Compliance Training

Enrollment Segment 2:
Background, Terminology and Resources

March 2010

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Before We Get Started….

- This is a two half hour course, which includes
  - this presentation,
  - a fun interactive game *and*
  - a short quiz at the end
- Please feel free to ask questions at any time!

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Training Disclaimers

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Training Disclaimers

- These training slides are meant to serve as an overview and background. They are high level.
- These slides may be used as a guide to the rules and regulations. *They should not be used as a replacement for the actual CMS issuances.*
  - *You will be given copies of the actual CMS guidance to use in conjunction with these training slides.*
- Although this training presentation outlines the current regulations, *any of the information discussed in this training is subject to change by law or CMS at any time*.

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Acronyms

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Frequently Used Acronyms A-H

- AEP: Annual Election Period
- AM: Account Manager
- BCSS: Batch Completion Summary Status report
- BEQ: Batch Eligibility Query
- CCP: Coordinated Care Plan
- CMS: Centers for Medicare & Medicaid Services
- CTM: Complaints Tracking Module
- ESRD: End Stage Renal Disease
- FFS: Fee for Service
- GEP: General Enrollment Period
- GHP: Group Health Plan
- HCFA: Health Care Financing Administration
- HCCP: Health Care Prepayment Plan
- HMO: Health Maintenance Organization

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Frequently Used Acronyms I-O

- ICEP: Initial Coverage Election Period
- IEP: Initial Enrollment Period
- IG: IntegriGuard
- LEP: Late Enrollment Penalty
- LIS: Low Income Subsidy
- M+C: Medicare + Choice
- MA: Medicare Advantage
- MA-PD: Medicare Advantage Prescription Drug
- MMR: Monthly Membership Report
- MSA: Medicare Medical Savings Account
- OEC: Online Enrollment Center
- OEP: Open Enrollment Period

Frequently Used Acronyms P-Z

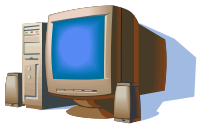
- P&P: Policy and Procedure
- PACE: **P**rogram of **A**ll Inclusive **C**are for the **E**lderly
- PDP: Prescription Drug Plan
- PFFS: Private Fee For Service
- PPO: Preferred Provider Organization
- RO: Regional Office
- SCC: State and County Codes
- SEP: Special Election Period
- SMI: Supplementary Medical Insurance
- SNP: Special Needs Plan
- SOP: Standard Operating Procedures
- SPAP: State Pharmaceutical Assistance Program
- SSA: Social Security Administration
- TRR: Transaction Reply Report

Background and Purpose

Background and Purpose

- Medicare Advantage Organizations (**MAO**) and PDP Sponsors are required to abide by the rules and regulations set forth by CMS.
- CMS issues these rules and regulations in the form of manuals
  1. Medicare Managed Care Manual (**MMCM)**: applicable to MA & MAPD plans
  2. Prescription Drug Benefit Manual (**PDBM**): applicable to PDP plans
- The manual's are broken down into chapters based on the topic of the regulation (i.e. MMCM, Chapter 2 "Enrollments and Disenrollments")
- Periodically CMS updates the regulations in these chapters.
  - CMS updates the chapters on an annual basis.
  - Any changes made to enrollment regulations mid-year are sent to plans via the Health Plan Management System (HPMS)
- The purpose of this training is to review the terminology of the MMCM Chapter 2 and the PDBM Chapter 3.

CMS' Systems



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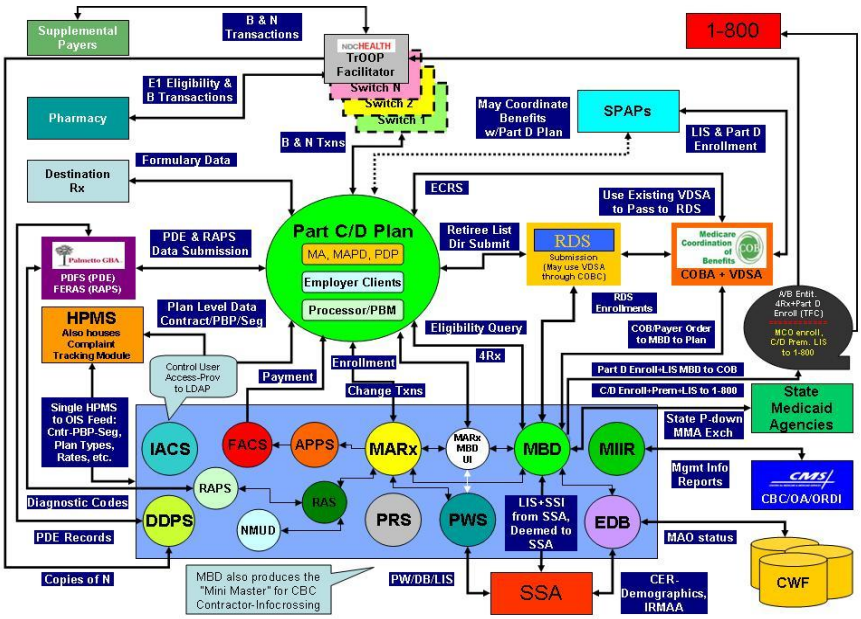
How Many Systems Does CMS Have?



Overview of HPMS

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What Is HPMS?

- Health Plan Management System (HPMS) is a secure website used as a communication mechanism between CMS and MAOs and PDP Sponsors.
  - When CMS releases a new memo, notice, or regulation it is distributed to MAOs and PDPs through HPMS.
    - Individuals with access to HPMS will receive an email with the memo, notice or regulation.
  - The Complaint Tracking Module (CTM) is also located inside HPMS.
    - CMS sends complaints to us through HPMS.
    - We download the complaints, investigate them, and communicate the resolution back to CMS through HPMS.
  - Enrollment letters and notices that require CMS approval are submitted to CMS for approval through HPMS.

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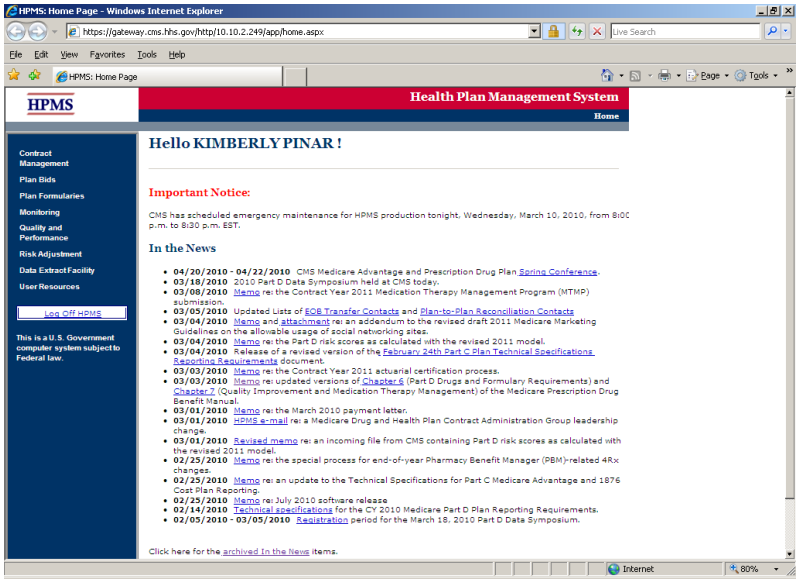
HPMS



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HPMS Memo

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CENTER FOR DRUG AND HEALTH PLAN CHOICE

DATE: July 21, 2009

TO: All Medicare Advantage Organizations, Part D Sponsors, Cost-based Plans and PACE Organizations

FROM: Thomas Hutchinson, Director, Medicare Plan Payment Group

SUBJECT: Retroactive Processing Contractor Changes

Effective August 3, 2009, Reed & Associates CPAs (hereafter referred to as 'Reed') will be the new retroactive processing contractor (RPC) for the Centers for Medicare and Medicaid Services. The current contract with Reed & Associates/IntegriGuard will expire on August 2, 2009.

Requests already submitted under the current contract will be transferred to the new contract; therefore, there is nothing for you to do regarding pending submissions. You will receive a Final Disposition Report (FDR) just as you are currently accustomed to receiving. You can expect the same quality of support and service you receive today with a few changes, as outlined below:

1. Beginning August 2, 2009, please send all of your correspondence, including retroactive processing requests, monthly CEO Certification of Enrollment Data for Payment and all other materials to the new address listed below:

   Reed & Associates, CPAs
   14301 FNB Parkway
   Suite 211
   Omaha, NE 68154

2. The website you access for information on retroactive processing and status changes, and for the tools you need to do this work will change to www.reedassociates.org.

3. The RPC also provides client services support to assist you. Contacts:
   - Phone Number: (402) 315-3660
   - E-mail: clientservices@reedassociates.org

Several documents and tools will be refreshed and updated to better assist you through this transition. Please visit the RPC's web address above beginning July 27, 2009 to obtain these updated tools and instructions.

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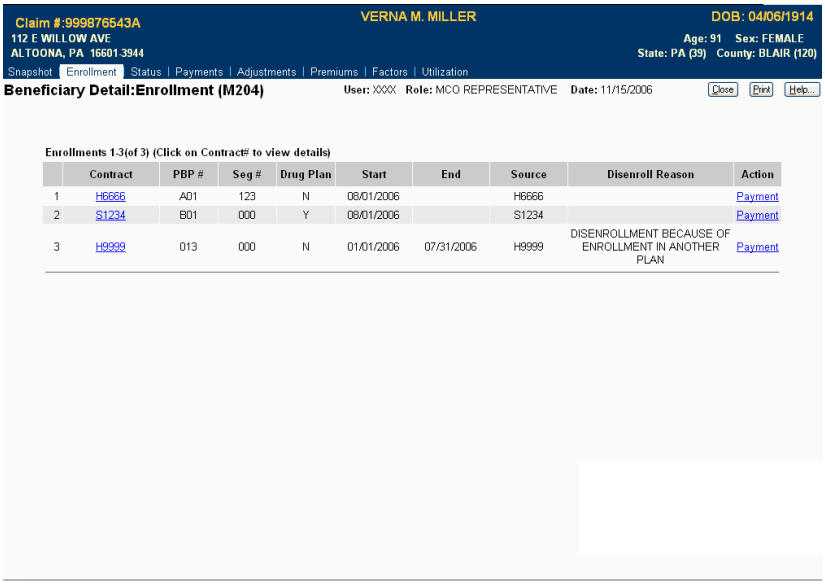
Overview of MARx

MARx

- MARx, which stands for Medicare Advantage RX (Prescription Drug) enables access to enrollment, eligibility, and 4Rx information for Medicare beneficiaries.
- It is a secure system maintained by CMS.
- An individual must apply, be approved and given security access to access MARx and beneficiary information.
  - When you apply you must agree to follow all federal requirements to safeguard PHI information and will be subject to individual prosecution if you do not follow those requirements.
  - Just as with any other Essence system, you are not permitted to share your access information (log-in and password) with anyone.

At Essence, we take our responsibility with regard to the MARx very seriously!

MARx



Claim #:999876543A
112 E WILLOW AVE
ALTOONA, PA 16601 3944

VERNA M. MILLER

DOB: 04/06/1914
Age: 91 Sex: FEMALE
State: PA (39) County: BLAIR (120)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | Factors | Utilization

Beneficiary Detail:Enrollment (M204) User: XXXX Role: MCO REPRESENTATIVE Date: 11/15/2006 Close Print Help...

Enrollments 1-3(of 3) (Click on Contract# to view details)

	Contract	PBP #	Seg #	Drug Plan	Start	End	Source	Disenroll Reason	Action
1	H6666	A01	123	N	08/01/2006		H6666		Payment
2	S1234	B01	000	Y	08/01/2006		S1234		Payment
3	H9999	013	000	N	01/01/2006	07/31/2006	H9999	DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	Payment

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Overview of the BEQ

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Batch Eligibility Query

- The Batch Eligibility Query (BEQ) provides a vehicle for all Plans, regardless of type or size, to submit batches of queries for individuals in order to obtain
  - confirmation of Medicare eligibility,
  - prescription drug program eligibility,
  - Low Income Subsidy (LIS) information, and
  - past drug coverage period information so that plans can determine the number of uncovered months relating to Late Enrollment Penalty (LEP) determinations

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A few facts about the BEQ

- There are no limitations to the number of BEQ Requests that a plan can submit.
- There is a template that plans must use to submit a BEQ Request.
- Each BEQ Request transaction on the BEQ Request File should identify a prospective or current Plan enrollee.
  - Plans may submit BEQ transactions only for individuals who have requested enrollment.
- CMS will generate one BEQ Response File every time a BEQ Request is processed during a regular business day.
  - If a Plan submits multiple BEQ Request Files during a regular business day, they will receive multiple BEQ Response files during that same business day.

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BEQ

- Each BEQ transaction is assigned a “Detail Record Sequence Number” which may be used to track individual transactions.
- Upon receipt of the BEQ request file, CMS will determine whether or not the file can be accepted or rejected.
  - There are two levels of acceptance for a BEQ Request, at the file level and at the record level.

BEQ Acceptance Levels

- At the file level: We must submit a minimum amount of information in a BEQ file request.
  - If we leave out any required information (like the column that houses all the HICN numbers) it would cause the entire file to be rejected.
- At the record level: Once the file is accepted, the request is looked at by beneficiary.
  - If there is any missing information for that beneficiary, or CMS is unable to locate the beneficiary, that one record will be rejected.

BEQ Submission File Layout

Record Type	HICN/RRB Number	SSN	Date of Birth	Gender Code	Detail Record Sequence Number	Filler	Filler 2	Filler 3	Unique_ Number
MMABEQRH	QRHS5768 2	009080300	0004651						2148436
DTL01	PHI Hidden		19790904	2	1152749				2148437
DTL01			19150712	2	1152751				2148438
DTL01			19260316	2	1152753				2148439
DTL01			19140514	2	1152732				2148440
DTL01			19570112	2	1148325				2148441
DTL01			19311113	2	1152757				2148442
DTL01			19540116	1	1152759				2148443
DTL01			19730618	2	1152756				2148444
DTL01			19561119	1	1152748				2148445
DTL01			19450828	2	1152750				2148446
DTL01			19440619	1	1152763				2148447
DTL01			19300107	2	1152752				2148448
DTL01			19431005	2	1152755				2148449
DTL01			19440408	1	1152760				2148450
DTL01			19420903	1	1152738				2148451
DTL01			19440808	2	1152758				2148452
DTL01			19690608	2	1152761				2148453
DTL01			19740510	2	1152770				2148454
DTL01			19620107	1	1152768				2148455
DTL01			19440829	2	1148881				2148456
DTL01			19831114	1	1152765				2148457
DTL01			19450927	2	1152772				2148458
DTL01			19310816	1	0779676				2148459
DTL01			19620530	1	1152769				2148460
DTL01			19760317	1	1152777				2148461
DTL01			19440702	2	1152781				2148462

BEQ Response File

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Terminology: All About Elections

All about Elections

- An Election is either an enrollment in or voluntary disenrollment from a MA, MAPD, PDP plan.
  - Likewise for an individual to be eligible to enroll or voluntarily disenroll from a MA, MAPD, PDP plan they must have an "election" available to do so.
- "Election periods" are time(s) during which an eligible individual may elect a plan.
  - The type of election period determines the effective date of coverage.
- All enrollment and disenrollment requests must be dated as soon as they are initially received. This is called the Election Receipt Date.
  - This date will be the date used to track the issuance of all required notices.

All about Elections – Enrollment Requests

There are several mechanisms available for individuals to request enrollment in, or disenrollment from, MA, MAPD and PDP plans.

- Paper enrollment application
- Telephonic Enrollment
- Enrollment via the internet
  - Medicare Online Enrollment Center
  - Plan sponsored website
- Auto Enrollments
- Facilitated Enrollments

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All about Elections – Enrollment Requests

- An existing member who wishes to elect another plan in the same organization, must complete a new election request *during a valid election period* to enroll in the new plan.
  - These enrollment requests must be handled the same as any other enrollment request.
  - The individual may use the following to make their enrollment request
    - a short enrollment form or a “plan selection” form,
    - via the Internet, or
    - by telephone

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All about Elections - Disenrollment Requests

- A current member may disenroll during an applicable election period.
- They may disenroll from their current plan by
  - Enrolling in another plan
  - In writing by giving or faxing a signed written notice to the plan, *or* through their employer/union group if applicable
  - Submitting a request via Internet to the plan
  - Calling 1-800-MEDICARE

Who can complete an Election?

- The Medicare beneficiary is generally the only individual who may execute a valid request for enrollment in or disenrollment from a MA, MAPD or PDP plan.
  - Another individual would be a legal representative.
  - CMS recognizes State laws that authorize persons to effect an *enrollment request* for Medicare beneficiaries.
    - Persons authorized under State law may be
      - court appointed legal guardians,
      - persons having durable power of attorney for health care decisions *or*
      - individuals authorized to make health care decisions under State surrogate consent laws, *provided they have authority to act for the beneficiary in this capacity*.

All about Elections – Complete Elections

- For an election request to be considered "complete" it must have the following:
  1. The election form/disenrollment request must be signed by the beneficiary or legal representative
     - There are exceptions for enrollment requests, received via an approved enrollment mechanism.
       - For example: A telephonic enrollment will not require a physical signature.
  2. For enrollments, we would need to acquire evidence of entitlement
     - For enrollment into a MA or MAPD, that would be entitlement to Medicare Part A ***and*** B.
  3. All necessary elements on the form are complete.

All about Elections – Evidence of Entitlement

- The MA, MAPD or PDP plan must verify Medicare entitlement for all enrollment requests using either the Batch Eligibility Query (BEQ) process or MARx online query.
- The applicant is not required to provide evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment request.
  - However, If CMS systems do not show Medicare entitlement, the plan may request proof of entitlement.
    - Acceptable proof of entitlement includes
      - a copy of the individual's Medicare ID card or
      - a SSA award letter that shows the Medicare HICN and effective date of Part A/B

All about Elections

- Incomplete Election Requests:
  - If the election request is incomplete, then we must request the information needed to make the election complete.
    - If the information requested is not received, we must deny the election request.
- Denial of Election Requests:
  - If we determine that the individual is not eligible to enroll for example, if they do not have an election, we must deny the enrollment or disenrollment request.
  - The enrollment or disenrollment request should not be submitted to CMS, instead we should send a letter to individual advising them that they are not eligible.

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All about Elections

- Rejection of Election:
  - This occurs when CMS has rejected an enrollment or disenrollment request submitted by the MAO or PDP Sponsor. The rejection could be due to
    - the MAO or PDP Sponsor incorrectly submitting the transactions,
    - system error, or
    - an individual's ineligibility to elect the plan.
- System Error:
  - A "system error" is an unintended error or delay in election request processing that is clearly attributable to a specific Federal government system (e.g., SSA system), and is related to Medicare entitlement information or other information required to process the request.

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All about Elections – Cancellation Of Election

- An election request may be canceled if the request to cancel the election is received *before* the effective date of the election.
  - For example:
    - If we receive a request for enrollment on December 2, using the Annual Election Period (AEP), the effective date will be January 1.
    - If the individual requests to cancel that enrollment request prior to January 1, the election request would be voided and the individual can use the (AEP) election to enroll into another plan of their choice.
- When an election request has been canceled, it has not been used and *the election* remains available for use during the applicable election period.

All about Elections – Cancellation Of Election

- The exception to this would be cancellation requests received through the Verification Call Process.
  - We must make at least three documented attempts to contact the applicant by telephone within **15 calendar days** of the receipt of the enrollment request.
  - If we are unable to successfully complete the verification on the first attempt we must send the applicant an enrollment verification letter.
  - The applicant may request to cancel their enrollment with Essence within **seven (7) calendar days** of the date of the letter **or** call or by the last day of the month in which the enrollment request was received, whichever is later.
    - For example: We receive an enrollment request on March 29. We must make 3 attempts to contact the member by phone by April 13. We reach the member on April 10. The member has until April 17 to request to cancel the enrollment request.

All about Elections - Reinstatements

- A reinstatement of election is viewed as a correction necessary to "erase" an invalid or erroneous disenrollment action to ensure no gaps in coverage occur.
  - Invalid or erroneous disenrollments include
    - Disenrollment due to erroneous death indicator;
    - Disenrollment due to erroneous loss of Medicare Part A and/or Part B indicator; and
    - Mistaken disenrollment. In unique circumstances, a plan may consult with CMS (or its designee) to reinstate members.
- CMS (or its designee), will approve reinstatements on a case-by-case basis.
- Reinstatements may be made retroactively.

Important Note

- Upon receipt of an enrollment or disenrollment request, we must of course process it in Essence's systems, however it is our responsibility to transmit the information to CMS so that their system reflects the same.
  - If this does not occur, there will be a discrepancy between what our records show and CMS's records.
  - This will cause a problem for both the member and Essence.

The Application Date

What is the "Application Date"

- The application date is generally the date the enrollment request is initially received by the organization.
  - For requests sent by mail, the application date is the date the application is received by the plan.
  - For requests received by fax, the application date is the date the fax is received on the organization's fax machine.
  - For requests submitted to sales agents, including brokers, the application date is the date the agent/broker receives (accepts) the enrollment request ***and not the date the organization receives the enrollment request from the agent/broker*.**
    - All CMS required timeframes for enrollment processing begin on this date.

What is the "Application Date"

- For requests accepted by approved telephonic enrollment mechanisms, the application date is the date of the call.
- For requests made via the Medicare.gov Online Enrollment Center (OEC), the application date is the date CMS "stamps" on the enrollment request at the time the individual completed the OEC process.
  - This is true regardless of when a plan ultimately retrieves or downloads the request.
- For internet enrollment requests made directly to the plan's website, the application date is the date the request is completed through the plan's website process.
  - This is true regardless of when a plan ultimately retrieves or downloads the request.

What is the "Application Date" for Employer Groups

- For all enrollments into employer group plans the application date used on the transaction submitted to CMS will always be the 1st of the month prior to the effective date of enrollment for all mechanisms at all times.
  - For the purposes of providing notices and meeting other timeframe requirements provided in this guidance, use the date the organization receives the request.
  - For example:
    A group enrollment request is received on January 24th for a February 1st effective date.
    - the receipt date for the provision of required notices is January 24th
    - the application date submitted for the enrollment transaction is January 1st.

What is the "Application Date"

- For "auto" or "facilitated" enrollment, the application date is the first day of the month prior to the effective date of the auto/facilitated enrollment.
  - This will ensure that any subsequent beneficiary generated enrollment request will supersede the auto or facilitated enrollment in CMS systems.
- CMS may require MA organizations to submit crosswalk transactions as part of the transition from one contract year to another.
  - The application date must be set to November 14th of the current year, with an effective date of the following January 1st and the election period identifier value of "X."

Dual Eligibility

What does it mean to be Dual Eligible?

The term Dual Eligible is used to describe an individual who has both Medicare and Medicaid coverage.

- The following chart describes the various categories dual eligibility.

Type of Medicaid Benefit				
Dual Eligible Category	**Part A Premium**	**Part B Premium**	**Medicare cost-sharing**	**Full Medicaid Benefits**
Medicaid Only	No	Yes	No	**Yes**
QMB	Yes	Yes	**Yes**	No
QMB Plus	Yes	Yes	**Yes**	**Yes**
SLMB	No	Yes	No	No
SLMB Plus	No	Yes	No	**Yes**
QI	No	Yes	No	No
QDWI	Yes	No	No	No

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Dual Eligibility Terminology

- Medicaid Only: Eligible for Medicaid benefits but do not meet the income or resource criteria for QMB or SLMB.
- Qualified Medicare Beneficiary (QMB): Entitled to Medicare Part A, an income of 100% Federal Poverty Level (FPL) or less, and resources not exceeding twice the SSI limit.
- Specified Low-income Medicare Beneficiary (SLMB): Entitled to Medicare Part A, income above 100% FPL but less than 120% FPL, and resources not exceeding twice the SSI limit.
- Qualifying Individual (QI): Entitled to Medicare Part A, income at least 120% FPL but less than 135% FPL, resources that do not exceed twice the SSI limit and not otherwise eligible for Medicaid benefits.
- Qualified Disabled and Working Individual (QDWI): Lost Medicare Part A benefits due to return to work, but is eligible to enroll in and purchase Medicare Part A. Must have income of 200% FPL or less and resources that do not exceed twice the SSI limit and not otherwise eligible for Medicaid benefits.
- QMB Plus and SLMB Plus categories were created to eliminate the requirement that QMBs and SLMBs could not otherwise qualify for Medicaid.

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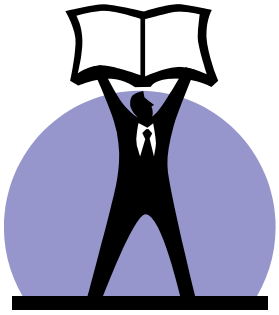
Other Common Terminology



Accrete and Accretion

- The term accrete is a term used in the Health Insurance Industry and although it is not specific to Medicare, it is commonly used to describe the enrollment file that we submit to CMS.
- The exact definition of accrete according to the Merriam Webster Dictionary is: to grow or become attached by **accretion**.
  - An example of the word in use: Plans are required to accrete an enrollment request to CMS within 7 calendar days of receipt.

Institutionalized Individuals

- Institutionalized Individuals are defined as those who reside in one of the following institutions:
  - Skilled nursing facility (SNF)
  - Nursing facility (NF)
  - Intermediate care facility for the mentally retarded (ICF/MR)
  - Psychiatric hospital or unit
  - Rehabilitation hospital or unit
  - Long-term care hospital
  - A swing-bed hospital

Involuntary Disenrollment

- An Involuntary Disenrollment is when the plan, as opposed to the member, initiates disenrollment from the plan.
  - Certain involuntary disenrollments are mandatory, in that the member is no longer eligible to remain enrolled in the plan.
  - The following are circumstances in which a plan ***must*** involuntarily disenroll a member.
    - A permanent change of residence outside the plan service area
      - for PDP and MA-PD plans, this includes incarceration
    - The member loses entitlement Medicare.
    - The member of a SNP that loses their special needs status.
    - The member dies.
    - The MAO or PDP Sponsor contract is terminated, or the plan *reduces the service* area *to exclude the member*.

Involuntary Disenrollment

- Certain involuntary disenrollments are ***optional*** for the plan.
- The following are circumstances in which a plan ***may*** involuntarily disenroll a member.
  - The member's premiums are not paid on a timely basis
  - The member engages in disruptive behavior
  - The member provides fraudulent information on an enrollment request, or if the member permits abuse of an enrollment card
- If a plan chooses to use any of these optional involuntary disenrollment circumstances, it must develop a process and apply the process equally amongst all membership.
  - For example: If a plan decides to disenroll members due to failure to pay plan premiums, they must follow the process for all members who fail to pay premiums.

Late Enrollment Penalty (LEP)

- Medicare beneficiaries may incur a late enrollment penalty (LEP) if
  - they delay enrollment into a Medicare Part D plan *or*
  - they have a continuous period of 63 days or more during which the individual was eligible for Medicare Part D but was not enrolled in a Medicare Part D plan *and*
  - they did not have any creditable prescription drug coverage.
- What is "Creditable prescription drug coverage"?
  - It is prescription drug coverage that is expected to pay at least as much as Medicare's standard prescription drug coverage.
- Some examples of Creditable prescription drug coverage includes:
  - some employer-based prescription drug coverage, including the Federal Employees Health Benefits (FEHB) Program;
  - Qualified State Pharmaceutical Assistance Programs (SPAPs);
  - Military-related coverage (e.g., VA, TRICARE)

Low Income Subsidy (LIS)

What is Low Income Subsidy (LIS)?

- Medicare beneficiaries who have limited income and resources may qualify for extra help to pay for prescription drugs costs.
  - This "low-income subsidy (LIS)" from Medicare provides financial assistance for beneficiaries who have limited income and resources.
  - Those who are eligible for LIS will get help paying for their monthly premium, yearly deductible, prescription coinsurance and copayments and will have no gap in their coverage.
- LIS is applicable to Part D only.
  - This includes PDP and MAPD plans.

Low Income Subsidy

- There are two ways a Medicare beneficiary can qualify for Low Income Subsidy.

1. They can apply at either their local Medicaid office or with the Social Security Administration.
   - The respective agency reviewing the application will *determine* if they are eligible for LIS.
   - Thus the term used for this process is **"determining"**
2. They may automatically qualify or be "deemed" eligible for LIS by having already applied and qualified for other federal programs, such as for state Medicaid benefits.
   - The term for individuals who automatically qualify for LIS is "deemed".

Low Income Subsidy

- CMS uses the term "Other Low Income Subsidy (LIS) Eligible Individuals" to describe the individuals who
  - are "determined" eligible for LIS
  - are "deemed" eligible for LIS by virtue of having QMB-only, SLMB-only, QI, SSI-only;
  - Note: this excludes those who are not full-benefit dual eligible individuals.

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Retroactive Processing Contractor (RPC)

- There may be times when we must request CMS to enroll or disenroll a member retroactively.
  - When this occurs we may submit retroactive enrollment or disenrollment requests to the Retroactive Processing Contractor in accordance with CMS regulations.
- The current RPC is Reed & Associates.
  - Reed & Associates was designated by CMS as the national contractor responsible for processing retroactive transactions.
  - They are a separate entity that does not have any affiliation with Essence.
  - You can learn more about Reed & Associates on their website at: http://www.reedassociates.org/payvalMMCPV.php

ESSENCE

State Health Insurance assistance Program (SHIP)

- The State Health Insurance Assistance Program (SHIP), is a state-based program that offers counseling and assistance to people with Medicare and their families.
- Through CMS funded grants directed to states, SHIPs provide free assistance via telephone and face-to-face interactive sessions, public education presentations, programs, and media activities.
- SHIPs were originally established to address the confusion caused by the increase in choices of Medicare supplemental insurance.
- Since the program's inception the role of the SHIPs in serving people with Medicare has greatly expanded.
  - Today, trained counselors offer information on a wide range of Medicare and Medigap matters, including
    - enrollment in Medicare prescription drug plans,
    - Medicare Advantage options,
    - claims and billing problem resolution,
    - Information on public benefit programs for those with limited income and
    - Information to Medicare beneficiaries about fraud and abuse.

State Pharmaceutical Assistance Program (SPAP)

- A State Pharmaceutical Assistance Program (SPAP) is a state-financed and state-administered program providing pharmaceutical assistance to certain populations, most often seniors.
- A SPAP may be considered a "qualified SPAP" if they
  - Provide financial assistance for the purchase or provision of prescription drug coverage or benefits;
  - Provide assistance to Part D eligible individuals in all Part D plans without discriminating based upon the Part D plan in which an individual enrolls;
  - Meets COB requirements;

Qualified SPAPs by State as of 2/17/09 (states A-Ne)	
State/Territory	**Program Names**
Colorado	Colorado Ryan White Title II ADAP
Connecticut	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE)
Delaware	Chronic Renal Disease Program; Prescription Assistance Program
Idaho	IDAGAP
Illinois	Illinois Cares Rx
Indiana	Hoosier Rx
Maine	Low Cost Drugs for the Elderly and Disabled Program
Maryland	Kidney Disease Program of Maryland; Maryland Senior Prescription Drug Assistance Program
Massachusetts	Prescription Advantage
Missouri	Missouri Rx Plan
Montana	Big Sky Rx Program; Montana Mental Health Program
Nevada	Disability Rx Program; Senior Rx Program
New Jersey	Prescription Assistance to the Aged and Disabled Program (PAAD); Senior Gold; General Public Assistance Program Medicare D Wraparound
New York	Elderly Pharmaceutical Insurance Coverage (EPIC)

Qualified SPAPs by State as of 2/17/09 (states No-Z)	
State/Territory	**Program Names**
North Carolina	NCRx
Pennsylvania	Pharmaceutical Assistance Contract for the Elderly (PACE); PACE Needs Enhancement Tier (PACENET); Pennsylvania Chronic Renal Disease Program and General Assistance Program; Special Pharmaceutical Benefits Program
Rhode Island	Rhode Island Prescription Assistance for the Elderly (RIPAE)
South Carolina	Gap Assistance Program for Seniors (GAPS)
Texas	Kidney Health Care Program; HIV SPAP
US Virgin Islands	Senior Citizens Affairs Pharmaceutical Assistance Program
Vermont	V-Pharm
Virginia	Virginia Department of Health HIV SPAP; DMHMRSAS Community SPAP
Washington	Washington State Health Insurance Pharmacy Assistance Program
Wisconsin	Chronic Renal Disease; Cystic Fibrosis Program; Health Insurance Risk Sharing Plan (HIRSP); Hemophilia Home Care; SeniorCare

Resources

- Centers for Medicare & Medicaid Website
  - http://www.cms.hhs.gov/
- Medicare Managed Care Manual, Chapter 2
  - http://www.cms.hhs.gov/MedicareMangCareEligEnrol/Downloads/2009MAenrollmentguidance.pdf
- Plan Communications User Guide (PCUG) and Appendices
  - http://www.cms.hhs.gov/MMAHelp/02_Plan_Communications_User_Guide.asp#TopOfPage
- HPMS Memos
- Code of Federal Regulations
  - 42 CFR 423.464 (e)

QUESTIONS