STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 05 OMM/ADM-5

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: November 7, 2005

SUBJECT: Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Medicare Part D)

SUGGESTED DISTRIBUTION:
Medicaid Staff
Fair Hearing Staff
Staff Development Coordinators

CONTACT PERSON:
Bureau of Local District Support
Upstate: (518)474-8887
NYC: (212)417-4500

ATTACHMENTS: None

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
			P.L. 108-173 SSL 366-2(b)(1)		GIS 05 MA/024 Dear Commissioner Letter dated June 7, 2005

I. PURPOSE

The purpose of this Administrative Directive is to provide Local Departments of Social Services (LDSS) with information and guidance regarding requirements of the Medicare Modernization Act (MMA), and the prescription drug benefit under Part D of Title XVIII of the Social Security Act.

II. BACKGROUND

Section 101 of the Medicare Modernization Act (Public Law 108-173), which was enacted into law December 8, 2003, adds sections 1860D-1 through 1860D-24 to the Social Security Act and establishes a new Medicare Part D program for voluntary prescription drug coverage.

The Centers for Medicare and Medicaid Services (CMS) has overall responsibility for implementing the Medicare Part D prescription drug benefit and published final rules on January 28, 2005 at 70 CFR 4193. Section 1860D-14 of the Act provides for premium and cost-sharing subsidies of prescription drug coverage for certain individuals with low income and resources. The purpose of the subsidy program is to assist Medicare beneficiaries with limited financial means, to pay for Medicare prescription drug coverage under Medicare Part D. Clients with low income and limited resources may be eligible for a subsidy to help pay for monthly premiums, coinsurances and the annual deductible under Medicare Part D.

An individual is eligible for the Medicare prescription drug program if he or she is entitled to Medicare Part A and/or enrolled in Medicare Part B.

III. ROGRAM IMPLICATIONS

A. Prescription Drug Plans

In order for Medicare beneficiaries to take part in the Medicare Part D prescription drug program, it is incumbent upon them to enroll in a prescription drug plan. Medicare prescription drug plans will provide insurance coverage for prescription drugs. These plans will be offered by insurance companies and other private companies and will cover both generic and brand name drugs. Those firms serving the fee-for-service Medicare population are called Prescription Drug Plans (PDPs) and those serving Medicare Advantage (Medicare HMO) enrollees are called Medicare Advantage Prescription Drug Plans (MA-PDs). When choosing, beneficiaries will be able to select from at least two plans. The plans will be responsible for addressing transition issues including circumstances where beneficiaries’ current drugs are not on the formulary (the list of drugs that are included in that prescription drug plan).

CMS is requiring Medicare prescription drug plans to establish an appropriate transition process for new enrollees including dual eligibles who are transitioning from Medicaid to Medicare for their prescription drug coverage.

B. Formulary

The minimum statutory requirement is that a formulary must include at least one (but often two) drugs in each approved category and class. CMS has developed a set of checks and oversight activities to ensure that prescription drug plans offer a comprehensive benefit that reflects best practices in the pharmacy industry as well as current treatment standards. As they develop their formularies, plans will need to recognize the special needs of particular types of beneficiaries, such as mental health patients, those with HIV/AIDS, those living in nursing homes, people with disabilities and other beneficiaries who are stabilized on certain drug regimens.

CMS has developed appeals procedures which ensure that enrollees quickly receive decisions regarding medically necessary medications. Pharmacies will distribute or post notices that instruct enrollees to contact their Medicare prescription drug plan if they need a certain drug and the pharmacist informs them that the drug is not included in the plan's formulary. If an enrollee requests an exception, the plan must make its decision as expeditiously as the enrollee's health condition requires after it receives the request, but no later than 24 hours for an expedited coverage determination or 72 hours for a standard coverage determination.

C. Standard (Non-Dual Eligible) Part D Benefit

All Medicare beneficiaries, beginning in 2006, will have access to the standard drug benefit. As previously stated, the drug plans will be allowed to provide limitations and restrictions on available drugs and other specifications, but the benefit offered must be at least equal to the standard benefit. For the standard benefit in 2006, the individual pays:

- A monthly premium (varies depending on the plan chosen);
- A yearly deductible of $250;
- 25% of the yearly drug costs from $250 to $2,250, and the plan pays the other 75%;
- 100% of the next $2,850 in drug costs (sometimes referred to as the donut hole);
- 5% of the drug costs (or a small copayment) for the rest of the calendar year after having spent $3,600 out-of-pocket. The plan pays the rest.

D. Low-Income Subsidy Benefit

The MMA provides extra help with prescription drug costs for eligible individuals whose income and resources are limited, in the form of a low-income subsidy. The subsidy provides assistance with the premiums, deductibles and co-payments of the program. Certain groups of Medicare beneficiaries will automatically qualify for the low-income subsidy and do not have to apply to get this extra help.

Medicaid recipients and Medicare Savings Program enrollees are "deemed" eligible for the subsidy and do not have to apply for this extra help.

1. Full-Benefit Dual Eligible – Deemed Eligible

Starting in January 2006, full-benefit dual eligible beneficiaries (Medicare beneficiaries who are also in receipt of Medicaid) will receive their prescription drug coverage through Medicare rather than through the Medicaid program. Medicare Part D replaces Medicaid as the primary pharmacy coverage for dual eligible recipients. Generally, if a person has private health insurance that includes a drug benefit, in addition to Medicare Part D, the private insurance would be billed prior to billing Medicare Part D.

In order to ensure that Medicaid individuals do not experience a gap in their prescription drug coverage, in October 2005 Medicaid recipients will receive a letter from CMS that will provide information about the new Medicare benefit. The letter will inform them that a prescription drug plan was randomly selected for them by CMS. Unless the individual picks another prescription drug plan by December 31, 2005, the plan that was randomly selected for them by CMS will become their prescription drug plan on January 1, 2006. Dual eligible individuals will be allowed to change Medicare Part D drug plans every thirty days, so that if the assigned plan does not meet their needs, they can join a different plan. Individuals enrolled in a Medicare Advantage Plan (Medicare HMO) will be assigned to a prescription plan sponsored by that plan.

The prescription benefit for Medicaid recipients under Medicare includes the following:

- No premiums if enrolled in a plan with a monthly premium at or below the low income premium subsidy amount (referred to as the "benchmark" plan);
- No deductibles;
- No "donut hole" (the amount of out-of-pocket drug costs that standard benefit beneficiaries are required to pay once their initial coverage limit of $2,250 is reached);
- $1 co-payment for generic drugs, $3 for brands name drugs;
- No co-payment for Medicaid recipients residing in a medical facility. A medical facility is defined as a nursing home, psychiatric center, residential treatment center, developmental center, intermediate care facility. Other group residences such as Assisted Living Programs (ALPs), group homes, and adult homes are subject to co-payments.

Note: All dual eligibles will be required to enroll and remain enrolled in a Medicare prescription drug plan. Although Medicare Part D is a "voluntary" program, New York State law requires Medicaid recipients to enroll in Medicare as a condition of

eligibility. Therefore, if an individual refuses to enroll or disenrolls from Medicare Part D, he/she will not be eligible for Medicaid.

On a monthly basis, the Department will identify those individuals who were determined eligible for Medicaid during that month and will provide that information to CMS. Full benefit dual eligibles (including those that have met their spenddown in the month) will be notified by CMS that a prescription drug plan has been selected for them. If the individual does not choose a different plan, they will be enrolled in the plan selected by CMS. Until such time as the enrollment process occurs, the individual will receive drug coverage through Medicaid. Once an individual is deemed eligible for the extra help by virtue of their Medicaid eligibility, they will remain eligible for the extra help for the remainder of the calendar year, even if they lose their Medicaid eligibility. This includes an individual who meets their spenddown in only one month during the year.

Once a month the State will receive a file back from CMS informing the State of who was enrolled in Medicare Part D and to which plan they were enrolled. The State will add this information to the Third Party Resource section of eMedNY and also the Data Warehouse. Information regarding a person's enrollment in a PDP or MA-PD will be provided to a pharmacist through the MEVS system, and the provider must bill Medicare for prescription drugs for individuals enrolled in Medicare Part D.

As of January 1, 2006, all Medicaid dual eligible individuals must be enrolled in Medicare Part D in order to receive drug benefits. Enrollment in Medicare is a condition of eligibility for Medicaid. An individual will lose **all** Medicaid benefits for failure to enroll or remain enrolled in a plan. New applicants who are Part D eligible do not need to be enrolled in a Medicare Prescription Drug Plan in order to open a Medicaid case. Once they have an open case, the State will send their name to CMS for auto-enrollment in a plan. The individual will then receive information from CMS regarding their plan enrollment.

Dual eligible individuals who reside in nursing homes will also be required to enroll in Medicare Part D. As stated earlier, such individuals will not have to pay any co-payments. The nursing home rate is being revised to carve out the cost of drugs for this population.

The State is currently developing procedures to auto-close individuals over the age of 21 who refuse to participate in the Prescription Drug Program. Further information regarding this process will be available soon.

The PDP or MA-PD will issue a prescription drug card to the enrollee which they must use when purchasing prescription drugs. The enrollee must use pharmacies that are part of their plans network. Some plans may allow enrollees to purchase their prescriptions through the mail. Plans will have a list of drugs covered by the plan. The drug list may not include a specific drug that the enrollee is taking. However, in most cases, a similar

drug will be available. Individuals may need to have their provider prescribe a similar drug to the one they are currently taking that is included in the plan's list. However, if the particular drug they are currently taking is medically necessary, and the drug is not included in the plan's formulary, the individual must call the plan, or ask the provider who prescribed the medication or pharmacist to call the plan to get an exception (also called coverage determination) from the plan to get that particular drug covered by the plan. If the plan still will not approve the request for that medication, Medicaid may be billed. Further information on billing in such instances will be forthcoming. Medicaid will continue to cover a very limited set of drugs which are not included in the Part D benefit such as barbiturates and benzodiazepines. Medical supplies and over the counter drugs that are currently covered by Medicaid, will continue to be covered by Medicaid.

Individuals who attain age 65, or reach their 25th month of receipt of disability benefits, and become eligible for Medicare after January 1, 2006, will undergo the same actions to determine their eligibility for the subsidy. These individuals will be matched monthly based on the information received from the State.

Under Medicaid law, pharmacies must give Medicaid recipients their prescription drugs, even if the recipient states that they cannot pay the Medicaid co-payment. Medicare Part D does **not** operate under this same law. Pharmacies may refuse to provide prescription drugs to Medicare recipients who do not pay the co-payment. Medicaid cannot be billed for the prescription drug in such situations, nor is there any authority for Medicaid to pay such co-payment on behalf of the recipient.

Some individuals may choose to enroll in a prescription drug plan that has a premium higher than the benchmark premium. The amount of the premium that the recipient is responsible for over and above the subsidized premium is the responsibility of the recipient. There is no authority for the State to pay this higher premium or to reimburse the individual for this cost. It is, however allowed as a deduction from income or can be applied to a spenddown. If the individual does not want to have this extra expense every month, they may switch to a plan that is at or below the benchmark premium amount. To switch plans, the recipient must contact the plan in which they wish to enroll.

2. Medicare Savings Program Enrollees – Deemed Eligible

Individuals enrolled in the QMB, SLIMB or QI program are deemed eligible for the low-income subsidy program and will not be required to file an application for such help. They will be required to choose a prescription drug plan. However, enrollment in a prescription drug plan is **not** a condition of eligibility for the Medicare Savings Program. If an MSP enrollee has not enrolled in a plan by May 2006, CMS will facilitate enrollment in a PDP or MA-PD for the Medicare Savings Program population. Similar to the dual eligible population, once an individual is determined eligible for the low-income subsidy, they remain eligible for the extra help for the remainder of the calendar year even if they lose their eligibility for the Medicare Savings Program.

The prescription benefit for the MSP population includes the following:

- No premium if enrolled in a plan with a monthly premium at or below the low income premium subsidy amount (referred to as "benchmark" plan);
- No deductibles;
- No "donut hole";
- Co-payments of $2 for generic drugs and $5 for all other drugs, up to the out-of-pocket limit ($3,600); and

3. Low-Income Subsidy for the Non-Deemed Population

Individuals who are not deemed eligible for the low-income subsidy may apply for the benefit. Beneficiaries may apply for the low-income subsidy through SSA starting May, 2005. The application, "Application for Help with Medicare Prescription Drug Plan Costs", SSA-1020, may be obtained by calling 1-800-Medicare, through the local SSA office or on-line at www.ssa.gov. Copies of the application may also be obtained through this Department by sending a request by fax to Michael Margiasso (518-486-1432).

Medicare beneficiaries with resources less than $10,000 (for a single person) or less than $20,000 (for a married couple) and income below 135% of the federal poverty line will receive the following benefit:

- No deductible;
- No premium if enrolled in a plan with a monthly premium at or below the low-income premium subsidy amount (referred to as a "benchmark" plan);
- Co-payments of $2 for generic drugs and $5 for all other drugs, up to the out-of-pocket limit ($3,600); and

Beneficiaries with resources below $10,000 (for a single individual) or $20,000 (for a married couple), and income between 135% and 150% of the federal poverty line will receive the following benefit:

- A sliding scale monthly premium that would average $18;
- A $50 deductible;
- Co-insurance of 15% up to the out-of-pocket limit. The government subsidy for cost-sharing counts toward the out-of-pocket limit; and
- Co-payments of $2 for generic drugs and preferred drugs that are multiple source drugs or $5 once the out-of-pocket limit is reached.

For Medicare beneficiaries who apply for the subsidy, income and resource rules are based on but not identical to the rules for the Supplemental Security Income (SSI) program. Most non-liquid resources will not be counted when determining eligibility for the subsidy, whereas many such non-liquid resources would be counted under SSI. The income of the applicant and that of a spouse living in the same household will be counted and compared to a Federal poverty level standard applicable to the size of the family, which includes the applicant, their spouse, and dependent family members who live with them. The resources of the applicant and the spouse, if any, will be counted and compared to the resource threshold, and generally include liquid resources that can be readily converted to cash within 20 days, such as checking and savings accounts and real estate that is not the applicant's primary residence.

CMS will be sending applications for the low-income subsidy to individuals who according to their records appear to meet the criteria for this program. They will be instructed to return the completed application to SSA.

E. Spenddown

Medicare individuals who are eligible for Medicare Part A or Part B who are eligible for Medicaid based on a spenddown are deemed eligible for the subsidy and do not have to apply for that benefit. Once deemed, as long as the individual remains eligible for Medicare, he/she will receive the subsidy for the remainder of the calendar year, regardless of whether they meet their spenddown again. Certain individuals who have used their prescription costs to help meet their spenddown, may find that Medicare covers their drug spending and they no longer "spend down" as quickly to become Medicaid eligible. However, with Medicare paying for their prescription drugs, they will have more available income. Any out-of-pocket costs paid or incurred for items such as Part D premium, coinsurance, deductible or co-payments may be used to meet a spenddown. Medical expenses other than prescription drug costs may continue to be used to meet their spenddown. Although the premium amount may be used as a deduction from income, there is no State authority to pay or reimburse the recipient for the Medicare Part D premium.

F. Enrollment

For the general Medicare beneficiary population, there will be an initial open enrollment period from November 15, 2005 through May 15, 2006, during which all Medicare beneficiaries can enroll in a plan. There will be subsequent enrollment periods for the Medicare prescription drug program each year. If a Medicare eligible individual does not enroll in a Medicare prescription drug plan by May 15, 2006 after a period of 63 days or more without drug coverage that is as good as or better than Medicare coverage, his/her Part D premium will increase at least 1% of the base beneficiary premium (a national number) per month for every month that s/he waited to enroll. The individual will have to pay this higher premium as long as the individual has a Medicare prescription drug plan.

Enrollment in Medicare Part D for dual eligibles is an automatic process. This Department will identify dual eligible beneficiaries and submit a monthly file to CMS of people who we have identified as having both Medicaid and Medicare. In October 2005, Medicaid recipients will receive a letter from CMS that will provide information about the new Medicare benefit. The letter will inform them that they have been assigned to a drug plan by CMS. Unless the individual picks another prescription drug plan by December 31, 2005, the plan assigned to them by CMS will become their prescription drug plan on January 1, 2006. At the same time CMS will notify Medicare prescription drug plans of the full-benefit dual eligibles assigned to their plan. Medicare prescription drug plans will mail enrollment materials to the beneficiaries assigned to their plan including the list of covered drugs and pharmacy network. Unlike the non-deemed population, full benefit dual eligibles will have the opportunity to change plans once a month.

The State has already begun sending a monthly file to CMS of all dual eligibles, including individuals who have met their spenddown in that month, and MSP enrollees. Anyone who is on that file will be automatically eligible for the low-income subsidy for the entire 2006 calendar year regardless of whether or not they lose Medicaid benefits.

Note: To the extent that a drug is covered by the individual's PDP or MA-PD, and the individual refuses to use Medicare for that drug or purchases the drug from an out of network provider, Medicaid cannot be billed. However, such medical expense can be used to meet his/her spenddown requirement.

Individuals enrolled in the Medicare Savings Program may enroll in a plan effective January 1, 2006. However, if the individual fails to enroll in a plan by May 2006, CMS will initiate a program to facilitate enrollment in a drug plan for the Medicare Savings Program population; a process identical to that for the dual eligibles.

For Medicare beneficiaries who want to receive the subsidy and are not in receipt of Medicaid or the Medicare Savings Program, such individuals or a person's authorized representative may file an application for the low-income subsidy by:

1. Completing the low-income subsidy application in paper form and sending it to SSA;
2. Completing the application on SSA's Internet Web site; or
3. Calling 1-800-Medicare for assistance in completing the application.

G. Effect on Other Benefits

Some Federal programs adjust income for high medical spending. Benefits under these programs may be affected by the low-income subsidy.

The Food Stamp Program offsets income with medical expenses over $35 per month. Therefore, people with high drug spending may see their food stamps benefit lowered as a consequence of lower drug spending if they receive extra help paying for Medicare prescription drug coverage. However, the reduction in food stamps should be more than offset by the value of the extra help they'll receive paying for a Medicare prescription drug plan. Generally, every $1 increase in adjusted income (because drug spending declines) results in only $0.30 decline in food stamps. Some people who currently receive the minimum food stamp benefit of $10 because high drug spending reduces their income enough to qualify for food stamps, may no longer qualify for food stamps as their drug spending declines.

Similarly, HUD offsets income with medical expenses over 3% of income. HUD housing assistance may be reduced as a consequence of lower drug spending for people who receive the low-income subsidy. However, just as with food stamps, any housing assistance reduction should be more than offset by the value of the extra help. Generally, every $1 increase in adjusted income (because drug spending declines), results in only $0.30 decline in HUD assistance. Most recipients of HUD housing assistance pay no more than 30% of adjusted income for rent. They may see their portion of the rent increase and their housing assistance decrease if they no longer have high drug spending, but they will not lose their eligibility for housing assistance.

Home energy assistance is based on a household's gross income with the exception of Social Security benefits which exclude the Medicare Part B deduction. As such, the Medicare Part D prescription drug benefit deduction will also continue to be excluded. Households in receipt of the low income subsidy will also have the subsidy disregarded as income.

Dual eligible recipients who are in receipt of other prescription drug benefits such as through an employer or the Veteran's Administration, will also be required to enroll in a Medicare prescription drug plan. However, some employers may change the way they provide prescription drug coverage to Medicare beneficiaries.

IV. REQUIRED ACTION

A. Non-Deemed Eligibles for Low-Income Subsidy

Medicare beneficiaries with limited income and resources who do not fall into one of the deemed eligible groups, may apply for the low-income subsidy to help them pay the cost of Medicare Part D. The law specifies that eligibility for subsidy assistance can be determined by either the Social Security Administration or the local Medicaid office.

SSA will mail applications for the low-income subsidy to Medicare beneficiaries who have been identified as potentially eligible for the subsidy, but who are not deemed eligible. The cover letter that will be sent with the application will explain that the purpose of the subsidy is to pay for some or all of the costs of the Medicare prescription drug costs including premiums, coinsurance and deductibles. The letter will encourage individuals

to complete the enclosed application and return it to SSA as soon as possible. Applicants for the low-income subsidy will also have the option of applying on-line at www.ssa.gov or at their local Social Security office. Individuals needing assistance completing the application can call Social Security at 1-800-772-1213. Additionally, individuals can call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov for general information. Individuals who are deaf or hard of hearing, may call toll-free TTY number, **1-800-325-0778**. Representatives are available Monday through Friday from 7 a.m. to 7 p.m.

Should an individual appear at the local Medicaid office with a completed low income subsidy application, a worker can offer to mail the application to SSA at: Social Security Administration, Wilkes-Barre Data Operations Center, P.O.Box 1020, Wilkes-Barre, PA 18767-1020 on behalf of the beneficiary.

B. Clients Requesting Local Determination

The MMA specifies that local Medicaid offices also accept and process applications for the low-income subsidy. Since extensive systems modifications and training efforts are required to ready local districts to accept and process these applications, New York State is not prepared to fully meet this requirement at this time. Individuals who contact local districts for information regarding applying for the low-income subsidy may be directed to the Social Security Administration as stated above. Such individuals may also be referred to the County Office for the Aging where Health Insurance Information, Counseling and Assistance Program (HIICAP) counselors can assist them in applying for the low income subsidy. Individuals may also call the HIICAP Hotline at 1-800-333-4114. The HIICAP Hotline operators have been trained to assist Medicare beneficiaries with filling out the application for the extra help as well as to answer beneficiaries' health care questions and to resolve health care related issues. If an individual requests that the local social services district determine his/her eligibility for the low income subsidy, we suggest that you offer the individual a regular Medicaid application or the shortened application for the Medicare Savings Program. If the individual is eligible for either Medicaid or the Medicare Savings Program they will be deemed eligible for the low-income subsidy. In this case, local districts would follow regularly established procedures for processing Medicaid or MSP applications, including sending required notices. If the person is not eligible for Medicaid or the Medicare Savings Program, but may still qualify for the low income subsidy, refer the individual to SSA (1-800 Medicare) or the HIICAP hotline at 1-800-333-4114.

C. Recipient Education and Outreach

This Department will be issuing two informational notices to all current dual eligible recipients. The first notice will explain that enrollment in the Prescription Drug Program is a condition of Medicaid eligibility. The second notice will provide information on how to use the prescription drug card in conjunction with the Medicaid card, in order to receive any drugs that are not covered by the prescription drug plan and information on how to appeal a decision by their drug plan. Copies of these notices will be sent to LDSSs along with information on who has received the notice.

Additional consumer resources are being developed and include a brochure describing important information and where to find personalized counseling and plan-specific information. This brochure will be distributed to pharmacies and LDSS offices. A specific web page devoted to Medicare Part D, including consumer friendly resources and frequently asked questions will be included on the DOH website. Informational meetings with providers and advocates for dual eligible recipients are being scheduled in upstate and downstate New York for the fall of 2005.

CMS has started and will continue to advertise and promote the prescription drug program. Letters to Medicare beneficiaries have already been mailed. Information regarding Medicare Part D and the different plans will be provided in the 2006 edition of the "Medicare and You" handbook. All Medicare beneficiaries receive a copy from CMS in the mail. Once an individual is enrolled in a plan, they will receive information from that plan about how to use their new benefit.

There are several differences between the current Medicaid fee-for-service prescription benefit, and the new Medicare Part D benefit. Key differences are:

1. There will be multiple plans providing services. Just like managed care, it is important that the recipient be aware of the specific plan in which they are enrolled and how to contact that plan. If the plan does not meet their needs, they should shop around to see if there is another plan that would more closely meet their needs. As stated earlier, Medicaid recipients may change plans every month.

2. The plan will have some limitations or restrictions on access to drugs. Most plans will have a formulary which may include a more limited set of drugs than under Medicaid. In addition, plans can have several types of management programs, including a preferred drug list, prior authorization, step therapy, and other requirements which the recipient or their prescriber must meet prior to receiving a specific drug.

3. Each plan has established an approved network of pharmacies, which have agreed to be enrolled with the plan to provide services. While Medicaid allows almost unrestricted access to most pharmacies in the state, the plan will have only specific pharmacies at which the recipient may obtain their medications.

Local Districts should expect to start receiving phone calls from recipients and their caregivers who are concerned about how this change will affect their Medicaid benefit. Staff should be prepared to answer such questions and to refer individuals to Medicare or to their Prescription Drug Plan when appropriate.

IV. SYSTEMS IMPLICATIONS

Numerous changes to eMedNY are currently in development. Part D coverage will be added to the third party system along with Part A and B coverage. Information will be provided regarding the initial eligibility date for Part D. Plan enrollment information will also be available for inquiry, including dates of prescription drug plan coverage. LDSS staff will only have inquiry capability. Updating Part D information will be conducted by the State. Changes to the claims processing system are also being developed.

Current notices on the Client Notice System (CNS) will be revised to include information about the Medicare Prescription Drug Program. Further information on these revisions will be forthcoming. In instances where the individual refuses to enroll or disenrolls in the Medicare Prescription Drug Program, Reason code V13: Disc MA/FHP Failure to Utilize Benefits should be used.

V. ADDITIONAL INFORMATION

If you would like to read more information about the new prescription drug program and how the low-income subsidy determination is made, you may refer to the following CMS website: http://www.cms.hhs.gov/default.asp. This site provides links to many resources and informational materials.

VII. EFFECTIVE DATE

January 1, 2006.

Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Manage