RESOURCES

THIRD PARTY RESOURCES

NOTE: Enrollment in Medicare is a condition of eligibility for Medicaid.

Beginning in 2006, persons entitled to Part A and/or enrolled in Part B are eligible for the prescription drug program, Medicare Part D. The Part D prescription drug program is insurance coverage offered by insurance companies and other private companies and covers 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). 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 replaced Medicaid as the primary pharmacy coverage for dual eligible recipients. All dual eligibles are required to enroll and remain enrolled in a Medicare prescription drug plan. An exception to this rule is applied in situations where it is determined that the Medicaid applicant/recipient has cost effective health insurance AND will lose that insurance if the recipient enrolls in Part D.

NOTE: This good cause exception will not be allowed in instances where Medicaid has been furnished to an individual whose legally responsible relative has failed or refused to provide medical support.

Medicare individuals who are eligible for Medicare Part A or Part B who are eligible for the QMB, SLIMB, or QI programs or are eligible for Medicaid based on a spenddown are deemed eligible for a subsidy to assist with the premiums, deductibles and co-payments of the Part D program.

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

RESOURCES

THIRD PARTY RESOURCES

- 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 coinsurance;
- No "donut hole" (the amount of out-of-pocket drug costs that standard beneficiaries are required to pay once their initial coverage limit is reached);
- Co-payment for generic and brand drugs (See **REFERENCE** CO-PAYMENT);
- 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. Medicaid recipients residing in other group residences such as Assisted Living Facilities (ALPs), group homes, and adult homes are subject to co-payments.

Spenddown recipients may apply out-of-pocket Part D premiums, coinsurance and deductibles or co-payments to meet a spenddown for the initial month only. Thereafter only the premium paid over the full subsidy amount is allowed as a deduction and copayments may be used to off-set the spenddown. Additionally Medical expenses other than prescription drug costs may continue to be used to meet the spenddown.

Chronic care recipients may only deduct the premium amount that exceeds the full subsidy amount.

MEDICARE ADVANTAGE PLANS (sometimes referred to as Medicare Part C or Medicare Managed Care, or Medicare HMOs) are health plan options available to Medicare beneficiaries. In order to enroll in a Medicare Advantage Plan, the individual must have both Medicare Part A and Part B. Individuals who join these plans receive their Medicare-covered health care through the plan. The plans may or may not include prescription drug coverage. In most of the plans there are additional services and lower co-payments than in the Medicare Program (traditional fee-for-service). Co-payments and premiums can vary by plan. Enrollment in Medicare Advantage Plans is voluntary.

RESOURCES

THIRD PARTY RESOURCES

Enrollees may have to see doctors who participate in the plan or go to certain hospitals to get Medicare covered services. However, there is **NO** requirement for a Medicaid recipient who has enrolled in a Medicare Managed Care Plan to only receive services from the Medicare Managed Care Plan. If an applicant receives a Medicaid covered service from a provider who is enrolled in Medicaid, but does not participate in the recipient's Medicare Managed Care Plan, Medicaid will cover the service.

When a Medicaid recipient is enrolled in the Medicare Buy-In System in eMedNY, and the plan charges a reduced Part B premium, the State is only charged for the lesser amount. If a Medicaid recipient is enrolled in a Plan that charges a premium that is higher than the traditional Part B premium, the local district must pay the difference as a health insurance premium when it has been determined to be cost effective. Medicare Advantage Plan premiums may also be used to meet a spenddown obligation, or may be used as a deduction from income in the determination of eligibility.

Medicaid must pay all deductibles, coinsurance and co-payments for Medicaid recipients enrolled in a Medicare Advantage Plan as long as the provider is also a Medicaid enrolled provider.

Not all Medicare Advantage prescription drug pans offer benchmark plans (a plan that is available to dual eligibles at no cost). Dual eligibles who are enrolled in certain Medicare Advantage Plans may have to pay an additional monthly premium for the prescription drug benefit. If a dual eligible does not want to pay the higher cost, they must disenroll from that Medicare Advantage Plan and choose a different Medicare Advantage Plan or choose traditional fee-for-service Medicare along with a stand-alone prescription drug plan that is a bench mark plan.

Individuals are responsible to pay the Medicare Part D co-payments regardless of whether they receive their drug benefit through a Medicare Advantage Plan or a stand-alone prescription drug plan. Part D co-payments or Part D premiums cannot be submitted to Medicaid for payment or reimbursement. However, such costs may be used to meet a spenddown obligation.

MEDICAID ADVANTAGE AND MEDICAID ADVANTAGE PLUS PLANS are two integrated care plans designed for dual eligible

recipients. Both plans allow dual eligibles to enroll in the same health plan for most of their Medicare and Medicaid benefits.

Both plans achieve integration of Medicare and Medicaid through a State contract with Medicare Advantage Plans (or Medicare Advantage Special Needs Plans) to provide a defined set of Medicaid wrap-around benefits to dual eligible enrollees on a capitated basis. The Medicaid Advantage Plan benefit includes acute care services not covered by Medicare; the Medicaid Advantage Plus Plan benefit also covers Medicaid long-term care benefits.

To enroll in a Medicaid Advantage Plus Plan, recipients must be eligible for nursing home level of care. If such individuals are residing in the community, they must document current resources and be otherwise eligible in order to participate. If the person enters a nursing home for other than short term rehabilitation, s/he must document resources for the lookback period in order to continue to be eligible to participate.

Dual eligible beneficiaries may enroll in the same managed care organization's Medicare Advantage Plan or Medicare Advantage Special Needs Plan (SNP) and corresponding Medicaid Advantage or Medicaid Advantage Plus Plan product. The Managed Care Organization (MCO) receives two capitation payments; one from CMS for the Medicare Advantage product and one from the State for the Medicaid Advantage or Medicaid Advantage Plus product. Because the State pays the plan directly for any recipient cost-sharing associated with the Medicare Advantage product, Medicaid will not pay Medicaid enrolled providers for co-payments or deductibles for covered benefits for recipients enrolled in Medicaid advantage or Medicaid Advantage Plus. However, enrollees in Medicaid Advantage or Medicaid Advantage Plus are entitled to all Medicaid services they would normally get under the State Medicaid Plan. Therefore, any Medicaid services not included in the combined Medicare and Medicaid Advantage or Medicaid Advantage Plus benefit package offered by the health plan continue to be available to the enrollee when provided by any Medicaid enrolled provider on a Medicaid fee-for-service basis.

RESOURCES

THIRD PARTY RESOURCES

Participation by Medicare Advantage Plans or SNPs in Medicaid Advantage or Medicaid Advantage Plus is voluntary. Enrollment in these integrated plans by dual eligibles is also voluntary, and is not limited to the open enrollment period. Medicaid Advantage Plus Plans may also enroll individuals who have a spenddown.