part D plan to the Linkage Line at 1-800-333-2433 or 1-800-MEDICARE (1-800-633-4227)/ TTY users 1-877-486-2048.

Example
Melissa is a Medicare beneficiary. She applies for MHCP on June 5, with coverage requested back to March 1. Melissa is eligible for MA effective March 1. She is not enrolled in a Medicare Part D plan. MA cannot pay for any prescription drugs that would have been covered by Medicare Part D had Melissa enrolled in a Part D plan for the retro, current or future months.

Melissa contacts the Linkage Line in June and enrolls in a Medicare Part D plan effective July 1. Melissa brings her MHCP card and her Medicare card to the pharmacy when she fills prescriptions in June. The pharmacist uses the Wellpoint point of sale plan to provide Melissa with her prescription drugs for June. Because Melissa has already enrolled in a plan beginning July 1, CMS does not enroll her in Unicare.

2. State-funded MA and GAMC

Some Medicare beneficiaries may be eligible for state-funded MA. State-funded MA includes:

- Program IM, Medical Assistance for individuals who would be eligible for MA except that they reside in Institutions for Mental Disease (IMDs); and
- Program NM, Medical Assistance for noncitizens who are not qualified for federally-funded MA.

Since nonqualified noncitizens are generally not eligible for Medicare, the instructions below and in section III (B) (3) apply primarily to Medicare beneficiaries applying for or enrolled in program IM.

NOTE: An MHCP enrollee who resides in an IMD may be enrolled in federally-funded MA, state-funded program IM, or GAMC, depending on the individual's age and basis of eligibility. For Medicare beneficiaries in an IMD, Extra Help eligibility, Part D plan enrollment, and prescription drug copays will vary based on which MHCP the individual participates in. See Attachment G.

Medicare beneficiaries are generally ineligible for GAMC because as people with disabilities or seniors age 65 and over, they have a basis of eligibility for MA. However, some Medicare beneficiaries who have End-Stage Renal Disease (ESRD) are not yet considered by SSA to be disabled. Medicare beneficiaries who cannot yet meet SSA disability criteria and who have no other MA basis of eligibility may be eligible for GAMC.

State-funded MA and GAMC cannot pay for any prescription drug included in the Medicare Part D benefit for any retroactive, current, or future month for Medicare beneficiaries. Medicare beneficiaries in state-funded MA or GAMC who are not enrolled or do not enroll in a Medicare Part D plan, and who do not have other creditable drug coverage, will have no prescription drug coverage, other than the few categories of drugs that state-funded MA and

GAMC continue to cover. See Bulletin #05-21-03 issued July 1, 2005, for the list of drugs that MA continues to cover. This list also applies to state-funded MA and GAMC.

Medicare beneficiaries who enroll in state-funded MA or GAMC are not full benefit dual eligibles. State-funded MA and GAMC enrollees do **not** automatically qualify for the Medicare Extra Help and are **not** automatically enrolled by CMS in a Part D plan. In addition, because they are not full benefit dual eligibles, they generally cannot join or switch Medicare Part D plans outside of the Annual Coordinated Election Period (AEP). In special circumstances, such as when a beneficiary moves or loses other creditable drug coverage, a beneficiary may be permitted to join or change Medicare plans outside of the AEP.

CMS has announced a new Special Enrollment Period for people who apply for and are determined eligible by the Social Security Administration (SSA) for the Extra Help after May 15, 2006. They will be able to join a Medicare Part D plan immediately following the determination of Extra Help. So, state-funded MA and GAMC enrollees who apply for Extra Help should be able to join a Medicare Part D plan as soon as they get the eligibility determination from SSA. In addition, CMS will facilitate enrollment for beneficiaries who are determined eligible for the Extra Help but fail to enroll in a Part D plan. CMS will automatically and randomly enroll these beneficiaries into benchmark Part D plans two to three months after they are identified as eligible for the Extra Help. When automatically enrolled by CMS, Extra Help eligible beneficiaries may change plans once in the calendar year outside of the AEP.

a. Medicare beneficiaries already enrolled in Medicare Part D plans when state-funded MA or GAMC begins.

Medicare beneficiaries who enroll in state-funded MA or GAMC may already be enrolled in a Part D plan, and may already receive the Extra Help. Individuals who were previously enrolled in federally-funded MA, and had Medicare concurrent with federally-funded MA for one or more months in the current calendar year should be both enrolled in a Part D plan and receiving the Extra Help, due to their previous full benefit dual status. Beneficiaries may also have enrolled in a Part D plan and applied for the Extra Help on their own.

Example

Harry is enrolled in federally-funded MA. He becomes entitled to Medicare as a disabled person effective August 1. He enrolls in a Medicare Part D plan, and is qualified for Extra Help effective August 1, because he is a full benefit dual eligible. In November Harry enters an IMD. His coverage is changed from federally-funded MA to state-funded MA, program IM. Harry continues to get his drug coverage from his Medicare Part D plan, and continues to be eligible for the Extra Help, through the end of the year because of his previous full benefit dual status. However, Harry is no longer a full benefit dual eligible, and he cannot switch Medicare Part D plans until the next AEP, with the new plan effective January 1.

Harry will also have to apply to SSA for the Extra Help for the next calendar year, if he remains in the IMD and does not regain federally-funded MA.

b. Medicare beneficiaries not enrolled Part D plans when state-funded MA or GAMC begins.

Medicare beneficiaries who are not enrolled in Medicare Part D plans, who then enroll in state-funded MA or GAMC may choose to continue their current form of drug coverage or they may choose to enroll in a Part D plan. However, because they are not full benefit dual eligibles, Medicare beneficiaries in state-funded MA or GAMC cannot join or switch Medicare Part D plans at any time. Enrollees who submit an application to SSA for the Extra Help can join a Medicare Part D plan when they receive the determination from SSA.

►Provide state-funded MA or GAMC applicants and enrollees with Extra Help applications or refer them to the SSA for an application. SSA will accept applications by mail, over the Internet and by telephone. Application forms with addressed and stamped envelopes are available from your local SSA office. Individuals can call SSA at 1-800-772-1213 or 1-800-325-0778, 7 a.m. - 7 p.m. Monday through Friday to request an application or to apply over the phone. The application is also available online at http://www.socialsecurity.gov/. Enrollees can also apply for Extra Help by calling the Linkage Line at 1-800-333-2433.

►Refer state-funded MA or GAMC applicants and enrollees who are entitled to Medicare to the Linkage Line at 1-800-333-2433 or to 1-800-MEDICARE for help signing up for a Part D plan through May 15, 2006.

►After May 15, 2006, refer enrollees who submit an application for the Extra Help to the Linkage Line or Medicare to sign up for a Medicare Part D plan. Enrollees who fail to sign up for a plan by May 15, 2006, and do not apply or are denied the Extra Help will have to wait until the AEP that begins November 15, 2006, to enroll in a plan.

3. MinnesotaCare

Applicants who are Medicare beneficiaries are ineligible for MinnesotaCare. There is an exception to this for children under age 21 with Medicare, in households with income at or below 150 percent of the Federal Poverty Guideline (FPG), because Medicare coverage is considered underinsured. However, disabled children at this income level are likely eligible for MA without a monthly premium.

►Contact MinnesotaCare applicants and enrollees who are children with Medicare (or contact their parents) to determine whether they want to apply for MA.

►For applications from children with Medicare received at MinnesotaCare Enrollment and Operations, transfer a copy of the application to the local county agency if the applicant would also like to apply for MA.

B. MHCP enrollees who subsequently become Medicare beneficiaries

MHCP enrollees who become entitled to Medicare must transition to a Medicare Part D plan if they want to continue prescription drug benefits once they are eligible for Medicare, unless they have other health coverage that includes creditable drug coverage. MHCP enrollees who have other health coverage that includes creditable drug coverage may choose to keep their other health coverage and not enroll in a Medicare Part D plan. See Bulletin #05-21-10 issued November 28, 2005, for more information about cost effective premiums and the treatment of MA enrollees with other health insurance and Medicare.

This section will provide information and instructions regarding MHCP enrollees who subsequently become Medicare beneficiaries. The information is organized as follows:

1. MHCP Benefit Change Notices (For HMCP enrollees in federally-funded MA, state-funded MA or GAMC who become Medicare beneficiaries.)
2. Federally-funded MA
3. State-funded MA and GAMC

MinnesotaCae enrollees who abecome Medicare beneficiaries are generally ineligible to continue MinnesotaCare coverage. See HCMP #0910.03 (Types of Other Coverage, MinnesotaCare). Follow the instructions in Section III (3) for children enrolled in MinnesotaCAre who become Medicare beneficiaries.

1. MHCP benefit change notices

Beginning in June 2006, the MMIS User Services Help Desk will issue benefit change notices to federally- and state-funded MA enrollees and GAMC enrollees who become entitled to Medicare while enrolled in MHCP. See Attachment H.

Enrollees who become entitled to Medicare have the right to appeal the change in their MHCP benefits. Enrollees who appeal before the effective date of the change in benefits or within ten days after the date of the notice receive continued prescription drug coverage while the appeal is pending. See Health Care Programs Manual (HCPM) 0917 (Appeals) for more information about appeals and continuation of benefits.

Enrollees who become entitled to Medicare will be provided at least ten-day notice prior to the change in their MHCP benefits. When ten-day notice is not possible, the change in benefits will not occur until the end of the following month. Ten-day notice will be provided to enrollees whose Medicare coverage began in a past month but was not known until the current month.

MAXIS will generate a daily report to identify MHCP enrollees who have new or changed Medicare data in MAXIS. MMIS User Services Help Desk staff will use the report to identify enrollees who are newly entitled to Medicare, will be entitled to Medicare in the near future, or who already have Medicare but it was just recorded in MAXIS.

MMIS User Services Help Desk staff will:

- Review the MAXIS report daily and verify Medicare data;
- Follow up with county workers to correct or change Medicare data as needed;
- Value the Appeal Indicator on the RBYD panel in MMIS (see below);
- Enter a case note in MMIS describing the action taken:
- Mail a benefit reduction notice to the affected enrollee;
- Send a MAXIS email to the assigned county worker to report that a notice has been mailed; and
- Upon appeal decision or expiration of the notice period, update the Appeal Indicator accordingly.

a. MMIS Appeal Indicator
MMIS User Services Help Desk staff will have security update capabilities for this new field located on the upper right hand side of the new RBYD screen. The field is displayed as "APPEAL MX RX:" and will allow the following new valid values:

- "Y" (APPEAL PENDING, PAY DRUGS)
- "N" (NO DRUGS PAID, MEDICARE ELIGIBLE)
- "I" (NOTICE ISSUED, PAY DRUGS)
- "T" (NOTICE ISSUED/APPEAL PENDING, PAY DRUGS)

If the field contains a Y, I, or T, the enrollee's MA benefit package will continue to pay for drugs normally covered by the new Medicare Part D program. If the field contains an N or space, claims processing with look to see if the enrollee has Medicare A or B eligibility. If Medicare Part A or Part B eligibility is indicated, MHCP will not pay for drugs that could be covered by Medicare Part D.

b. Worker instruction

►Upon receipt of a MAXIS email from the MMIS User Services Help Desk, record a MAXIS case note indicating that an MA Benefit Change Notice has been sent, and the effective date of the change in benefits.

►Contact the MMIS User Services Help Desk by sending a MAXIS e-mail to MHLP if

an appeal is requested due to the change in benefits. On the subject line put "Medicare Part D Appeal."

►Contact the MMIS User Services Help Desk by sending a MAXIS e-mail to MHLP when the appeal has been decided. On the subject line put "Medicare Part D Appeal Update."

2. Federally-funded MA

Enrollees in federally-funded MA who become entitled to Medicare gain full benefit dual eligible status on the first day they have Medicare concurrent with their federally-funded MA coverage. For enrollees with a spenddown, once they meet their spenddown they are full benefit dual eligibles. As full benefit dual eligibles, enrollees in federally-funded MA are automatically eligible for the full Medicare Extra Help for the rest of the calendar year. Full benefit dual eligibles may join or change Medicare Part D plans at any time.

Enrollees in federally-funded MA who become Medicare beneficiaries will receive benefit change notices mailed by the MMIS User Services Help Desk. Enrollees must enroll in a Medicare Part D plan unless they have other creditable drug coverage, if they want continued prescription drug coverage after the effective date of the change in MA benefits.

►Encourage federally-funded MA enrollees who become entitled to Medicare to proactively enroll in a Medicare Part D plan and not to wait for Unicare enrollment or random enrollment in a Part D plan. (See section III (A) (2) (iii).)

►Encourage federally-funded MA enrollees to sign up for a Medicare Part D plan early in the month. Enrollees who wait until late in the month to sign up or switch Medicare Part D plans may have problems at the pharmacy due to the timing of data sent to the Part D plan. More information about early-in-month enrollment is available online at:

http://www.cms.hhs.gov/partnerships/downloads/earlyinmonthtipsheet.pdf

►See Bulletin #05-56-07 issued November 30, 2005, for guidance about helping full benefit dual eligibles determine if they need assistance choosing or switching Medicare Part D plans.

►Refer beneficiaries seeking help with Medicare prescription drug coverage and with choosing a Part D plan to the Linkage Line at 1-800-333-2433 or 1-800-MEDICARE (1-800-633-4227)/ TTY users 1-877-486-2048.

a. Enrollees receiving SSI who turn age 65

Federally-funded MA enrollees who receive only Supplemental Security Income (SSI) and who are or become age 65 and older **must** enroll in Medicare Part A and Part B if they are eligible. SSI-only enrollees who turn age 65 must also transition to a Medicare Part D plan if they want to continue prescription drug benefits once they are eligible for Medicare.

SSI-only recipients who are age 65 must pay a monthly premium for Medicare Part A, as well as Part B. (People who do not receive SSI but who are eligible as Qualified Working Disabled (QWD) are also eligible for Part A with a premium. See HCPM §0907.21.09.07 (Medicare Savings Programs: QWD).) DHS pays the Medicare Part A premium directly to the SSA through the automated buy-in process. SSI-only recipients must be active on Qualified Medicare Beneficiary (QMB) or QWD to have Part A premiums paid through the buy-in. See HCPM §0907.21.09.03 (Medicare Supplement Programs: QMB). SSI-only recipients must apply for and be enrolled in Medicare before payments can begin through the buy-in.

MMIS currently generates a worker message two months in advance for SSI-only MA enrollees who are turning age 65, "Client turns 65. Enter Medicare claim number."

Beginning in June 2006, the MMIS User Services Help Desk will process reports that identify MA enrollees who receive SSI, three months in advance of their 65th birthdays. This process will initiate the Medicare enrollment process for SSI-only enrollees one month earlier than the current worker message. MMIS User Services Help Desk staff will send MAXIS emails to workers for MA enrollees who are identified on the reports.

When notified by the MMIS User Services Help Desk:

►Complete the County Agency section of the Medicare Buy-in Referral Letter (DHS 3439) and provide it to the enrollee with a county-addressed return envelope. The enrollee must take this form and the county-addressed envelope to the SSA when applying for Medicare. The DHS 3439 is available online at:

http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3439-ENG

►Track for return of the letter in 30 days.

►Contact the enrollee if the letter has not been returned at the end of 30 days. Determine whether he/she complied with the request to apply for Medicare. Provide a second referral letter if necessary. Track for an additional 30 days.

►Upon receipt of the completed referral letter, process and approve QMB eligibility. Do not provide retroactive SLMB coverage, even if the referral form shows a Medicare begin date in the past or current month.

►Enrollees who fail to cooperate with applying for Medicare are ineligible for MA. Cancel MA coverage with 10-day notice for enrollees who fail to cooperate.

b. MAXIS instruction

►Check TPQY in MAXIS (which should exist due to receiving SSI) for discrepancies in:

- Recipient Name - first, last, middle initial; or
- Date of Birth.

If a discrepancy exists, include this information with the referral to SSA to ensure the applicant or enrollee has the error resolved when he/she goes to the SSA to apply for Medicare. If the TPQY response is older than 6 months, initiate a new Query to obtain the most current information.

►When referring an applicant or enrollee to SSA, update STAT/PBEN with benefit type "19" (Other), the referral date, verification code of "5" (Other document) and a DISP (disposition) code of "P" (Pending).

►Use DAIL/TIKL to track for return of the referral form.

►Upon receipt of the completed referral form Enter the STAT/MEDI panel with the Medicare Claim Number found on the referral form along with the anticipated Medicare Part A and Part B begin dates. Update any additional fields required in the upper portion of STAT/MEDI. Once Medicare data is entered, the MMIS User Services Help Desk will send a benefit change notice. (See section III (B) (1).)

►Update STAT/HCRE if needed to process QMB eligibility in HC ELIG and approve. Put in a DAIL/TIKL if the month Medicare begins is not yet available for processing on MAXIS.

Example
Referral letter is received in May stating Medicare will begin 7-1-06. July is not yet available for processing on MAXIS. Put in a DAIL/TIKL for June 1st to determine QMB eligibility as July would now be available on MAXIS.

c. MMIS Instruction

►Confirm on RMCR that Medicare participation data (claim number, Part A and Part B participation dates) has correctly interfaced from MAXIS to MMIS. If it has not, contact the MMIS User Services Help Desk to complete the interface.

►Enter QMB eligibility on RELG. This may be completed no sooner than two months before the effective date of the QMB eligibility.

►Review the RBUY and RBYB panels for accretion request dates. These will display on each panel after QMB has been approved AND a buy-in accrete/delete processing (scheduled 8 days before the end of the month) has occurred.

Examples
QMB was approved May 13 effective for July 1. As this date is PRIOR TO May's accrete/delete processing date of May 19, RBUY/RBYB accrete request dates will display on May 20.

QMB was approved May 22 effective for July 1. As this date is AFTER May's accrete/delete processing date of May 19, RBUY/RBYB accrete request dates will display on June 22, after JUNE'S accrete/delete processing date of June 21.

3. State-funded MA and GAMC

State-funded MA and GAMC enrollees who become entitled to Medicare:

- Do not gain full benefit dual status;
- Do **not** automatically qualify for the Medicare Extra Help;
- Are **not** automatically enrolled by CMS in a Part D plan; and
- Generally cannot join or switch Medicare Part D plans outside of the AEP.

Enrollees in state-funded MA and GAMC who become Medicare beneficiaries will receive benefit change notices mailed by the MMIS User Services Help Desk.
Enrollees must enroll in a Medicare Part D plan unless they have other creditable drug coverage, if they want continued prescription drug coverage after the effective date of the change in MHCP benefits.

►Provide state-funded MA or GAMC applicants and enrollees who are going to become Medicare beneficiaries with Extra Help applications; or

►Refer them to the Social Security Administration (SSA) for an application. SSA will accept applications by mail, over the Internet and by telephone. Application forms with addressed and stamped envelopes are available from your local SSA office. Individuals can call SSA at 1-800-772-1213 or 1-800-325-0778, 7 a.m. - 7 p.m. Monday through Friday to request an application or to apply over the phone.

The application is also available online at: http://www.socialsecurity.gov/. Enrollees can also apply for Extra Help by calling the Linkage Line at 1-800-333-2433.

►Refer state-funded MA or GAMC applicants and enrollees who are becoming Medicare beneficiaries to the Linkage Line at 1-800-333-2433 or to 1-800-MEDICARE for help signing up for a Medicare Part D plan through May 15, 2006. Enrollees who do not sign up

for a Medicare Part D plan by May 15, 2006, must apply and be determined eligible for the Extra Help to join a plan before the next AEP.

IV. Legal References

Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public Law 108-173; 42 Code of Federal Regulations, Part 423, subparts A through S.

Laws of Minnesota 2005, First Special Session, Chapter 4, Article 8, Sections 5 and 33.

V. Attachments

Attachment A	Bulletin Summary
Attachment B	Glossary of Terms
Attachment C	Benchmark Part D Plans for Minnesota Medicare Beneficiaries
Attachment D	CMS Memo to Part D Plans: Incorrect Cost Sharing Charges to Dual Eligible Beneficiaries
Attachment E	Medicare Part D Enrollment Periods Chart
Attachment F	Chart of Excess Premiums to Apply to Spenddown
Attachment G	IMD Residence Reference Chart
Attachment H	Model MHCP Benefit Reduction Notice

VI. Special Needs

This information is available in other forms to people with disabilities by contacting us at (651) 431-2283 or toll free at (800) 938-3224 or through the Minnesota Relay Service at (800) 627-3529 (TDD), 711 or (877) 627-3848 (speech to speech relay service).

ATTACHMENT A

Bulletin Summary

QUICK FACTS ABOUT…

All Minnesota Health Care Programs (MHCP) Applicants/Enrollees with Medicare:

- Do not have to change their Part D plan or the manner in which they receive their Medicare prescription drugs when they enroll in MHCP coverage;
- Are not required to enroll in a Part D plan as a condition of MHCP eligibility. However, MHCP cannot pay for prescription drugs covered by Medicare Part D for any enrollee eligible for Medicare Part D;
- If they have other health insurance with creditable drug coverage they can continue to receive their drug coverage through that other health insurance, but MHCP cannot pay any prescription drug cost sharing charged by the other health insurance;
- Will get a ten-day notice of benefit change with appeal rights when they become eligible for Medicare; and
- Should switch Medicare Part D plans by enrolling in a new plan. Beneficiaries do not have to disenroll from their old Part D plans, since enrollment in the new plan will trigger disenrollment from the old plan.

Federally-Funded MA Applicants/Enrollees with Medicare:

- Are full benefit dual eligibles;
- Are automatically qualified for the Extra Help;
- Are included on the monthly data file DHS sends to Medicare;
- Will experience a delay in being recognized by their Part D plan as eligible for the Extra Help (CMS is working on this problem.);
- Should choose a Part D plan and not wait for automatic enrollment;
- Will have fully subsidized ($0) monthly Part D plan premiums only if they are enrolled in benchmark Medicare Part D plans. New MA enrollees may want or need to switch to a benchmark Medicare prescription drug plan or an MSHO or MnDHO plan to avoid the monthly Part D plan premiums;
- Can use the portion of the Part D premiums that they pay out-of-pocket toward a spenddown if they are enrolled in a non-benchmark Part D plan;
- Must sign up for a new Medicare Part D plan ahead of time if they disenroll from MSHO or MnDHO, to avoid a gap in plan coverage;
- Should be able to fill prescriptions through the Wellpoint point of sale process if they haven't signed up for a Part D plan or are between plans; and
- Must be referred to the SSA to apply for Medicare if they are SSI recipients age 65 or older.

State-Funded MA or GAMC Applicants/Enrollees with Medicare:

- Are not full benefit dual eligibles;
- Are not automatically eligible for the Extra Help and need to apply through the SSA;
- Are not automatically enrolled in Part D plans unless they apply for the Extra Help;
- Get a Special Enrollment Period if they are determined eligible for the Extra Help; and
- Should be encouraged to apply for the Extra Help and to sign up for a Part D plan.

GLOSSARY OF TERMS
MEDICARE PART D PRESCRIPTION DRUG COVERAGE

Coinsurance – a fixed percentage of the negotiated discount price of a covered drug that is paid by the Medicare beneficiary. In 2006, the standard Medicare Part D benefit requires coinsurance of 25 percent for prescription drugs following the $250 deductible until total drug costs reach $2,250.

Copayment or Copay – a fixed dollar amount to be paid by the Medicare beneficiary for each prescription dispensed. In 2006, full benefit dual eligibles with income at or below 100 percent of Federal Poverty Guidelines (FPG) pay prescription copays of $1 generic and $3 brand name. Full benefit dual eligibles with income above 100 percent FPG pay prescription copays of $2 generic and $5 brand name.

Creditable Coverage – includes a drug benefit through an employer or union plan, TriCare, Federal Employees Health Benefit Plan, or Veteran's benefits that is at least as good as the Medicare Part D benefit. People who have creditable drug coverage do not have to pay the late enrollment penalty or higher premium for failing to enroll in Medicare Part D as soon as they are eligible.

Deductible – an amount the Medicare beneficiary must pay before benefits are paid by the Medicare Part D plan. In 2006, the standard benefit includes a $250 deductible before the plan begins to pay for prescriptions.

Extra Help Paying Medicare Part D Plan Costs (Extra Help) – a subsidy available to Medicare beneficiaries with limited income and resources to help pay their Medicare Part D plan costs. Extra Help pays monthly Medicare Part D plan premiums, deductibles, coinsurance and other cost sharing. Beneficiaries may qualify for the full Extra Help or a partial Extra Help. Full benefit dual eligibles and Medicare Savings Program enrollees automatically qualify for the full Extra Help.

Full Benefit Dual Eligible – a Medicare beneficiary who is qualified to receive Medical Assistance benefits. Effective January 1, 2006, full benefit dual eligibles receive their prescription drug coverage from Medicare Part D plans. They automatically qualify for the full Extra Help subsidy.

Medicare Part D – the part of the Medicare program that provides prescription drug coverage. In general, Medicare Part A covers hospital services, Part B covers physician services, and Part C is Medicare Advantage, the comprehensive managed care program.

Medicare Part D Plan – either a Prescription Drug Plan (PDP) to add to traditional Medicare, or a Medicare Advantage plan that offers Medicare prescription drug coverage (MA-PD).

Medicare Savings Programs (MSP) – Medicaid programs that help Medicare beneficiaries pay their Medicare Part A and B premiums and other costs. Programs include Qualified Medicare Beneficiary (QMB), Service Limited Medicare Beneficiary (SLMB) and Qualified Individual-1 (QI-1). Medicare beneficiaries must meet income and asset guidelines to qualify for an MSP. MSP enrollees are automatically qualified for the Extra Help subsidy.

Prescription Drug Plan (PDP) – a plan that offers coverage for prescription drugs only to beneficiaries who choose to receive their other Medicare benefits in the traditional way.

Qualified Individual -1 (QI-1) – a Medicare Savings Program under Medicaid that pays for Medicare Part B premiums. People qualify for QI-1 if they have income below 135 percent of FPG and in Minnesota have assets no greater than $10,000 for an individual or $18,000 for a couple. Beneficiaries enrolled in QI-1 automatically qualify for the full Extra Help.

Qualified Medicare Beneficiary (QMB) – a Medicaid program that pays for Medicare out-of-pocket costs including Medicare Part A and B premiums, deductibles, coinsurance and copayments. Beneficiaries qualify for QMB if they have income below 100 percent of FPG and in Minnesota have assets no greater than $10,000 for an individual and $18,000 for a couple. Beneficiaries enrolled in QMB automatically qualify for the full Extra Help.

Service-Limited Medicare Beneficiary (SLMB) – a Medicaid program that pays Medicare Part B premiums. Beneficiaries qualify for SLMB if they have income below 120 percent of FPG and in Minnesota have assets no greater than $10,000 for an individual or $18,000 for a couple. Beneficiaries enrolled in SLMB automatically qualify for the full Extra Help.

Standard Part D Benefit or Standard Coverage – the standard formula that apportions the annual costs of Medicare Part D prescription drug coverage among the Medicare beneficiary, the Medicare Part D plan, and the federal Medicare program. Each Medicare Part D plan must offer standard coverage to make it easier for potential enrollees to compare different plans. In 2006, standard coverage has a $250 deductible, followed by 25 percent coinsurance on the next $2000 in drug costs, then 100 percent beneficiary payment of drugs until total drug costs exceed $5,100.

Updated May 2006 ATTACHMENT C

Minnesota's Medicare Prescription Drug Benefit (Part D) Plan Options in Minnesota

This chart reflects options available to certain full dual eligibles, Medicare enrollees who are also enrolled in Medical Assistance. This includes enrollees in:

Medical Assistance
Medical Assistance with a spenddown
Minnesota Senior Health Options (MSHO)
Minnesota Disability Health Options (MnDHO)
Medical Assistance for Employed Persons with a Disability (MA-EPD)

The enrollees above and Medicare Savings Program enrollees will have no monthly premium or annual deductible for the plans listed below. They will have co-payments of $1-$5 per prescription. Beneficiaries may enroll in a more expensive plan, not listed on this chart, but provided by the various organizations. Beneficiaries who enroll in a more costly plan (listed on chart #1) will be charged an additional premium amount which will not be paid by Medical Assistance, Medicare or Social Security. Dual Eligible Beneficiaries may opt out of their plan at any time, and enroll in another option.

Chart Color Codes:

	These plans provide enrollees with all of their Medical Assistance and Medicare Part A, B and D benefits. Beneficiaries may opt out of their coordinated care plan (MSHO) at any time and enroll in a different Medicaid option, Medicare option and/or pharmacy option.
	This plan is the MnDHO plan that will provide Medicare prescription drug coverage to their enrollees. Enrollees receive all of their Medical Assistance and Medicare Part A, B and D benefits from the plan. Beneficiaries may opt out of their coordinated care plan (MnDHO) at any time and enroll in a different Medicaid option, Medicare option and/or pharmacy option.
	This plan is a Medicare Advantage Special Needs Plan that provides Medicare Part A, B and D benefits to beneficiaries under age 65 with disabilities. It does not provide Medical Assistance benefits. It is not a MnDHO plan. It is available to beneficiaries who are in fee-for-service Medical Assistance.
	These plans are the stand alone Medicare prescription drug plans that only provide Medicare prescription drug coverage, and are available premium free to Medical Assistance fee-for service, Medical Assistance with a spend down, and MA-EPD enrollees. Enrollees will be randomly assigned to one of these plans by the Centers for Medicare & Medicaid Services (CMS). These assignments will be random and not based on the prescription drugs the beneficiary is taking nor the pharmacy the beneficiary may prefer. Beneficiaries who do not want to be enrolled in their assigned plan can enroll in a different plan beginning November 15, 2005.

ORGANIZATION NAME	NAME OF PLAN	TYPE OF PLAN	MONTHLY PREMIUM	ANNUAL DEDUCTIBLE	BENEFITS PROVIDED	AREA OF AVAILABILITY	WHO CAN ENROLL IN THIS OPTION?
First Plan Blue	First Plan Blue - MSHO	Medicare Advantage Special Needs Plan	$0	$0	Medical Assistance and Medicare Part A, B and D	Northeastern MN	Age 65 and older in PMAP
HealthPartners	Classic for Minnesota Senior Health Option	Medicare Advantage Special Needs Plan	$0	$0	Medical Assistance and Medicare Part A, B and D	Twin Cities Metro Area	Age 65 and older in PMAP
Itasca Medical Care	IMCare Classic	Medicare Advantage Special Needs Plan	$0	$0	Medical Assistance and Medicare Part A, B and D	Itasca, North Aitkin and South Koochiching counties	Age 65 and older in PMAP
Medica	Medica Dual Solution	Medicare Advantage Special Needs Plan	$0	$0	Medical Assistance and Medicare Part A, B and D	MN specific counties	Age 65 and older in PMAP
Metropolitan Health Plan	MHP-MnSHO	Medicare Advantage Special Needs Plan	$0	$0	Medical Assistance and Medicare Part A, B and D	MN specific counties	Age 65 and older in PMAP
PrimeWest HealthSystem	PrimeWest Senior Health Complete	Medicare Advantage Special Needs Plan	$0	$0	Medical Assistance and Medicare Part A, B and D	West Central and Southwest MN	Age 65 and older in PMAP
Blue Cross Blue Shield of MN	SecureBlue	Medicare Advantage Special Needs Plan	$0	$0	Medical Assistance and Medicare Part A, B and D	MN specific counties	Age 65 and older in PMAP

South Country Health Alliance	SeniorCare Complete	Medicare Advantage Special Needs Plan	$0	$0	Medical Assistance and Medicare Part A, B and D	MN specific counties	Age 65 and older in PMAP
UCare Minnesota	Minnesota Senior Health Options	Medicare Advantage Special Needs Plan	$0	$0	Medical Assistance and Medicare Part A, B and D	MN specific counties	Age 65 and older in PMAP
UCare Minnesota	UCare Complete	Medicare Advantage Special Needs Plan	$0	$0	Medical Assistance and Medicare Part A, B and D	Metro area	Under age 65 and Medical Assistance eligible
Community Care Rx	Community Care RX Basic	Stand alone PDP	$0	$0	Medicare Part D only	National	All ages; can be in fee-for-service or PMAP
Humana Inc	Humana PDP Standard	Stand alone PDP	$0	$0	Medicare Part D only	Statewide	All ages; can be in fee-for-service or PMAP
Blue Cross Blue Shield of MN	MedicareBlue Rx Option 1	Stand alone PDP	$0	$0	Medicare Part D only	Statewide	All ages; can be in fee-for-service or PMAP
Medco Health Solutions, Inc.	YourRx Plan	Stand alone PDP	$0	$0	Medicare Part D only	National	All ages; can be in fee-for-service or PMAP
PacifiCare Life and Health Insurance Company	PacifiCare Saver Plan	Stand alone PDP	$0	$0	Medicare Part D only	National	All ages; can be in fee-for-service or PMAP
Prescription Pathway	Prescription Pathway Bronze Plan	Stand alone PDP	$0	$0	Medicare Part D only	Statewide	All ages; can be in fee-for-service or PMAP
RxAmerica	Advantage Freedom Plan	Stand alone PDP	$0	$0	Medicare Part D only	Statewide	All ages; can be in fee-for-service or PMAP
RxAmerica	Advantage Star Plan	Stand alone PDP	$0	$0	Medicare Part D only	Statewide	All ages; can be in fee-for-service or PMAP
SilverScript	SilverScript	Stand alone PDP	$0	$0	Medicare Part D only	National	All ages; can be in fee-for-service or PMAP

Unicare	Medicare RX Rewards	Stand alone PDP	$0	$0	Medicare Part D only	National	All ages; can be in fee-for-service or PMAP
United HealthCare Insurance Company	AARP Medicare Rx Plan	Stand alone PDP	$0	$0	Medicare Part D only	National	All ages; can be in fee-for-service or PMAP
United HealthCare Insurance Company	United Medicare MedAdvance	Stand alone PDP	$0	$0	Medicare Part D only	National	All ages; can be in fee-for-service or PMAP
United HealthCare Insurance Company	United HealthRx	Stand alone PDP	$0	$0	Medicare Part D only	National	All ages; can be in fee-for-service or PMAP
WellCare	WellCare Signature	Stand alone PDP	$0	$0	Medicare Part D only	National	All ages; can be in fee-for-service or PMAP

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

MEMORANDUM

TO: All Part D Plan Sponsors

FROM: Gary Bailey, Deputy Director

RE: Incorrect Cost Sharing Charges to Dual Eligible Beneficiaries

DATE: May 5, 2006

CMS has received numerous complaints concerning full benefit dual eligible beneficiaries being charged incorrect co-payments at the pharmacy. We are aware that a number of factors are contributing to the incorrect cost sharing for full benefit dual eligible individuals, including the lags associated with the scheduled reporting of information from the State to CMS, delays in Part D plans updating their systems, CMS's prior instruction to the States to report only current or prospective changes to beneficiary institutional status, and confusion in the long-term care provider community regarding when an institutionalized beneficiary qualifies for a zero copayment. To clarify this last point, an individual is considered institutionalized and qualified for a zero copayment when he or she is a full benefit dual eligible, a resident in a long-term care facility for a full calendar month, and under a covered Medicaid stay. Qualification for the zero copayment is effective on the first day of the month in which a beneficiary is expected to remain in a long term-facility for a full calendar month stay that is covered by Medicaid.

This memorandum is part of a three-step approach CMS is taking to address the issue of incorrect cost sharing. We initiated these efforts on March 22, 2006 by requesting that States begin to report retroactive changes in beneficiary institutional status on the State Monthly MMA Enrollment File no later than July 2006. As a second step, we are conducting additional outreach with the pharmacy community. In this outreach, we will explain when a beneficiary is considered institutionalized for the purposes of the zero copayment as well as address the data lag associated with monthly state reporting and its impact on the Part D plan's systems updates. We encourage you to undertake similar outreach efforts with your pharmacy networks.

The final step in this effort to mitigate incorrect cost sharing to dual eligible beneficiaries is to outline CMS's expectations in three areas related to Part D plans changing a beneficiary's cost sharing levels.

- Best Available Data -- Part D plans are required to use the "best available data" when they have knowledge that a beneficiary's cost sharing level is not correct. For example, if the plan has knowledge from the nursing facility, or an advocate acting on behalf of the beneficiary, that the individual is covered by Medicaid for his/her institutional stay or that the beneficiary is a full benefit dual eligible, the plan should make changes to its systems to accommodate the revised copayment level. As part of the confirmation process, plans will be required to keep appropriate records in order to reconcile low-income subsidy payments with CMS. We are working on an automated process for updating our systems when after a lag the correct copayment level is still not reflected.

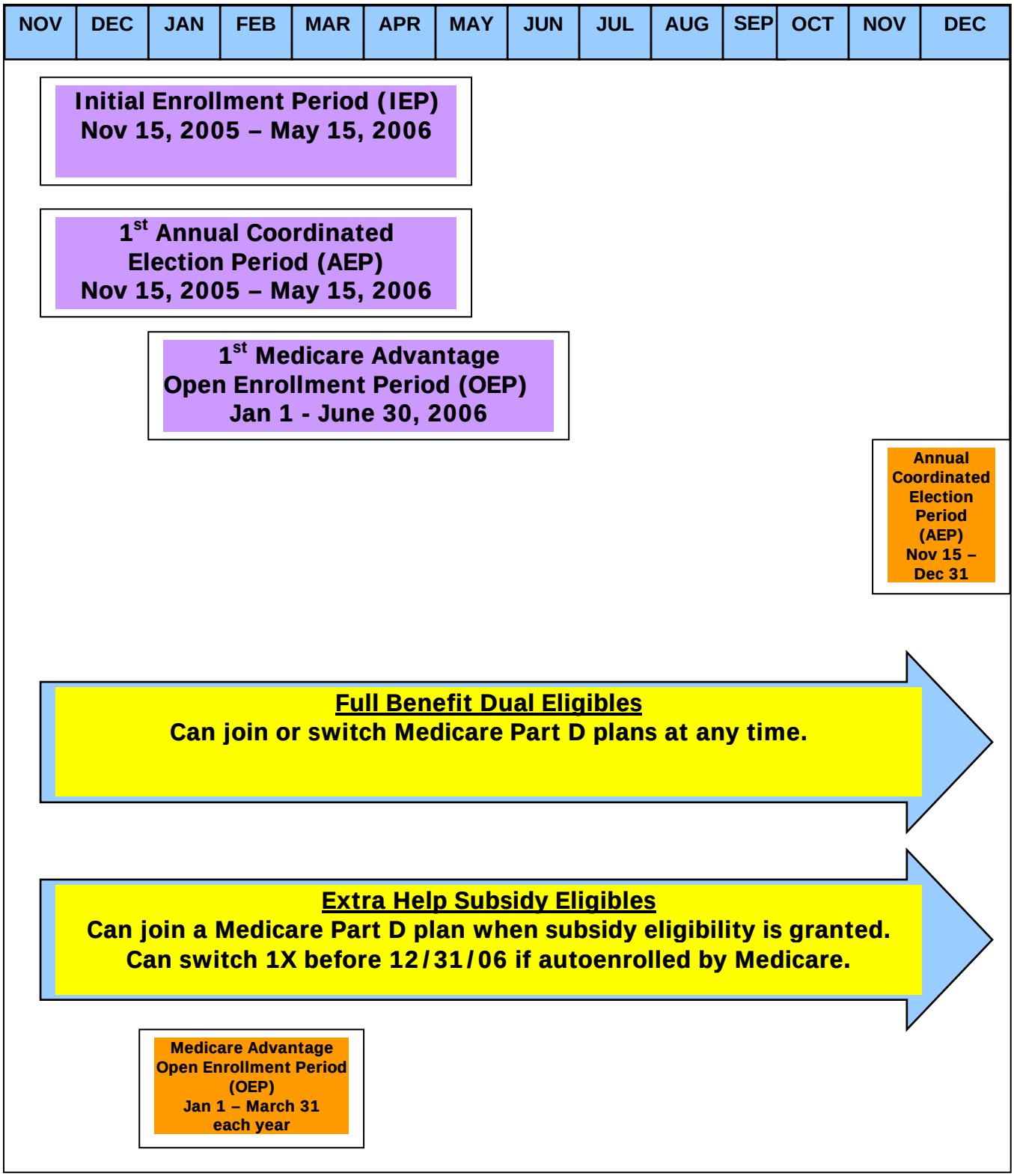
- Plan Systems Lag -- Part D plans must update their systems for changes in copayment status when processing the transaction reply reports (TRRs) from CMS. We are aware of examples where institutional status indicators have been successfully transmitted by the states, but the drug claims are being processed against non-zero copayment amounts. Plans must ensure these critical systems updates are processed timely in order to avoid a prolonged lag period in which plan databases are not reflecting correct beneficiary copayment status.

- LTC Pharmacy Reimbursement for Incorrect Copayments Charged – Part D plans are encouraged to reimburse LTC pharmacies directly when implementing retroactive subsidy level changes. Plans should not automatically reimburse beneficiaries residing in long-term care facilities because it is unlikely that the LTC pharmacies have billed the beneficiaries for their copayments.

Please contact your account manager is you have any questions concerning this memorandum.

Medicare Part D 2006 Enrollment Periods

Attachment E



Initial Enrollment Period (IEP): For the implementation of Medicare Part D, all beneficiaries eligible for Medicare before February 2006 had an IEP from November 15, 2005, through May 15, 2006. Beneficiaries who qualify for Medicare on or after February 1, 2006, have an IEP when they first become eligible for Medicare, three months before and three months after the month of the 65th birthday. Beneficiaries who qualify for Medicare due to disability have an IEP three months before and three months after their 24th month of cash disability benefits.

Annual Coordinated Election Period (AEP): During the AEP, beneficiaries can join or switch, to or from any Part D plan or type of plan. For implementation only, the first AEP was November 15, 2005 though May 15, 2006. Each year, the AEP will be November 15 through December 31. Changes in plans are effective January 1 the following year.

Medicare Advantage Open Enrollment Period (OEP): In 2006, beneficiaries have until June 30, 2006, to join a Medicare Advantage plan or other Medicare Health Plan. However, beneficiaries already enrolled in a Medicare Advantage or other Medicare Health Plan with prescription drug coverage who want to switch plans between May 15 and June 30, 2006, can only switch to another Medicare Advantage or Medicare Health Plan that offers drug coverage. Likewise, beneficiaries who have a plan without prescription drug coverage can only switch to another plan that doesn't have prescription drug coverage.

The annual Medicare Advantage OEP will be January 1 through March 31 each year.
Enrollment changes are limited during the OEP:

If coverage is	**Can use OEP to get**	**<u>Cannot</u> use OEP to get**
Medicare Advantage w/prescription drug coverage (MAPD) →→	A different MAPD Original Medicare and PDP	MA-only (no PD coverage) Original Medicare only
Medicare Advantage with no prescription drug coverage (MA-only) →→	MA-only Original Medicare only	MAPD Original Medicare and PDP
Original Medicare and a prescription drug plan (PDP)	MAPD	MA-only A different PDP to use with Original Medicare
Original Medicare only	MA-only	MAPD Original Medicare and PDP

Special Enrollment Periods (SEP): Medicare can grant a SEP under exceptional circumstances.
Examples include:

- Beneficiaries who change residence during the year;
- Beneficiaries who lose their creditable drug coverage involuntarily; and
- Full benefit dual eligibles who lose Medical Assistance (Medicaid) coverage have a 3-month SEP to join/change Part D plans.

Attachment F

2006 Medicare Prescription Drug Coverage Premiums: Amounts in Excess of the Benchmark Premiums

Medical Assistance applicants and enrollees with Medicare (Dual MA enrollees) who have enhanced Medicare prescription drug coverage can use the amounts they pay in excess of the benchmark premium toward a spenddown. The benchmark premium amount, and any other cost sharing paid except co-pays, will be reimbursed to them under the extra help subsidy. Applicants and enrollees enrolled in benchmark Medicare plans (basic plans with $0 premium for full benefit dual eligibles) will not have a premium amount to apply toward a spenddown, since 100% of the premium they paid will be reimbursed. The charts below provide the amounts in excess of the benchmark premiums that can be applied toward a spenddown.

41 Prescription Drug Plans (PDP)

Organization Name	Plan Name	Total Drug Plan Premium	Amount in excess of the benchmark premium (Can be applied to spenddown)
Aetna Medicare	Aetna Medicare Rx Essentials	$35.94	2.83
Aetna Medicare	Aetna Medicare Rx Plus	$48.40	15.29
Aetna Medicare	Aetna Medicare Rx Premier	$64.78	31.67
Blue Cross and Blue Shield of Minnesota	MedicareBlue Rx Option 1 (Benchmark plan)	$13.58	0
Blue Cross and Blue Shield of Minnesota	MedicareBlue Rx Option 2	$53.90	20.79
Blue Cross and Blue Shield of Minnesota	MedicareBlue Rx Option 3	$99.90	66.79
CIGNA HealthCare	CIGNATURE Rx Value Plan	$33.62	0.51
CIGNA HealthCare	CIGNATURE Rx Plus Plan	$38.97	5.86
CIGNA HealthCare	CIGNATURE Rx Complete Plan	$46.59	13.48
Coventry AdvantraRx	AdvantraRx Value	$21.05	2.00
Coventry AdvantraRx	AdvantraRx Premier	$33.43	2.20
Coventry AdvantraRx	AdvantraRx Premier Plus	$43.64	10.53
FOX Insurance Company	Fox Rx Care	$57.58	24.47

Organization Name	Plan Name	Total Drug Plan Premium	Amount in excess of the benchmark premium (Can be applied to spenddown)
Humana Inc.	Humana PDP Standard S5884-083 (Benchmark plan)	$1.87	0
Humana Inc.	Humana PDP Enhanced S5884-023	$4.91	3.04
Humana Inc.	Humana PDP Complete S5884-053	$38.70	36.83
Medco Health Solutions, Inc.	YOURx PLAN (Benchmark plan)	$31.28	0
MEMBERHEALTH	Community Care Rx BASIC (Benchmark plan)	$29.46	0
MEMBERHEALTH	Community Care Rx CHOICE	$37.52	4.41
MEMBERHEALTH	Community Care Rx GOLD	$41.48	8.37
PacifiCare Life and Health Insurance Company	PacifiCare Saver Plan (Benchmark plan)	$30.11	0
PacifiCare Life and Health Insurance Company	PacifiCare Select Plan	$45.76	12.65
PacifiCare Life and Health Insurance Company	PacifiCare Comprehensive Plan	$49.40	16.29
Pennsylvania Life Insurance Company	Prescription Pathway Bronze Plan Reg 25 (Benchmark plan)	$25.29	0
Pennsylvania Life Insurance Company	Prescription Pathway Silver Plan Reg25	$34.76	1.65
Pennsylvania Life Insurance Company	Prescription Pathway Gold Plan Reg 25	$46.87	13.76
RxAmerica	Advantage Star Plan (Benchmark plan)	$29.48	0
RxAmerica	Advantage Freedom Plan (Benchmark plan)	$32.15	0
SilverScript	SilverScript (Benchmark plan)	$23.84	0
SilverScript	SilverScript Plus	$50.29	17.18
Sterling Prescription Drug Plan	Sterling Prescription Drug Plan	$54.30	21.19
Unicare	MedicareRx Rewards (Benchmark plan)	$20.65	0
Unicare	MedicareRx Rewards Plus	$28.56	4.90
Unicare	MedicareRx Rewards Premier	$38.07	9.61
United American Insurance Company	UA Medicare Part D Prescription Drug Coverage	$34.70	1.59
United Healthcare	United HealthRx (Benchmark plan)	$22.67	0
United Healthcare	AARP MedicareRx Plan (Benchmark plan)	$25.25	0
United Healthcare	United Medicare MedAdvance (Benchmark plan)	$28.37	0
WellCare	WellCare Signature (Benchmark plan)	$24.45	0
WellCare	WellCare Complete	$43.41	19.62
WellCare	WellCare Premier	$45.97	19.26

17 Medicare Health Plans (includes Medicare Advantage and Cost Plans

Organization Name	Plan Name	Total Drug Plan Premium	Amount in excess of the benchmark premium (Can be applied to spenddown) $
Blue Cross & Blue Shield of MN (Regional PPO)	MedicareBlue PPO Enhanced Plus Rx 1	40.58	7.47
Blue Cross & Blue Shield of MN (Regional PPO	MedicareBlue PPO Enhanced Plus Rx 2	53.90	20.79
Blue Cross & Blue Shield of MN (Regional PPO)	MedicareBlue PPO Essential Plus Rx 1	40.58	7.47
HealthPartners (Local Medicare Advantage HMO plan)	HealthPartners Classic	20.67	0
HealthPartners (Cost plan)	HealthPartners Freedom Plan I Standard RX	19.88	0
HealthPartners (Cost plan)	HealthPartners Freedom Plan II Standard RX	19.88	0
HealthPartners (Cost plan)	HealthPartners Freedom Plan III Standard RX	19.88	0
HealthPartners (Cost plan)	HealthPartners Freedom Plan I Enhanced RX	67.66	46.99
HealthPartners (Cost plan)	HealthPartners Freedom Plan II Enhanced RX	67.66	46.99
HealthPartners (Cost plan)	HealthPartners Freedom Plan III Enhanced RX	67.66	46.99
Humana Insurance Company (Local Medicare Advantage Private Fee For Service)	Humana Gold Choice PFFS H1804-025	0	0
Medica Health Plans (Local Medicare Advantage Private Fee For Service)	Medicare Advantage Solution Choice	1.87	0
Medica Insurance Company (Cost plan)	Prime Solution Basic	26.53	0
Medica Insurance Company (Cost plan)	Prime Solution Enhanced	26.53	0
North Star Advantage/North Star Advantage Plus (Local Medicare Advantage HMO plan)	North Star Advantage Plus	42.90	9.79
UCare Minnesota (Local Medicare Advantage HMO plan)	UCare for Seniors Classic	31.07	0
UCare Minnesota (Local Medicare Advantage HMO plan)	UCare for Seniors Value Plus	30.30	0

11 Special Needs Plans			
Organization Name	**Plan Name**	**Total Drug Plan Premium**	**Amount in excess of the subsidized premium (Can be applied to spenddown)**
Blue Plus SecureBlue	Blue Plus SecureBlue	0	0
First Plan Blue	First Plan Blue Minnesota Senior Health Option	0	0
HealthPartners Classic MN Senior Health Options (MSHO)	Classic for Minnesota Senior Health Option	0	0
Itasca Medical Care	IM Care Classic	0	0
Medica Dual Solution	Medica Dual Solution	0	0
Metropolitan Health Plan	Metropolitan Health Plan	0	0
Prime West	Prime West	0	0
South Country Health Alliance	Senior Care Complete	0	0
South Country Health Alliance	AbilityCare (not MnDHO under age 65 with disabilities)	0	0
UCare Minnesota	Minnesota Senior Health Options	0	0
UCare Minnesota	UCare Complete (MnDHO)	0	0

IMD Residence Reference Chart **ATTACHMENT G**

MN Health Care Program	Program Code	Drug Coverage	Eligibility for Low Income Subsidy (LIS)	Part D Plan Enrollment	Cost Sharing
Federal Medical Assistance (Under age 21 or 65 and older)	MA	MA provides drug coverage	N/A	N/A	No MA copays due to institutional residence
Federal Medical Assistance *and Medicare* (Under age 21 or 65 and older)	MA & Medicare	Medicare provides most drug coverage MA provides coverage of excluded drugs only	Automatically deemed eligible for LIS	Medicare will automatically enroll in a Part D plan if none chosen	No copays for Medicare covered drugs due to institutional residence paid for by federal MA No copays for MA covered excluded drugs due to institutional residence
State Medical Assistance (Between ages 21 and 65)	IM	State MA provides drug coverage	N/A	N/A	No MA copays due to institutional residence
State Medical Assistance *and Medicare* (Between ages 21 and 65)	IM & Medicare	Medicare provides most drug coverage MA provides coverage of excluded drugs only	Not automatically eligible for LIS Must complete LIS application Exception: Individuals who have had previous Federal Medical Assistance concurrent with Medicare in current calendar year are already deemed eligible for LIS through the end of current year.	Not automatically enrolled in a Part D plan. Must wait for annual open enrollment to join or switch plans. Exception: Individuals deemed eligible for the LIS due to previous Federal Medical Assistance with Medicare would also have been automatically enrolled in a Part D plan.	Medicare copays apply to Medicare covered drugs: Income ≤ 100% FPG $1 generic/$3 brand Income > 100% FPG $2 generic/$5 brand Copays apply for Medicare covered drugs because institutional residence is **not** being paid by federal MA. No copays for MA covered excluded drugs due to institutional residence

KGiusto/May 2006

IMD Residence Reference Chart

ATTACHMENT G

MN Health Care Program	Program Code	Drug Coverage	Eligibility for Low Income Subsidy (LIS)	Part D Plan Enrollment	Cost Sharing
General Assistance Medical Care	GAMC	GAMC provides drug coverage	N/A	N/A	No copays for GAMC covered drugs due to institutional residence.
General Assistance Medical Care *and Medicare* **Note: The only Medicare beneficiaries who should be on GAMC are individuals with End Stage Renal Disease who have not yet been certified disabled.**	GAMC & Medicare	Medicare provides most drug coverage GAMC provides coverage of excluded drugs only	Not automatically eligible for LIS Must complete LIS application Exception: Individuals who have had previous Federal Medical Assistance concurrent with Medicare in current calendar year are already deemed eligible for LIS through the end of current year.	Not automatically enrolled in a Part D plan. Must wait for annual open enrollment to join or switch plans. Exception: Individuals deemed eligible for the LIS due to previous Federal Medical Assistance with Medicare would also have been automatically enrolled in a Part D plan.	Medicare copays apply to Medicare covered drugs: Income ≤ 100% FPG $1 generic/$3 brand Income > 100% FPG $2 generic/$5 brand Copays apply for Medicare covered drugs because institutional residence is **not** being paid by federal MA. No copays for GAMC covered excluded drugs due to institutional residence

DRAFT Attachment H

date

Worker #
County Agency Name
County Agency Address
City, State, Zip+4

Enrollee Name

Case Number: #

Mailing Name
Mailing Address
City, State, Zip+4

IMPORTANT INFORMATION REGARDING THIS DOCUMENT:

- This information is available in other forms to people with disabilities by calling your county worker, County Worker Name at Phone #.

- For TDD users and those with speech difficulties, please contact your county worker through the Minnesota Relay at 711 or 1-800-627-3529 (TDD) or 1-877-627-3848 (speech-to-speech relay service).

- The page titled "Important Information" lists your appeal rights and responsibilities.

MINNESOTA HEALTH CARE PROGRAMS NOTICE OF ACTION

Minnesota Health Care Programs (MHCP) benefits will change for Enrollee Name starting date because Medicare will begin paying for your prescription drugs. Since you have Medicare, MHCP will stop covering most prescription drugs for you.
(Laws of Minnesota 2005, First Special Session, Chapter 4, Article 8, Sections 5 and 33)

MHCP cannot pay for your Medicare covered drugs, because the law requires us to stop paying as soon as you get Medicare. This law applies only to people who have both Medicare and MHCP. Our files show that you have both Medicare and MHCP. If you think this is wrong, call your worker right away.

The only drugs that MHCP may still cover for you while you have Medicare are:

- benzodiazepines,
- barbiturates,
- certain drugs that promote weight gain,
- certain prescription and over-the-counter drugs for cough and colds,
- certain nonprescription drugs, and
- certain vitamin and mineral products.

If your Medicare drug plan covers these drugs, MHCP will not cover them.

It is important for you to know how to get your medicines. To get your prescriptions paid for through Medicare, you need to join a Medicare drug plan. If you have not already joined a plan, or if you need help choosing the plan that's right for you, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, you can call the Linkage Line at 1-800-333-2433.

Insert text about Extra Help for state-funded MA and GAMC enrollees.

***** IMPORTANT APPEAL RIGHTS! READ THIS NOW! *****

If you don't agree with the action taken on your case, you can call your financial worker or an attorney. You also have the right to request an appeal. Because this change is due to State laws, your appeal might be decided without a hearing.

If you ask for an appeal because you think we do not have the right facts about you or you think the law does not apply to you, you will have a hearing. If you ask for an appeal because you think the law is bad, your appeal might be decided without a hearing.

To keep your benefits until the hearing, you must appeal:

- Within 10 days, or
- Before the first day of the month when the action takes place.

If you miss the 10 day deadline, you can appeal within 30 days from the date you get this notice, but your benefits will not start again unless you win the appeal. To find out more, read the Important Information sheet that came with this notice.

Important Information

- **Appeal Rights.** An "appeal" is a legal process where a state referee reviews a decision made by the county agency. You may represent yourself at the hearing, or you may have someone (an attorney, relative, friend or another person) speak for you.

  Because this change is due to a change in State law, your appeal might be decided without a hearing. If you ask for an appeal because you think we do not have the right facts about you or you think the law does not apply to you, you will have a hearing. If you ask for an appeal because you think the change in law is bad, your appeal might be decided without a hearing.

- **For Minnesota Health Care Programs**, you may appeal *within 30 days* from the date you received this notice by sending a letter saying you do not agree with the decision. You can send this letter to the county agency or directly to the State Appeals Office. If you show *good cause* for not appealing *within 30 days*, the agency can accept your appeal for *up to 90 days* from the date you received this notice. "*Good cause*" is when you have a good reason for not appealing on time. The human services office will decide if your reason is a good cause reason.

  Write: State Appeals Office
  Department of Human Services
  444 Lafayette Road
  St. Paul, MN 55155-3813

  or

  Call: 651-296-5764 (metro)
  651-296-7385 (TDD)
  1-800-657-3510 (outside of metro)

  If you want to keep getting your benefits until the hearing you must appeal before the date of the proposed action or within 10 days after the date the notice is mailed, *whichever is later*. If you file your appeal on time, you will get your benefits until an appeals referee decides your appeal. You can ask the county to end your benefits until the decision. If you lose your appeal, you will have to pay back the benefits you got while your appeal was pending. Ask your county worker to explain how the timing of your appeal could affect your present or future assistance.

- **You have the right to reapply** at any time if your benefits stop.

- **Access to free legal services.** You may be able to get legal advice or help with an appeal from your local legal aid office. To contact your local legal aid office call:
  Hennepin……..612-334-5970
  Ramsey……..651-222-4731
  All other Minnesota counties……..1-888-354-5522

- **Your right to complain.** If you feel we treated you differently in the handling of a public assistance application or payment because of race, color, national origin, political beliefs, religion, sex, sexual orientation, age or disability (including access to buildings or programs) you may file a complaint with one or more of these agencies:

  State Agencies

  Minnesota Department of Human Services
  Office for Equal Opportunity, Affirmative Action, and Civil Rights
  444 Lafayette Road
  St. Paul, Minnesota 55155-3812

  Minnesota Department of Human Rights
  Army Corps of Engineers Centre
  190 East 5th Street, Suite 700
  St. Paul, Minnesota 55101
  1-800-657-3704 (voice)
  651-296-1283 (TDD)

  Federal Agency

  Office of Civil Rights – Region V
  U.S. Department of Health and Human Services
  233 North Michigan Avenue, Suite 240
  Chicago, Illinois 60601