

Medicare for Individuals Under Age 65

Webinar # 3

An Overview of Medicare Part D, Including Areas of Special Interest to Disabled Individuals

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INTRODUCTION: PART D FOR PERSONS UNDER 65

- Part D generally the same for seniors and persons under 65, but..
 - Disabled more likely to be lower income and in need of assistance to pay for Part D due to long waiting periods for Medicare coverage, exhaustion of personal resources, and inability to work
 - Many are dually eligible for Medicaid and Medicare
 - To pay for Part D, likely to need assistance from the Part D Low Income Subsidy known as “Extra Help”
- Some Medicare rules may be advantageous to persons under 65 (e.g., second IEP)
- Some individuals may have problems transitioning to Part D from full Medicaid or Marketplace plans due to “off label” rules.

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PART D IMPLEMENTATION

- Authorized under the 2003 Medicare Modernization Act (MMA). For the first time, Medicare covered outpatient prescription drugs!
 - Before Part D, the only drugs covered under Medicare were given in hospital/SNF (Part A), or doctor's office (Part B). Needed to have private insurance (some Medigaps), or have SPAP, for outpatient drugs.
- Implemented January 1, 2006. Subsequent MIPPA and ACA modifications over time.
- First Annual Enrollment Period (AEP) – Jan. 1 to May 15, 2006.
- Ten years ago!

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A QUICK VIEW FROM TEN YEARS OUT...

- Per CMS and other sources: Part D has been great success, providing outpatient drug coverage at lower than anticipated costs.... BUT...
- Ten years out... two major problems exist:
 - In most states, eligibility for the Part D Low Income Subsidy is capped at 150% FPL. Many beneficiaries over this limit are still skipping refills, splitting pills, or taking meds every other day because they cannot afford their drugs.
 - Many are unable to obtain essential drugs at all due to rigid "off-label" restrictions under Part D. CMS enforcement of the Part D off label prohibition stepped up in 2016.

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PRIMARY SOURCES OF PART D COVERAGE

- Medicare contracts with private insurance companies. Two primary types of insurance companies:
 - **PDPs** = “stand-alone” Prescription Drug Plans. Offer Part D drug coverage only. (“S” Plans)
 - **MA-PDs** = Medicare Advantage Prescription Drug Plans. Offer hospital, medical and Part D prescription drug coverage. (“H” or “R” Plans)
 - MA-PDs can be HMOs, PPOs, or PFFS (“any willing provider”)
 - Part D benefit structure is identical in PDPs and MA-PDs, but plans compete with each other to increase market share. Have different formularies, premiums and cost sharing.

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OTHER SOURCES OF PART D COVERAGE

- **SNPs = Special Needs Plans.** A type of MA-PD that covers special populations:
 - dual eligibles (Medicare & Medicaid)
 - institutionalized individuals (nursing homes, assisted living, or getting nursing care at home)
 - chronic diseases (e.g. diabetes, HIV/AIDs, CHF, dementia)
- **EGHPs = Employer Group Health Plans** (or unions) may offer Part D coverage to their Medicare-eligible retirees. (“E” Plans)
 - May partner with an existing MA-PD or may form own Part D plan.
 - These plans are not open to the public, but members have all the same rights as those in public Part D plans (including eligibility for the Part D Low Income Subsidy).

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MA-ONLY Plans

- These are Medicare Advantage plans that do not offer drug coverage.
 - Typically members have no immediate drug needs OR have other drug coverage (e.g., VA coverage) that they deem to be sufficient. (Risky!!!)
 - Cannot have an MA-PD, or an MA-only plan, with a PDP!
 - If in a Medicare Advantage plan and need Part D coverage, **MUST** take that coverage from one's own Medicare Advantage plan.
 - Exception: May have a PDP with a PFFS plan that does not offer drug coverage.
 - Not every state has PFFS plans

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THE PART D STANDARD BENEFIT

- Sponsors design their own plans (subject to CMS approval). But all plans must offer a minimum basic benefit package set by Medicare. Basic package = "Standard Benefit."
- Most plans offer some variation on the Standard Benefit:
 - Modify or eliminate deductible
 - Tiered cost sharing
 - Enhanced coverage during Donut Hole
- Average monthly PDP premium is about \$32, but actual premiums may range from under \$20/mo. to over \$120./mo.
 - Some MA-PDs have \$0 premiums (Caveat emptor!)

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THE 2016 STANDARD BENEFIT (Stages of Coverage)

Annual Deductible – pay 100% of drug costs until deductible is met	\$360 max.
Initial Coverage Period (ICP) – Drug cost sharing = pay flat 25%, or tiered co-pays and co-insurance actuarially equivalent to 25% (E.g., T1, T2, T3 & T4 = \$5, \$45, \$95 and 33%)	
Initial Coverage Limit – Once member AND the plan <u>together</u> have spent this amount on drugs, member enters the Donut Hole	\$3,310
Donut Hole – Member pays discounted prices for both brand name and generic drugs. Discounts will increase annually until Donut Hole is closed in 2020.	
Catastrophic Coverage – Begins when the <u>member's</u> true out-of-pocket (“TROOP”) costs (including discounts) equals this amount	\$4,850
Cost sharing during Catastrophic Coverage (continues to end of calendar year)	\$2.95 (generics) / \$7.40 brand name OR 5%, whichever is <u>greater</u>

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THE DONUT HOLE

- When Part D began in 2006, the Donut Hole was a gap in coverage similar to another “deductible.”
 - While in the Donut Hole members paid 100% drug costs until they reached the Catastrophic Coverage “threshold.” The value of drugs bought during the Donut Hole = “TrOOP” (True Out-of- Pocket Costs)
 - Only discounted formulary drugs paid by the member, CADAP, LIS, SPAP, counted toward TrOOP
- The following never count toward TrOOP
 - Premiums
 - Non formulary drugs (unless approved by exception)
 - Drugs purchased outside the US

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CLOSING THE DONUT HOLE

- Congress closing the Donut Hole through gradually increasing discounts and subsidies from 2010 to 2020. These will help members get out of the Donut Hole faster and less expensively.
 - All manufacturers required to sign agreement to discount brand name drugs 50% during the Donut Hole. Virtually all manufacturers participate. Generics are not discounted but are subsidized by Medicare. Plan subsidies (5%) added in 2013.
 - The discount is given at the pharmacy counter
 - Best to use network pharmacies to obtain discount
 - LIS-eligibles not eligible for discount
 - In 2016, 95% of brand name drug costs, and 58% of generic drug costs, count toward Troop.

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DONUT HOLE PHASE-OUT 2010 - 2020

YEAR	Mfg. Brand Name Discount (+ plan subsidies)	Generic Subsidy (all Medicare \$)
2010	\$250 rebate if reached the Donut Hole during 2010	
2011	50%	7%
2012	50%	14%
2013	50% (+ 2.5% plan subsidy)	21%
2014	50% (+ 2.5% plan subsidy)	28%
2015	50% (+ 5% plan subsidy)	35%
2016	50% (+ 5% plan subsidy)	42%
2017 - 2019	Increasing discounts and reductions of amount need to reach Catastrophic Coverage	
2020	Members pay 25% for all prescriptions before Catastrophic Coverage	

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NETWORK PHARMACIES

- Plans must provide reasonable pharmacy access to all their members
- Contract with retail and mail order pharmacies
 - Most large pharmacy chains are on all the plans' networks
 - Members must use network pharmacies. But costs may vary among network pharmacies because some have "preferred" status.
 - Costs at preferred pharmacies are not always lower!
- Must offer adequate access to home infusion and LTC pharmacies.
- Most plans offer mail-order.
 - May charge more for mail order. Buyer beware!
 - More difficult to resolve problems with mail order.

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THE PART D PLAN FINDER

- One way to compare retail and mail order prices is to check the Medicare Plan Finder at www.medicare.gov. Can also:
 - View all plans in each state
 - Compare up to 3 plans at a time
 - View plan formularies
 - View utilization management restrictions on specific drugs
 - Enroll in a plan
 - Check current enrollment status
- Never enroll by premium alone! Always check the Plan Finder to be sure drugs are on formulary!!!

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THE LOW INCOME SUBSIDY (a/k/a “Extra Help”)

- Helps low income to pay for Part D premiums & cost sharing
- “Deemed” individuals automatically qualify:
 - Full Duals (Medicaid and Medicare)
 - Partial Duals (Medicare Savings Program and Medicare)
 - SSI and Medicare
- All others must apply and have income below 150% FPL to qualify:
 - \$17,820/year income limit (single) / \$1,485/month
 - Treatment of income generally follows SSI rules
 - No “spenddown” of income!
 - Countable resources for single may not exceed \$13,640 (includes presumptive \$1,500 burial fund set-aside)

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2016 CO-PAYS FOR LIS “DEEMED” (Medicaid, MSP or SSI and Medicare)

	Monthly Premium	Annual Deductible	Co-Pays ICP	Co-Pays Donut Hole	Co-Pays Catastrophic Coverage
Dual Eligible: institutionalized or HCBS	\$0 (up to benchmark)	\$0	\$0	\$0	\$0
Dual Eligible < 100% FPL	\$0 (up to benchmark)	\$0	\$1.20/ \$3.60	\$1.20/ \$3.60	\$0
Dual Eligible > 100% FPL	\$0 (up to benchmark)	\$0	\$2.95/ \$7.40	\$2.95/ \$7.40	\$0
SSI or a Medicare Savings Program	\$0 (up to benchmark)	\$0	\$2.95/ \$7.40	\$2.95/ \$7.40	\$0

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2016 LIS INCOME AND ASSET LEVELS AND CO-PAYS FOR THE “UNDEEMED”

Annual Income Limit	Asset Limit	LIS Type	Monthly Premium	Annual Deduct.	Co-pays Initial Cover. Period	Co-pays during Donut Hole	Co-pays during Catastr. Coverage
Up to 135% FPL	\$8,780 (s) \$13,930 (c)	Full Subsidy	\$0 (up to benchmark)	\$0	\$2.95 / \$7.40	\$2.95 / \$7.40	\$0
Up to 150% FPL	\$13,640 (s) \$27,250 (c)	Partial Subsidy	Sliding scale (25%, 50%, 75%)	\$74	15%	15%	\$2.95 / \$7.40

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MEDICARE SAVINGS PROGRAMS - ELIGIBILITY and BENEFITS - (In Most States - 2016)

PROGRAM	INCOME LIMIT	RESOURCE LIMIT	BENEFIT
QMB (Qualified Medicare Beneficiary)	100% FPL + \$20 \$1,010 single / \$1,355 couple	\$7,280 single \$10,930 couple	Pays Part A + B premium, acts as a Medigap, <u>auto LIS</u> No balance billing!
SLMB (Specified Low Income Medicare Beneficiary)	120% FPL + \$20 \$1,208 single / \$1,622 couple	\$7,280 single \$10,930 couple	Pays Part B premium, <u>auto LIS</u>
QI (Qualifying Individual)	135% FPL + \$20 \$1,357 single / \$1,823 couple	\$7,280 single \$10,930 couple	Pays Part B premium, <u>auto LIS</u>

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“BACKDOOR” TO LIS ELIGIBILITY (In Some States)

- In most states, individuals with income over 150% FPL are over-income for LIS. They receive no help with the cost of their Part D drugs. But:
 - People on MSP are automatically eligible for the LIS
- States are permitted to modify their Medicare Savings Programs to encourage wider access to the Part D Low Income Subsidy. They may:
 - Increase income limits
 - Eliminate asset tests
 - Eliminate estate recovery for this benefit
- Residents of these states have greater help with Part D cost-sharing.

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PROBLEM SOLVING (How More People Can Qualify for LIS)

1. In “ideal” world, SSI would employ an MNIL “spenddown” model to determine eligibility for LIS (similar to Medicaid in some states).
 - Allow actual incurred medical expenses to reduce countable income!
2. Currently, states can modify their MSP programs to allow more residents to qualify for LIS
 - These states have higher MSP income limits or lower asset limits: Alabama, Alaska, Arizona, Connecticut, Delaware, DC, Hawaii, Maine, Minnesota, Mississippi, New York, Vermont.*
 - Source: Medicare Rights Center Pub. 2014

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ENROLLMENT

- Anyone with Medicare is eligible to enroll in a Part D plan:
 - For PDP, must have Part A OR Part B
 - For MA-PD, must have Part A AND Part B
- Must live in the plan's service area.
- Cannot be incarcerated.
- Cannot enroll in MA or MA-PD if have ESRD!
- No other eligibility requirements.
- Enrollment is voluntary, with two major exceptions.

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“INITIAL ELECTION PERIOD” (IEP)

- Medicare usually begins 25 months after SSDI begins
 - Exceptions: ESRD and ALS
- The IEP is the seven-month period surrounding 25th month
 - Must enroll in Part D no later than 63 days from end of IEP!
- If Medicare is retroactive, Part D may also be retroactive.
 - If retroactive, can be reimbursed for drugs purchased during the retro period (LINET)
- Most people have one IEP per lifetime (when they turn 65)
 - People who get Medicare before age 65 get a second IEP when they turn 65.
 - Any Part D Late Enrollment Penalties incurred before age 65 are vacated upon reaching 65.

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“ANNUAL ELECTION PERIOD” (AEP)

- Can enroll in or change PDP or MA-PD during the Annual Coordinated Election Period (“AEP”)
 - a/k/a “open enrollment”
- Oct. 15 – Dec. 7 of every year. Coverage begins Jan. 1
- “Locked in” to plan for rest of calendar year, unless eligible for MADP or a Special Enrollment Period (SEP).

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“MEDICARE ADVANTAGE DISENROLLMENT PERIOD”

- Members of MA-PD or MA-only plan may return to original Medicare, and enroll in a PDP, during the first 45 days of the year (Jan. 1 – Feb 14).
 - This is called the “MADP”
 - Switch by Jan 30, new coverage effective Feb 1
 - Switch by February 14, new coverage effective March 1
- Locked into chosen PDP for rest of year, unless eligible for SEP.
- Cannot switch from one MA plan to another during the MADP!

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SPECIAL ENROLLMENT PERIODS (SEPs)

- Allow people to change plans outside the AEP or MADP.
- May need to change plans to for a more compatible formulary, especially if auto-enrolled in a plan.
- Dual eligibles, MSPs and all other LIS-eligibles have an on-going SEP that allows them to change plans every month!
- Other SEPs:
 - move out of plan's service area
 - involuntary loss of creditable coverage
 - not accurately informed of creditable coverage status
 - enroll in or maintain other creditable coverage, including EGHP

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SEPs, continued

- Other SEPs:
 - error by federal employee
 - marketing fraud
 - institutionalized in LTC facility such as a nursing home (move in, reside in or move out)
 - Medicare entitlement determined retroactively
 - SPAP– one opportunity to change yearly
 - 5-Star SEP –one opportunity to change to a 5-star plan (Very few 5 star plans!)
 - Low Performing Plans - may disenroll from low performing plans (less than 2 stars). Must call Medicare.

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EXCEPTION TO VOLUNTARY ENROLLMENT (LIS-Eligibles)

- For most people enrollment is voluntary. However, some people are required to enroll in Part D:
 - Dual Eligibles (Medicaid and Medicare)
 - Partial Dual Eligibles (MSP and Medicare)
 - SSI and Medicare

- If these groups do not enroll on their own, CMS will enroll them into a Part D “Benchmark” plan. This is done through the “auto-enrollment” process.

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BENCHMARK PLANS

- Plans that are authorized by CMS to accept low income auto-enrollees (Duals, MSP, and SSI)
 - Always PDPs (never MA-PDs)
 - Coverage is “basic” rather than enhanced
 - Premiums at or below state’s “benchmark threshold” amount
 - Enrollment is random (formulary may not be compatible)
 - CMS will not trump beneficiary’s own choice if self-enrolled
 - Most benchmark plans have “skimpy” formularies. Some have lower star ratings.
 - LIS-eligibles are not locked into benchmark plans! May enroll in better plans if pay the excess premium over benchmark.

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AUTO-ENROLLMENT

- Process is completely random
 - Formularies not always compatible with beneficiary needs
- Dual Eligibles are initially assigned to a “LINET” plan for about two months, then switched to a benchmark plan.
- MSP eligibles are initially assigned to a benchmark plan.

- If CMS has information that a dual eligible already has creditable coverage, CMS will send an “opt out” letter giving person the opportunity to stay with their existing coverage and not enroll in Part D.

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SAFETY-NET

- LIS-eligibles who “slip thru the cracks” (either did not enroll themselves or were not enrolled by CMS) can be enrolled in LINET plan right at the pharmacy, may get meds same day
 - Need to verify LIS eligibility
- This is called “Point of Sale (POS) Enrollment”
- POS Enrollment is performed by “LINET”

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LINET

“Limited Income Newly Eligible Transition ” Program

- LINET has three functions:
 1. At initial auto-enrollment, LINET is a temporary (2 months) plan for full dual eligibles
 2. “POS” (point-of-sale) enrollment contractor for all LIS-eligibles who are not auto-enrolled
 3. Reimburses duals who paid for drugs out-of-pocket during any Part D retroactive period. (Can reimburse full duals 36 months retro; other LIS-eligibles 30 days retro.)

- LINET is administered by Humana (open formulary, no Utilization Management Restrictions, no network restrictions)

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CREDITABLE COVERAGE

- Any drug coverage that is at least as valuable as the Part D benefit (“as good as or better than”) is considered creditable for Part D
 - E.g., drug policy with a \$2,000 annual drug cap would not be creditable.
 - Unlike Part B, creditable coverage is not tied to “current employment”
 - Unlike Part B, COBRA insurance is creditable in Part D

- VA, TriCare, and Federal employee insurances are all examples of creditable coverage. Many Employee Group Health Plans (EGHPs) also creditable
 - Most Medigap policies are not creditable

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EXCEPTION TO VOLUNTARY ENROLLMENT (Creditable Coverage)

- Generally, cannot have Part D and another creditable insurance at same time (there are some exceptions, e.g., VA).
 - Enrolling in Part D may cause loss of creditable coverage and other health insurance; may not be able to get back coverage once lost
 - Could also affect any dependents covered by the policy
 - Imperative to check with insurance Benefits Administrator before enrolling in a Part D plan!
 - See “Opt Out Letter” at Auto-Enrollment slide

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CREDITABLE COVERAGE NOTICE

- Employers, unions and other insurers that provide coverage to Medicare beneficiaries must send annual “Notice of Creditable Coverage” by September 30 each year.
 - Important to **SAVE** these notices in case need to enroll in a Part D plan in later years.
 - Must be able to document that had creditable coverage to avoid future penalties.
- Have 63 days from involuntary loss of creditable coverage to enroll in a Part D plan without incurring penalty or waiting period.

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LATE ENROLLMENT PENALTIES

“LEP”

- Unless exempt, there is a penalty for having a lapse in creditable coverage greater than 63 days after the IEP
 - may also be a waiting period for coverage, e.g., may not be able to enroll until the next AEP
 - Penalty is 1% of national base beneficiary premium for every full month could have been enrolled
 - In 2016 penalty = 1% (\$34.10) x number of full months...
 - Is a lifetime penalty, BUT... if the penalty is incurred before age 65, it is vacated when reach age 65.
 - LIS-eligibles are statutorily exempt from the penalty

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COVERED DRUGS

- Part D covers outpatient drugs that are:
 - Approved by the FDA
 - Available only by prescription
 - Medically necessary and for a “medically accepted indication” (no “off label” coverage)
 - Mandatory under the Medicaid program.
- Part D also covers:
 - Insulin and insulin syringes (Test strips, meters, etc. still covered by Part B.)
 - Smoking cessation drugs.
 - Vaccines that are not covered under Part B, e.g., shingles

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EXCLUDED DRUGS

- Excluded under Part D:
 - Over-the-Counter (OTC) drugs
 - Drugs for weight loss or gain (some exceptions)
 - Cough and cold preparations (some exceptions)
 - Fertility, cosmetic, ED drugs and most vitamins
 - Drugs coverable by Medicare Part A or Part B
 - Compound drugs that do not contain at least one Part D drug
 - Compound drugs consisting solely of “bulk powders” not covered
 - DESI drugs (old pre 1962 “grandfathered” drugs) and those determined to be “less than effective” (LTE) by the FDA.
 - “Off label” drugs (not prescribed for a “medically accepted indication”)

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OFF LABEL DRUGS

- Prescribed for a use not approved by the FDA, and for which there is no support in one of three compendia named in law.
 - E.g., Lidocaine Patch 5% is widely prescribed for many types of pain, (spinal stenosis, severe OA, degenerative disc disease) but it is only approved for diabetic neuropathy or post hepatic neuralgia (post shingles pain). Only alternative to patch may be opiates.
- In the US, 20% of all drugs prescribed off label. Many of these are prescribed to treat life-threatening diseases.
- Most private insurance, ACA “Marketplace” plans, and Medicaid cover off label drugs.
- Disabled individuals transitioning from other insurance on to Medicare may be deeply affected by Part D off label rules.
 - Some consider giving up Medicare.

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OFF LABEL ISSUES

- CMS greatly increased scrutiny of off label use in Part D in 2016.
 - Appeals rarely successful because the rule is in law rather than regulation or policy. If coverage is granted by ALJ, decision usually reversed by Medicare Appeals Council
 - Compendia are proprietary and very expensive.
 - Peer reviewed literature only accepted for cancer diagnoses
 - But in Part B, peer reviewed literature may be accepted for any diagnosis
 - Manufacturer Patient Assistance Programs will not cover if used off label. (Canadian pharmacies?) (Discount cards?)
 - In the case of rare diseases, there may be no FDA approved drug.
 - Clinical Trials?
 - Off label problem requires a statutory “fix.” (political will?)

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PART D GRIEVANCES and APPEALS

Appeal

- if denied a drug for any reason
- multi-step legal process, beginning with an “exception” request
- can go as high as federal district court level
- strict adherence to steps and timelines established in federal regulations.
- may take years at higher levels of appeal

Grievance

- other types of complaints, e.g., poor customer service, mail order delays.
- not a legal process.
- can’t take further action if grievance denied, but should notify 1-800-Medicare if not acted upon

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FORMULARY VS. TIERING EXCEPTIONS

Formulary Exceptions – asking plan to cover:

- non-formulary drug, or
- exception to plan's prior authorization, quantity limit or step-therapy requirement
- MUST have doctor's statement of support.
- If non-formulary drug approved drug will be moved to Tier 4
 - cannot then ask for a tiering exception.

Tiering Exceptions – asking plan to reduce cost of a drug

- must have doctor's statement of support.
- no tiering exceptions for high cost or unique drugs if the plan has a special tier for such drugs, i.e., Tier 4 or 5.
- cannot get brand name drug at the generic price if plan has a special tier for generics.

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PHYSICIAN STATEMENT

- Cannot overstate importance of physician statement! Doctor must explain why this drug – and no other – is medically necessary at the dosage or quantity prescribed. Doc need not “write a book,” but:
 - Must describe results other drugs tried, including therapeutic failure, allergy, adverse outcomes, toxicity, etc.
 - Should state if complicated patient stable on current drug and specify risk of adverse clinical outcome if drug changed.
- Plan does not begin to review until receipt of physician statement.
- Plan not required to provide a transitional supply of drugs while exception or appeal is being pursued – UNLESS in LTC facility.
 - If in LTC, may receive up to 90-day supply in 30-day increments.

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SPECIAL TOPICS:

1. Self-Administered Drugs / Observation Status

- Some drugs administered to a patient while in “observation status” at a hospital are called “self-administered drugs” because they are not required under the Part B-covered outpatient service.
 - CMS defines as “drugs you take on your own”
 - Charges for self-administered drugs are itemized and billed to the patient and are coverable under the patient’s Part D plan, with these caveats:
 - Drug must be Rx and not OTC
 - Cannot be received in ED or outpatient setting “on a regular basis”
 - Must be on the Part D plan’s formulary or approved by exception.
 - Hospitals often bill patients more than the actual cost of self-administered drugs.

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Self-Administered Drugs (Getting Reimbursement from the Plan)

- Effective 10/30/2015, hospitals may waive or discount patient’s self-administered drug charges, provided they do so uniformly for all patients.
- If the hospital does not waive charges, member pays and asks for reimbursement from plan
 - Member must request plan approval for using out-of-network (OON) pharmacy
 - Using hospital pharmacy while in an ED constitutes reasonable OON use
 - May be charged out-of-network cost sharing
 - Any remaining deductible, and co-pays, are patient’s responsibility
 - Co-pay amount may depend on type of plan (defined standard or other) and/or stage of Part D coverage.

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SPECIAL TOPICS

2. Provider Enrollment in Medicare

- In order to prescribe Part D drugs, physicians, psychiatrists and other must either be enrolled in Medicare in an approved status, or must formally opt out of Medicare
 - May enroll to be reimbursed for all Medicare services, or just for the purpose of prescribing Part D drugs. Separate forms for each.
 - Applications and opt-out affidavits were due to the Medicare Part B Administrative Contractors (MACs) by January 1, 2016. Late submission may cause delays.
 - On a case-by-case basis, plans must allow beneficiaries a 3-month provisional supply of meds to allow time for their prescriber to enroll or time to find a new provider.
 - Plans may pay claims for other “authorized prescribers” who are allowed to prescribe under state law but not eligible to enroll in Medicare.

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Acknowledgements: Under 65 Project Partners and Advisors

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Next in the Medicare for Individuals Under Age 65 Webinar Series

Webinar #4

Medicare Home Health Coverage for People With Long-term
Conditions (Including a Jimmo Update)

Presenter: Judith Stein
July 27, 2016 at 2PM EDT

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Future Topics in the Under Age 65 Webinar Series

- Transitioning into (and out of) Medicare
- Medicare Part A, Part B and Medigap Coverage
- Medicare Advantage
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies
- Connecting Through Social Media
- Connecting Through Outreach and Education
- The Jimmo Case

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