



**CMS 2010 BI-REGIONAL MEDICARE HEALTH PLAN COMPLIANCE  
CONFERENCE**

**Boston & New York – Serving Our Beneficiaries Together**

Verbatim Transcript  
Medicare Part D – Pharmacy Updates  
Dayle Berke, John Cocchiara, Adele Pietrantonio

>> GOOD AFTERNOON,  
AND WELCOME

TO MEDICARE PART D  
PHARMACY UPDATES.

IF YOU'RE HERE  
FOR A DIFFERENT WORKSHOP,

YOU DON'T WANT TO BE  
IN THIS ROOM.

YOU PROBABLY WANT  
TO BE NEXT DOOR.

HI, COME ON IN.

WE'RE JUST STARTING.

WE'RE REALLY LUCKY TO HAVE  
2 VERY SPECIAL AND TALENTED

PEOPLE WITH US TODAY.

ADELE--ADELE PIETRANTONI  
JOINED CMS

IN 2005 AS REGIONAL PHARMACIST  
IN THE BOSTON OFFICE,

WHERE SHE PLAYED A KEY ROLE  
IN THE IMPLEMENTATION

OF THE MEDICARE  
PRESCRIPTION DRUG BENEFIT.

SHE SERVES AS LIAISON  
TO PHARMACISTS,

BENEFICIARY ADVOCATES, AND  
PARTNERS THROUGHOUT THE REGION.

ADDITIONALLY, SHE WORKS  
CLOSELY WITH OTHER CMS STAFF

IN THE OVERSIGHT  
OF THE PART D BENEFIT.

PRIOR TO COMING TO CMS,

ADELE WORKED FOR A NOT-FOR-  
PROFIT MASSACHUSETTS HMO

AS MANAGER, CLINICAL  
PHARMACY PROGRAMS,

WHERE SHE WAS RESPONSIBLE  
FOR THE CLINICAL

AND REGULATORY ASPECTS OF  
THE PLAN'S PHARMACY BENEFITS.

ADELE RECEIVED A B.A.  
FROM BOSTON COLLEGE

IN COMMUNICATION AND ENGLISH,

AND A B.S. IN PHARMACY  
FROM THE MASSACHUSETTS COLLEGE

OF PHARMACY AND HEALTH  
SCIENCES IN BOSTON.

SHE ALSO COMPLETED  
A PHARMACY RESIDENCY

IN MANAGED CARE PHARMACY  
AND HAS EXPERIENCE

AS A COMMUNITY PHARMACIST  
IN A CHAIN SETTING.

SHE'S ACTIVE IN PROFESSIONAL  
PHARMACIST ASSOCIATIONS

AND HAS BEEN HONORED  
WITH SEVERAL AWARDS,

INCLUDING THE MASSACHUSETTS  
PHARMACISTS ASSOCIATION

PRESIDENT'S PHARMACIST OF  
THE YEAR IN 2002 AND 2004,

AS WELL AS BEING  
NAMED FELLOW

OF THE AMERICAN PHARMACISTS  
ASSOCIATION IN 2006.

JOHN COCCHIARA IS CURRENTLY  
SERVING AS SPECIAL ASSISTANT

TO THE CONSORTIUM  
ADMINISTRATOR FOR MEDICARE

HEALTH PLAN OPERATIONS  
AT CMS IN THE, UM...

AND RESIDES IN THE NEW YORK  
REGIONAL OFFICE.

IN HIS ROLE, HE SERVES AS  
CMS'S LEAD REGIONAL PHARMACIST

FOR THE MEDICARE  
PRESCRIPTION DRUG PROGRAM,

WITH INVOLVEMENT  
IN OTHER VARIOUS MEDICARE

PHARMACY-RELATED INITIATIVES.

JOHN INITIALLY JOINED  
CMS IN EARLY 2005

AS A NEW YORK REGIONAL  
PHARMACIST CONSULTANT

IN THE DIVISION  
OF MEDICARE OPERATIONS

AND WAS CHARGED WITH ASSISTING

IN THE IMPLEMENTATION OF  
THE MEDICARE PART D PROGRAM.

HIS CONTRIBUTIONS  
HAVE BEEN RECOGNIZED

BY THE U.S. DEPARTMENT  
OF HEALTH AND HUMAN SERVICES,

THE CMS ADMINISTRATOR,

AND THE NEW YORK CITY  
FEDERAL EXECUTIVE BOARD.

PRIOR TO GOING TO CMS,

HE WAS PRACTICING AS  
A REGISTERED PHARMACIST

FOR 20 YEARS.

HIS AREAS OF EXPERTISE ARE  
IN THE OPERATIONAL MANAGEMENT

OF LONG-TERM CARE  
AND COMMUNITY PHARMACY.

HE HAS DEVELOPED, MANAGED,  
AND DIRECTED OPERATIONS

IN RETAIL PHARMACY SETTINGS,

AS WELL AS INSTITUTIONAL  
AND NON-INSTITUTIONAL

LONG-TERM CARE  
PHARMACY SETTINGS.

JOHN GRADUATED FROM THE ARNOLD  
AND MARIE SCHWARTZ COLLEGE

OF PHARMACY AND WAS

THE RECIPIENT OF THE 2007

DANIEL STATEMAN DISTINGUISHED  
ALUMNUS AWARD.

PLEASE JOIN ME IN  
WELCOMING ADELE AND JOHN.

[APPLAUSE]

>> THANK YOU  
VERY MUCH, DAYLE.

I'M ADELE PIETRANTONI,

AND I'M THE PHARMACIST  
IN THE BOSTON REGIONAL OFFICE,

SO WELCOME TO ALL OF YOU,

AND THANK YOU  
FOR BEING HERE.

UH, BRIEFLY, THIS IS OUR  
AGENDA FOR THIS SESSION.

WE'RE GOING TO TALK A BIT  
ABOUT PLANNED BENEFIT CHANGES,

SUPPLEMENTAL FILE CHANGES,  
BENEFIT REVIEW, COMPLIANCE,

SOME TRANSITION REQUIREMENT  
SCENARIOS, AND, FINALLY,

JUST BRIEFLY TOUCH ON  
THE MEDICARE COVERAGE GAP

DISCOUNT PROGRAM.

I WILL BE TALKING ABOUT THE  
FIRST 3 ITEMS ON THE AGENDA,

AND JOHN WILL TAKE OVER  
AND TALK ABOUT MOST

OF THE REMAINING  
ITEMS ON THE AGENDA.

THE--THE AGENDA REALLY

IS FOCUSED--

THE FIRST PART OF IT--

ON THE APRIL 16 HPMS MEMO  
FOR PBP SUBMISSION AND REVIEW

REQUIREMENTS, WHICH REALLY  
ADDRESS SOME PROVISIONS

FROM THE AFFORDABLE CARE ACT

IF AMENDED BY THE  
RECONCILIATION ACT,

AS WELL AS THE FINAL  
REGULATIONS THAT CMS PUBLISHED

ON APRIL 6 THAT MADE A NUMBER  
OF REVISIONS TO THE PARTS C

AND D PROGRAM,  
PARTICULARLY TO MAKE SURE

THAT DIFFERENT PBPs PROVIDED  
MEANINGFULLY DIFFERENT BENEFITS

AND THAT COST-SHARING DESIGNS  
ARE NOT DISCRIMINATORY.

SO, THE FIRST SECTION HERE  
TALKING ABOUT THE PBP CHANGES

IS GOING TO--THESE  
ARE REQUIREMENTS

FOR YOUR SUBMISSIONS THAT WILL  
HELP MEET THOSE REQUIREMENTS.

SO THE FIRST AREA THAT I'D  
LIKE TO TOUCH ON IS THE NUMBER

OF TIERS FOR 2010--2011,  
EXCUSE ME--WE WILL ALLOW

A MAXIMUM OF 6 TIERS PER PBP,  
AND WE WOULD ENCOURAGE FEWER.

AND THE REASON WE'RE LOOKING  
AT THIS AND THE REASON WE'RE

DOING THIS IS BECAUSE CMS HAS  
RECEIVED NUMEROUS COMPLAINTS

FROM BENEFICIARY AND  
BENEFICIARY ADVOCATES,

AND THEY'VE RAISED CONCERNS  
THAT THE LARGE NUMBER

OF DRUG TIERS AND  
NON-STANDARDIZED LABELING

IS CONFUSING WHEN  
BENEFICIARIES ARE TRYING

TO MAKE A SELECTION AND CHOOSE  
AMONG VARIOUS PLAN OFFERINGS.

SO, AGAIN, FOR THOSE PLANS-  
OTHER THAN DEFINED STANDARD

THAT HAVE TIERS, THEY'LL  
BE A MAXIMUM OF 6 TIERS.

ADDITIONALLY,  
TO FURTHER ENSURE

THAT THERE'S STANDARDIZATION,

WE ARE STANDARDIZING  
THE LABELS.

THESE LABELS WILL  
BE DERIVED IN PART

FROM THE MOST COMMON  
DRUG TIER NAMES USED

BY SPONSORS IN THE 2010  
BID PROCESS.

AND I WANT TO REMIND YOU HERE  
THAT THE SPECIALTY TIER--

THE DOLLAR THRESHOLD LIMIT  
FOR THAT TIER IS STILL \$600.

THERE'LL BE A DROP-DOWN MENU,

YOU'LL SELECT  
YOUR TIER DESIGNATIONS,

AND IF YOUR TIER TYPE  
IS A SPECIALTY--

IF YOU HAVE SPECIALTY  
DRUGS IN THAT TIER,

YOU NEED TO DESIGNATE IT  
AS A SPECIALTY TIER.

THESE LABELS WILL APPEAR  
IN YOUR SUMMARY OF BENEFITS,

AS WELL AS BE REFLECTED IN  
THE MEDICARE PRESCRIPTION DRUG

PLAN FINDER TOOL.

ANOTHER AREA WHERE  
WE WILL BE STANDARDIZING

THE LABEL DESCRIPTIONS, IF YOU  
WILL, IS IN THE COVERAGE GAP.

WE WILL BE STANDARDIZING  
THE GAP COVERAGE LEVEL

DESCRIPTIONS AND THEY WILL--

THAT STANDARDIZATION WILL BE  
BASED ON THE PERCENTAGE

OF DRUGS--FORMULARY DRUGS--

THAT ARE COVERED THROUGH THE  
GAP, EXCLUSIVE OF THOSE DRUGS,

THE GENERIC DRUGS,  
THAT YOU'RE REQUIRED

TO COVER AT 7% IN THE GAP.

SO IT'S OVER AND ABOVE THOSE.

AND I'D LIKE TO TAKE THIS  
OPPORTUNITY TO REMIND YOU

THAT A GENERIC DRUG



IS DEFINED IN REGULATION

AS THOSE DRUGS THAT  
HAVE AN ABBREVIATED

NEW DRUG APPLICATION,

THAT WERE APPROVED BY THE FOOD  
AND DRUG ADMINISTRATION

UNDER AN ABBREVIATED  
NEW DRUG APPLICATION.

THE INNOVATIVE DRUG WOULD  
USE A NEW DRUG APPLICATION.

THE GENERICS USE AN ABBREVIATED  
NEW DRUG APPLICATION.

SO REGARDLESS OF WHERE  
THAT PARTICULAR DRUG IS

ON A SPONSOR'S FORMULARY,  
THROUGH THE COVERAGE GAP,

YOU WILL NEED TO COVER  
THAT AT 7%.

SO WHAT ARE THOSE  
COVERAGE GAP DESCRIPTIONS?

WELL, THEY'RE CONSISTENT WITH  
WHAT WE USED THIS YEAR IN 2010

AND THEY RANGE FROM 100%  
COVERAGE--WHICH IS,

OF COURSE, SELF-EXPLANATORY.

AND THEN YOU CAN SEE THAT IT  
GOES ALL THE WAY DOWN TO ZERO,

AND THOSE ARE FOR GAP COVERAGE

WHERE FEWER THAN 15 DRUGS  
ARE COVERED.

AGAIN, REFLECTING ADDITIONAL  
COVERAGE OVER THAT 7%

COVERAGE THAT'S REQUIRED,  
AND THE EXCLUDED DRUGS THAT

YOU COVER IN A SUPPLEMENTAL  
BENEFIT WILL NOT BE INCLUDED

IN THE DETERMINATION HERE.

NOW RELATIVE TO THIS, CMS WILL  
BE CALCULATING AND ASSIGNING

A DESCRIPTION TO YOUR GAP  
COVERAGE BASED ON THE NUMBER

OF DRUGS THAT YOU SUBMIT AS  
BEING COVERED DURING THE GAP.

SO YOU WON'T BE ENTERING THOSE  
DESCRIPTIONS INTO YOUR PBP.

AND IN THE SUMMER THERE WILL  
BE A REPORT AVAILABLE FOR YOU

TO SEE HOW CMS HAS DESIGNATED  
THOSE GAP COVERAGE TIERS--

OR LEVELS, EXCUSE ME.

NOW I KNOW THERE ARE  
A LOT OF MA-PD SPONSORS,

AND, AS YOU ALL ARE AWARE,

YOU'RE REQUIRED  
TO OFFER A PRESCRIPTION DRUG

BENEFIT THROUGHOUT YOUR  
SERVICE AREA, AND YOU CAN

EITHER HAVE  
A BASIC PART D PLAN,

OR ENHANCED  
ALTERNATIVE PLAN.

WHEN YOU DO AN EITHER/OR  
SITUATION LIKE THAT,

YOU NEED TO MAKE SURE  
THAT YOU'RE USING

YOUR MA SUPPLEMENTAL PAYMENT  
TO, UH, TO--YOU'RE USING

YOUR MA PAYMENT  
TO COVER THE PREMIUM

FOR THE SUPPLEMENTAL  
COVERAGE ON THE PART D SIDE.

SO THERE WILL BE 2 QUESTIONS  
IN THE PBP THAT WILL ASK YOU

ABOUT THIS TO ENSURE THAT  
YOU ARE BEING COMPLIANT

WITH THIS REQUIREMENT.

NOW, ANOTHER PBP CHANGE  
AND REQUIREMENT IN THE PBP

SUBMISSION WILL BE THE  
OVER-THE-COUNTER DRUGS,

THE UTILIZATION MANAGEMENT  
OF OVER-THE-COUNTER DRUGS.

SO PART D SPONSORS MAY OFFER  
OVER-THE-COUNTER DRUGS

AS EITHER PART OF A GENERAL  
STEP THERAPY PROGRAM

OR A GENERAL DRUG UTILIZATION  
MANAGEMENT PROGRAM.

AND I WILL BE DISCUSSING  
THIS A LITTLE BIT FURTHER

WHEN WE TALK ABOUT SOME  
SUPPLEMENTAL FILE CHANGES.

ADDITIONALLY, MA-PD  
SPONSORS MUST PROVIDE

AN ATTESTATION STATEMENT TO  
ATTEST THAT YOU'RE NOT COVERING

THE SAME DRUGS,  
OVER-THE-COUNTER DRUGS,

IN PART C AS  
YOU ARE IN PART D.

>> AND, FINALLY,  
IN THE PBP SECTION

OF THIS PRESENTATION,  
THE PART D NOTE SECTION,

WE ARE LIMITING THAT  
TO 225 CHARACTERS.

AND THIS LIMITATION WAS ADDED  
SINCE INFORMATION PREVIOUSLY

SUBMITTED THIS WAY,  
SUCH AS OVER-THE-COUNTER DRUGS

AND HOME INFUSION DRUGS,  
WILL NOW BE SUBMITTED

ON SUPPLEMENTAL FILES,  
WHICH I WILL BE DISCUSSING

IN THE NEXT SECTION.

SO IN SUPPLEMENTAL FILE  
CHANGES I'M GOING TO TALK

SPECIFICALLY ABOUT  
HOME INFUSION DRUGS

AND OVER-THE-COUNTER DRUGS.

FIRST, OVER-THE-COUNTER DRUGS--

EXCUSE ME, HOME INFUSION  
DRUGS--YOU CAN BUNDLE THEM

AS PART OF A PART C  
MANDATORY BENEFIT,

AND IF YOU ELECT  
THE BUNDLING OPTION,

YOU ARE REQUIRED TO APPLY  
THIS COVERAGE CONSISTENTLY.

CHANGES TO HOME INFUSION

COVERAGE ARE ONLY PERMITTED

WHEN YOU SUBMIT THEM AND THEY  
GET APPROVED IN ACCORDANCE

WITH CMS GUIDANCE  
REGARDING FORMULARY CHANGES.

SO, AGAIN, IF YOU BUNDLE  
HOME INFUSION DRUGS

UNDER YOUR PART C BENEFIT,  
YOU NEED TO SUBMIT IT

AND COMPLY WITH FORMULARY  
COVERAGE RULES.

THE OVER-THE-COUNTER  
SUPPLEMENTAL FILE--

IF YOU ELECT TO COVER  
OVER-THE-COUNTERS

AS PART OF STEP THERAPY

OR A GENERAL DRUG UTILIZATION  
MANAGEMENT PROGRAM,

YOU NEED TO SUBMIT THEM  
IN A SUPPLEMENTAL FILE.

AND THAT LAYOUT INCLUDES  
THE TYPE OF STEP THERAPY

THAT YOU'LL BE USING THOSE  
OVER-THE-COUNTERS WITH.

AND ALSO INCLUDES  
THE STEP THERAPY FIELDS

NOW THE OVER-THE-COUNTER  
STEP THERAPY INFORMATION

MUST BE CONSISTENT WITH WHAT  
YOU SUBMIT IN YOUR PBP

AND FORMULARY  
FILE INFORMATION.

INCONSISTENT SUBMISSIONS

WILL BE REJECTED BY CMS.

SO REALLY THE MEAT OF THAT  
MEMO AT THE END OF APRIL

IS REALLY ABOUT  
THE BENEFIT REVIEW,

AND MEANINGFUL DIFFERENCES,

AND PART D COST SHARING  
NOT BEING DISCRIMINATORY.

SO, FIRST, WITH RESPECT  
TO MEANINGFUL DIFFERENCES,

PLAN OFFERINGS--CMS WILL BE  
ENSURING THAT THOSE PLAN

OFFERINGS UNDER THE MEDICARE  
PRESCRIPTION DRUG PROGRAM

ARE MEANINGFULLY DIFFERENT.

OUR GOAL IS TO ENCOURAGE  
ROBUST COMPETITION

WITHIN PART C AND D,  
WHILE PROVIDING CLEAR CHOICES

TO OUR BENEFICIARIES  
WITH LITTLE CONFUSION.

CMS HAS THE AUTHORITY  
TO REJECT ANY PLAN PACKAGES

WE JUDGE THAT ARE NOT  
IN THE BEST INTEREST

OF OUR BENEFICIARIES

FOR REASONS OF  
DISCRIMINATORY COST SHARING

OR CONFUSING BENEFIT DESIGN.

AND, AGAIN,  
THE OPERATIONAL ASPECTS

OF THIS WERE DISCUSSED

IN THE APRIL 16 MEMO.

WE ARE--IN THE SAME VEIN  
OF MEANINGFUL DIFFERENCES,

WE WILL ALSO BE CONDUCTING  
OUT-OF-POCKET COST COMPARISONS.

AND WE'LL CALCULATE  
THESE PLAN OFFERINGS

BY THE SAME SPONSOR  
IN A SERVICE AREA,

BY EVALUATING EXPECTED  
OUT-OF-POCKET COSTS

FOR EACH OFFERING, UTILIZING  
A UNIFORM BASKET OF DRUGS.

SO, AGAIN, IT'LL BE  
ESTIMATED BASED ON EACH

PART D SPONSOR'S BENEFIT DESIGN,

AND THE 2010 VALUES  
WILL BE AVAILABLE IN HPMS.

YOUR PDP OFFERINGS  
WITHIN A SERVICE AREA

NEED TO BE  
MEANINGFULLY DIFFERENT,

SO WE WILL BE COMPARING  
THE OUT-OF-POCKET COSTS

CALCULATED USING THAT  
MARKET BASKET OF DRUGS,

AND LOOKING  
TO MAKE SURE THAT THERE'S

AT LEAST A \$22  
A MONTH DIFFERENCE

IN OUT-OF-POCKET EXPENDITURES  
FOR A BENEFICIARY,

EXCLUSIVE

OF THEIR PREMIUM AMOUNTS.

AND IF THERE ARE PDPs OFFERED--  
2 ENHANCED PDPs ARE OFFERED,

THE SECOND MUST HAVE  
A HIGHER VALUE THAN THE FIRST,

AND INCLUDE COVERAGE OF SOME  
BRAND NAMES IN THE DRUGS--

SOME BRAND-NAME DRUGS  
IN THE COVERAGE GAP.

AND WE DEFINE "SOME"  
AS BEING 10-65%.

SO 10% YOU HAVE  
TO COVER SOME BRANDS,

IF YOU'RE GOING TO OFFER  
2 ENHANCED PDPs IN ORDER--

AND MEET ALL THE OTHER  
REQUIREMENTS FOR IT TO BE

MEANINGFULLY DIFFERENT.

WE WILL BE NEGOTIATING  
TO LIMIT SPONSORS TO NO MORE

THAN 3 STAND-ALONE OFFERINGS,

ONE BASIC PLAN,  
AND 2 ENHANCED PLANS.

ANOTHER AREA ON  
THE MEANINGFUL DIFFERENCES

ARE LOW ENROLLMENT PLANS,  
THE SUR WHERE THE MMA SET UP

CONTRACT LEVEL  
ENROLLMENT REQUIREMENTS

FOR PART D PLANS AT THE SAME  
LEVELS AS MA-PD PLANS.

SO 5,000 BENEFICIARIES  
TYPICALLY,



OR 1,500 IN A NON-URBAN AREA.

AND WE'LL BE LOOKING  
AT THE LOWEST 20% OF 2010 PLANS

THAT RANKED BY ENROLLMENT.

SO THOSE WITH THE LOWEST  
ENROLLMENTS,

WE'LL BE LOOKING AT THOSE.

AND THIS DOES NOT--THIS  
APPLIES TO NON-EMPLOYER PLANS.

SO, AGAIN, WE ENCOURAGE YOU  
TO TAKE A LOOK,

IF YOU ARE THE SPONSOR OF ANY  
OF THOSE LOW ENROLLMENT PLANS,

AND TAKE A LOOK  
AT CONSOLIDATING THEM,

OR WITHDRAWING THEM,

SO YOU CAN HAVE SOME  
MEANINGFUL DIFFERENCES.

FINALLY, RELATIVE TO PART D  
COST SHARING, UNDER THE MMA,

THE SECRETARY CAN ONLY  
APPROVE PLANS IF BENEFITS

ARE NOT LIKELY TO DISCOURAGE  
CERTAIN PART D ELIGIBLES.

BASED ON THAT AUTHORITY  
IN THE APRIL 6 REGULATIONS,

WE UPDATED THE REGULATIONS  
BY ADDING A NEW PARAGRAPH

THAT TIERED COST SHARING MAY  
NOT EXCEED LEVELS

DETERMINED ANNUALLY BY CMS.

SO THESE ARE  
THE DISCRIMINATORY--

THE SO-CALLED DISCRIMINATORY  
COST SHARING LEVELS.

SO IN 2010, THOSE THRESHOLDS  
ARE THERE AND YOU'RE FAMILIAR

WITH THOSE--TIER 1 BEING \$10,  
TIER 2 \$45, AND TIER 3 \$95.

AND WE WILL BE IDENTIFYING  
THE OUTLIERS BASED

ON THOSE THRESHOLDS.

AND NEW FOR 2011,

WE'LL BE PROVIDING--WE'LL BE  
HAVING INCREASED SCRUTINY

OF THE CO-INSURANCE TIERS.

SO THOSE THAT ARE A PERCENT  
CO-INSURANCE WILL BE MOVING

TO CONSISTENTLY COMPARE THE  
CO-PAYS AND THE CO-INSURANCE,

AND SEE  
THE COST SHARING IMPACT.

SO CONSISTENT WITH MEANINGFUL  
DIFFERENCES REVIEWS,

CMS WILL NOTIFY SPONSORS  
WHERE BENEFIT STRUCTURES

INCLUDE DRUG TIERS THAT EXCEED

OUR DISCRIMINATORY COST  
SHARING THRESHOLD LIMITS

AND CONDUCT NEGOTIATION  
CALLS AS APPLICABLE,

PRIOR TO BID APPROVAL.

SO THAT'S THE HIGHLIGHTS

OF THAT MEMO.

AND WITH THAT I WILL BRING  
UP MY COLLEAGUE, JOHN,

TO TALK FURTHER  
ABOUT COMPLIANCE.

>> THANK YOU, ADELE, AND THANK  
YOU ALL FOR COMING TODAY.

BASICALLY, MY PRESENTATION  
WILL SERVE AS A REVIEW.

THE MEAT OF THE PRESENTATION  
IS AROUND THE PLAN'S

REQUIREMENT TO MEET  
OUR TRANSITION POLICY.

COMPLIANCE.  
WHAT DOES THAT MEAN?

SPONSORS NEED TO BE  
COMPLIANT WITH CMS REGULATION

AND GUIDANCE--VERY SIMPLE.

SOME OF THE ACTION THAT CMS  
HAS TAKEN OVER THE PAST FEW

MONTHS AGAINST SPONSORS  
WERE RELATED

TO FORMULARY ADMINISTRATION.

THE ISSUES RELATED TO FAILURE  
TO ADD PROTECTED CLASS DRUGS

TO A PART D'S FORMULARY  
ON A TIMELY BASIS,

FAILURE TO ADHERE TO THE CMS  
TRANSITION POLICY, AND UTILIZING

UTILIZATION MANAGEMENT EDITS,  
SUCH AS PRIOR AUTHORIZATION

OR STEP THERAPY EDITS THAT  
WERE NOT APPROVED BY CMS.

ADDITIONALLY, WE HAVE SEEN  
MARKETING MATERIAL THAT IS NOT

CONSISTENT WITH THE SPONSOR'S  
APPROVED FORMULARIES,

FAILURE TO PROCESS POINT-OF-  
SALE DRUG CLAIMS IN ACCORDANCE

WITH APPROVED FORMULARIES,

AND, LASTLY, WE HAVE SEEN  
SPONSORS LACKING IN OVERSIGHT

OVER THEIR DELEGATED  
ENTITIES, LIKE THEIR PBM.

NOW I WILL REVIEW SOME OF  
THE KEY POINTS THAT ARE LISTED

IN CHAPTER 6, SECTION 30.4

OF THE MEDICARE PRESCRIPTION  
DRUG BENEFIT MANUAL.

A PLAN'S TRANSITION PROCESS  
MUST ADDRESS SITUATIONS

IN WHICH AN INDIVIDUAL FIRST  
PRESENT AT THE PARTICIPATING

PHARMACY WITH A PRESCRIPTION

FOR A DRUG THAT  
IS NOT ON THE FORMULARY.

THEY ARE UNAWARE OF WHAT  
IS COVERED BY THE PLAN

OR THE PLAN'S EXCEPTIONS PROCESS

TO PROVIDE ACCESS TO PART D  
DRUGS THAT ARE NOT COVERED.

PART D SPONSORS MUST  
PROVIDE A TEMPORARY SUPPLY

OF NON-FORMULARY DRUGS,  
INCLUDING FORMULARY DRUGS

HAVING PRIOR AUTHORIZATION  
AND STEP THERAPY

WHEN IT IS DETERMINED THAT

THE BENEFICIARY  
IS IN A TRANSITION.

BENEFICIARIES ARE IN  
TRANSITION WHEN THEY ARE NEW

TO THE MEDICARE BENEFIT,  
THEY ARE NEW ENROLLEES

FOR THE SPONSOR, AND WHEN THEY  
ARE IN A NEW TREATMENT SETTING.

THE TRANSITION SUPPLY MUST BE  
PROVIDED AT THE POINT-OF-SALE,

NOT DAYS LATER OR HOURS LATER.

WITHIN THE FIRST 90 DAYS OF  
ENROLLMENT, ENROLLEES THAT ARE

CHANGING PDPs OR THOSE  
THAT ARE NEWLY ELIGIBLE,

MUST BE AFFORDED  
A TEMPORARY 30-DAY REFILL

OF NON-FORMULARY DRUGS,

INCLUDING THOSE DRUGS WITH  
UTILIZATION MANAGEMENT EDITS.

IF AN ENROLLEE PRESENTS WITH  
A PRESCRIPTION FOR A QUANTITY

THAT IS LESS THAN  
A FULL 30-DAY SUPPLY,

THE SPONSOR MUST  
ALLOW FOR REFILLS

UP TO THAT 30-DAY SUPPLY.

SOME OF THE DIFFERENCES

TO THIS POLICY ARE FOR  
THE LONG-TERM CARE RESIDENTS.

THIS POPULATION MUST BE  
AFFORDED A 31-DAY SUPPLY,

PLUS MULTIPLE REFILLS  
TOTALING A 93-DAY SUPPLY.

SPONSORS HAVE 2 OPTIONS FOR  
TRANSITIONING ENROLLEES THAT

ROLLOVER INTO A NEW BENEFIT  
YEAR AND THEY ARE EXPERIENCING

A NEGATIVE FORMULARY CHANGE.

THE FIRST OPTION IS TO HAVE  
A TRANSITION PROCESS

THAT IS IN LINE WITH THAT

THAT THEY CURRENTLY UTILIZE  
FOR NEW ENROLLEES.

THIS INCLUDES PROVIDING THE  
TEMPORARY SUPPLY OF MEDICATION

AND MAILING THE CMS-APPROVED  
TRANSITION LETTER

WITHIN THE 3-BUSINESS DAY  
TIMEFRAME REQUIREMENT.

THE SECOND OPTION IS TO  
EFFECTUATE A TRANSITION PRIOR

TO THE START  
OF THE NEXT BENEFIT YEAR.

THIS CAN BE DONE BY  
PROSPECTIVELY TRANSITIONING

ENROLLEES TO A THERAPEUTICALLY  
APPROPRIATE FORMULARY

ALTERNATIVE, OR BY COMPLETING  
AN EXCEPTION REQUEST

FOR AN ENROLLEE.

IN THE EVENT THAT THIS OPTION  
DOES NOT PROVIDE A MEANINGFUL

TRANSITION, SPONSORS  
NEED TO OFFER ENROLLEES

A TRANSITION SUPPLY AS  
IF THEY WERE NEW ENROLLEES.

OVERALL, MOST SPONSORS UTILIZE  
THE NEW ENROLLEE TRANSITION

PROCESS FOR ROLLOVER  
BENEFICIARIES.

WHAT HAPPENS TO AN EXPIRING  
FORMULARY OR TIERING EXCEPTION

OF A CONTINUING BENEFICIARY

AT THE START OF  
A NEW BENEFIT YEAR?

SPONSORS CAN CHOOSE TO  
CONTINUE TO HONOR THAT GRANTED

EXCEPTION THROUGH  
THE NEXT BENEFIT YEAR.

IF THEY CHOOSE NOT TO DO SO,

THEY MUST NOTIFY THE ENROLLEE

AT LEAST 60 DAYS  
PRIOR TO THE END

OF THE CURRENT  
BENEFIT YEAR.

THESE BENEFICIARIES  
WOULD EITHER BE OFFERED

A PROSPECTIVE EXCEPTION  
OR A TRANSITION SUPPLY

AT THE START  
OF THAT BENEFIT YEAR.

SPONSORS NEED TO MAKE

ARRANGEMENTS TO CONTINUE

TO PROVIDE NECESSARY  
PART D DRUGS

TO ENROLLEES VIA AN EXTENSION  
OF THE TRANSITION PERIOD.

THIS SHOULD HAPPEN ON A CASE-  
BY-CASE BASIS TO THE EXTENT

THAT THEIR EXCEPTION REQUEST  
HAS NOT BEEN PROCESSED

BY THE END OF THE MINIMUM  
TRANSITION PERIOD,

AND UNTIL SUCH TIME  
AS A MEANINGFUL TRANSITION

HAS BEEN MADE.

LEVEL OF CARE CHANGES  
PERTAINS TO ENROLLEES

THAT MAY BE OUTSIDE  
OF A TRANSITION PERIOD

WHO ARE GOING FROM ONE  
TREATMENT SETTING TO ANOTHER.

THE MOST COMMON OF THESE  
LEVELS OF CARE CHANGES IS SEEN

WHEN A BENEFICIARY  
IS DISCHARGED

FROM A HOSPITAL SETTING.

IN AN EFFORT TO CONTINUE  
THERAPY AND TREATMENTS--

CURRENT THERAPIES AND  
TREATMENTS--PLANS ARE STRONGLY

ENCOURAGED TO IMPLEMENT  
A TRANSITION PROCESS

FOR ENROLLEES EXHIBITING  
A LEVEL OF CARE CHANGE.



LONG-TERM CARE RESIDENTS  
ARE REQUIRED TO RECEIVE

THEIR PRESCRIBED DRUGS  
WITHOUT DELAY.

OFTEN THAT MEANS WITHIN  
HOURS WHEN A NEW PRESCRIPTION  
IS WRITTEN.

AS A RESULT, THESE ENROLLEES  
ARE AFFORDED AN ADDITIONAL  
PROTECTION  
SOMETIMES REFERRED TO

AS THE LONG-TERM CARE  
EMERGENCY FIRST FILL.

THIS LONG-TERM CARE EMERGENCY  
SUPPLY SERVES AS AN EXTENSION

OF THE NORMAL TRANSITION  
PERIOD WHEN AN ENROLLEE

IS IN AN LTC SETTING  
AND HE OR SHE ARE OUTSIDE

THE NORMAL 90-DAY  
TRANSITION PERIOD.

THE SPONSOR MUST PROVIDE  
A MINIMUM OF A 31-DAY SUPPLY

OF A NON-FORMULARY DRUG,  
INCLUDING THOSE DRUGS

THAT ARE ON THE PLAN'S FORMULARY

BUT ALSO HAVE A UTILIZATION  
MANAGEMENT EDIT.

AS A REVIEW, THESE 6 CLASSES  
OF CLINICAL CONCERN ARE ALSO

SOMETIMES REFERRED  
TO AS THE PROTECTED CLASSES.

WE HAVE THE ANTICONVULSANTS,  
THE ANTIDEPRESSANTS,

THE CANCER DRUG OR  
THE ANTINEOPLASTIC DRUGS,

THE ANTIPSYCHOTIC DRUGS,

THE HIV/AIDS DRUGS, ALSO KNOWN  
AS THE ANTIRETROVIRAL DRUGS,

AND THE IMMUNOSUPPRESSANT  
DRUGS.

NEW DRUGS ON THE MARKET THAT  
BELONG TO ONE OF THESE CLASSES

NEED TO BE REVIEWED  
FOR FORMULARY INCLUSION

WITHIN THE FIRST 90 DAYS

WHEN THESE DRUGS  
APPEAR ON THE MARKET.

PART D SPONSOR FORMULARIES  
MUST INCLUDE ALL

OR SUBSTANTIALLY ALL OF THE  
DRUGS IN THESE CATEGORIES.

CMS INSTITUTED THIS POLICY  
BECAUSE IT WAS NECESSARY

TO ENSURE THAT MEDICARE  
BENEFICIARIES RELIANT UPON

THESE DRUGS WERE NOT  
SUBSTANTIALLY DISCOURAGED

FROM ENROLLING IN CERTAIN PART D  
PLANS, AS WELL AS TO MITIGATE

THE RISK AND  
COMPLICATIONS ASSOCIATED

WITH AN INTERRUPTION OF THERAPY

FOR THIS VULNER--FOR THESE  
VULNERABLE POPULATIONS.

SOME EXCEPTIONS TO THIS  
ALL OR SUBSTANTIALLY ALL

ARE AS FOLLOWS--THE MULTI-SOURCE  
BRANDS, THE SUSTAINED-RELEASE

XR PRODUCTS WHEN THERE IS  
AN IMMEDIATE RELEASE PRODUCT

CURRENTLY AVAILABLE ON  
THE MARKET OR ON THE PLAN'S

FORMULARY, PRODUCTS THAT HAVE  
THE SAME ACTIVE INGREDIENTS--

THE BRAND VERSUS GENERICS,  
AND DOSAGE FORMS THAT ARE

AVAILABLE FOR ADMINISTRATION  
BY THE SAME ROUT.

AS AN EXAMPLE, AN ORAL AGENT  
MAY BE AVAILABLE IN BOTH

TABLETS AND CAPSULES.

A SPONSOR CAN ELECT  
TO HAVE ONE OR THE OTHER...

WHILE STILL  
MEETING THE CRITERIA.

PLAN SPONSORS MAY UTILIZE  
UTILIZATION MANAGEMENT EDITS,

SUCH AS PRIOR AUTHORIZATION  
OR STEP THERAPY,

ON DRUGS IN THESE  
PROTECTED CLASSES.

BUT--BUT THEY MUST ENSURE THAT  
THESE EDITS DO NOT STEER

BENEFICIARIES WITHIN THESE--  
WITHIN THESE CLASSES

FOR ENROLLEES WHO ARE  
CURRENTLY TAKING THE DRUG.

A KEY POINT.

THIS PROHIBITION APPLIES TO  
THOSE BENEFICIARIES ALREADY

ENROLLED IN THE PLAN,  
AS WELL AS NEW ENROLLEES.

IF A SPONSOR CANNOT DETERMINE  
AT THE POINT-OF-SALE THAT

AN ENROLLEE IS NOT  
CURRENTLY TAKING THE DRUG,

THE SPONSOR SHALL  
TREAT THE ENROLLEE

AS CURRENTLY TAKING THE DRUG.

FOR HIV/AIDS DRUGS, UTILIZATION  
MANAGEMENT TOOLS ARE NOT

GENERALLY EMPLOYED  
AND WIDELY USED.

POST-DISPENSING PART D  
SPONSORS MAY CONDUCT

CONSULTATIONS WITH PHYSICIANS  
REGARDING THESE TREATMENTS.

LET'S REVIEW SOME OF THE  
METHODS THAT SPONSORS CAN

UTILIZE TO FACILITATE  
TRANSITION OVERRIDES

AT THE POINT-OF-SALE.

THE FIRST METHOD INVOLVES THE  
USE OF SMART SYSTEMS THAT LOOK

AT ENROLLMENT FILES AND/OR  
PAST CLAIMS DATA TO DETERMINE

WHEN A TRANSITION SUPPLY  
SHOULD BE AFFORDED.

THIS IS AN EFFECTIVE METHOD

WHEN DETERMINING NEW ENROLLEE

VERSUS CONTINUING ENROLLEE.

THE SECOND METHOD INVOLVES  
THE USE OF SPECIFIC AND CLEAR

POINT-OF-SALE MESSAGING  
DIRECTING PHARMACISTS

ON NEXT STEPS FOR PROCESSING  
TRANSITION OVERRIDES.

SPONSORS NEED TO BE  
AWARE THAT WHEN UTILIZING

A CLAIMS LOOK-BACK  
SYSTEM TO DETERMINE

NEW PRESCRIPTION STARTS  
VERSUS ONGOING THERAPY,

CIRCUMSTANCES MAY  
EXIST WHEN CLAIMS DATA

DOES NOT REFLECT  
CURRENT DRUG REGIMEN.

WHEN THIS OCCURS, SPONSORS  
NEED TO ESTABLISH A PROCESS

FOR MANUAL OVERRIDES.

SOME SITUATIONS WHICH CLAIMS  
DATA LOOK-BACK MAY NOT REFLECT

CURRENT THERAPY  
ARE AS FOLLOWS--

ENROLLEES CASH PURCHASES,

OR ENROLLEES USE  
OF OTHER INSURANCE,

THE USE OF SAMPLES,

OR DRUG THERAPY  
THAT WAS STARTED

WHILE THE ENROLLEE

WAS ON A PART A STAY.

THESE EXAMPLES WILL NOT BE  
REFLECTED WHEN A SPONSOR DOES

A LOOK-BACK.

WHEN USING THE NCPDP 5.1  
TELECOMMUNICATION STANDARD

FOR REJECT ERROR CODES,

THE MESSAGE TO THE PHARMACIST

NEEDS TO BE CLEAR--  
AS CLEAR AS POSSIBLE.

THE STANDARD ALLOWS BOTH  
FOR A PRIMARY AND SECONDARY

MESSAGING TO BE DISPLAYED  
AT THE POINT-OF-SALE.

THE PRIMARY MESSAGE  
IS HARD-CODED.

SOME OF THE EXAMPLES OF THESE  
HARD-CODED MESSAGES

ARE IN FRONT  
OF YOU--CODE 70--

PRODUCT SERVICE  
NOT COVERED,

75--PRIOR AUTHORIZATION  
REQUIRED,

76--PLAN LIMITATIONS EXCEEDED,

AND 78--COST EXCEEDS MAXIMUM.

THE SECONDARY MESSAGING  
IS FREE TEXT AND IT'S USED

TO GUIDE PHARMACISTS  
ON THE NEXT STEPS.

PLAN SPONSORS NEED TO GIVE  
APPROPRIATE MESSAGING THAT

INCLUDE A PLAN PHONE NUMBER,  
A CODE FOR AN OVERRIDE,

OR ANY  
OTHER USEFUL INFORMATION.

THE USE OF VAGUE AND  
INAPPROPRIATE MESSAGING WILL

GIVE THE IMPRESSION OF AN  
ACCESS ISSUE, WHICH MAY LEAD

TO AN INCREASED  
NUMBER OF COMPLAINTS

AND POSSIBLE CMS ACTION.

>> NOW, AS WE GET CLOSE TO  
THE END OF MY PRESENTATION,

LET'S REVIEW SOME SCENARIOS.

SCENARIO NUMBER 1.

THE BENEFICIARY  
GOES INTO THE PHARMACY

TO HAVE AN ANTI-RETROVIRAL  
DRUG ATRIPLA FILLED

FOR THE FIRST TIME.

THE DRUG IS ON  
THE PDP'S FORMULARY.

AT THE POINT-OF-SALE THE  
CLAIM DENIES BECAUSE THE PDP

HAS A HIGH DOLLAR COST EDIT.

IS THE BENEFICIARY  
ENTITLED TO THE MEDICATION?

ANY HANDS?

[INDISTINCT CHATTER]

>> GOOD.

[AUDIENCE LAUGHTER]

>> YES, THE BENEFICIARY  
IS ENTITLED TO ATRIPLA.

THE PDP IS ALLOWED  
TO UTILIZE THIS TYPE OF EDIT

EVEN ON ANTI-RETROVIRALS,

PROVIDED THAT  
THE PRESCRIPTION CAN

STILL BE PROCESSED AT THE  
POINT-OF-SALE BY THE PHARMACY

SO THE BENEFICIARY CAN LEAVE  
THE PHARMACY WITH THE DRUG

IN THEIR HANDS.

INADEQUATE MESSAGING AT THE  
POINT-OF-SALE WOULD BE SEEN

THROUGH THE USE OF  
THE NCPDP ERROR CODE 75,

PRIOR AUTHORIZATION  
REQUIRED.

THAT ALONE.  
NO SECONDARY MESSAGING.

THIS PUTS THE BENEFICIARY AT  
RISK FOR LEAVING THE PHARMACY

WITHOUT THE MEDICATION.

THERE WAS A PRIMARY MESSAGING,

SECONDARY MESSAGING  
WAS NOT UTILIZED.

MORE APPROPRIATE MESSAGING  
THAT SHOULD HAVE BEEN UTILIZED

IS THE NCPDP ERROR CODE 78,  
COST EXCEEDS MAXIMUM,

ALONG WITH THE



SECONDARY MESSAGING

PROVIDING A SPONSOR'S PHONE  
NUMBER FOR A PHARMACY

TO OBTAIN AN OVERRIDE.

WHILE HIGH DOLLAR COST  
EDITS SHOULD BE UTILIZED,

STRATEGIES NEED TO BE EMPLOYED

THAT REDUCE  
UNNECESSARY BURDENS.

SUCH STRATEGIES INCLUDE NOT  
PLACING HIGH DOLLAR COST EDITS

AT SUCH A LOW LEVEL THAT  
WOULD AFFECT ALL DRUGS

IN THE SPECIALTY TIER.

SCENARIO NUMBER 2.

A BENEFICIARY DROPS OFF

A PRESCRIPTION FOR LEXAPRO,  
AN ANTI-DEPRESSANT.

HER PDP HAS A NEW STEP  
THERAPY EDIT ON LEXAPRO,

NECESSITATING THE USE  
OF A PREFERRED ALTERNATIVE

TO CITALOPRAM.

SHE IS A NEW ENROLLEE WHO  
WAS PREVIOUSLY STABILIZED

ON LEXAPRO. SAME QUESTION.

IS THE BENEFICIARY ENTITLED  
TO A TRANSITION SUPPLY?

ANY HANDS?

LEXAPRO IS A DRUG IN ONE  
OF THE PROTECTED CLASSES.

SINCE CMS PROHIBITS  
SPONSORS FROM UTILIZING

UTILIZATION MANAGEMENT  
EDIT ON ENROLLEES

CURRENTLY TAKING  
A DRUG IN ONE

OF THE 6 CLASSES  
OF CLINICAL CONCERN,

A UM--A UTILIZATION  
MANAGEMENT OVERRIDE--

A UTILIZATION  
MANAGEMENT OVERRIDE

NEEDS TO BE GRANTED  
AT THE POINT-OF-SALE,

NOT JUST A TEMPORARY  
TRANSITION SUPPLY.

IF YOU NEED MORE  
INFORMATION ON THIS,

I REFER YOU TO CHAPTER 6  
OF THE DRUG BENEFIT MANUAL,

SECTION 30.2.5. IS  
EVERYONE CLEAR ON THIS?

APPROPRIATE MESSAGING AT THE  
POINT-OF-SALE SHOULD BE DONE

THROUGH THE USE OF  
THE NCPDP ERROR CODE 75,

PRIOR AUTHORIZATION REQUIRED,

ALONG WITH THE  
SECONDARY MESSAGING--

STEP THERAPY REQUIRED  
FOR NEW STARTS ONLY,

CALL 1-800-YOUR-PLAN

FOR AN OVERRIDE  
OR TRANSITION SUPPLY.

NOW I WILL PASS IT BACK

TO ADELE FOR  
THE REMAINING SLIDES.

>> OUR LAST SCENARIO  
WITH 2 PARTS.

SO SCENARIO 3, ON JANUARY 2,

A BENEFICIARY  
GOES TO A PHARMACY

AND DROPS OFF  
A PRESCRIPTION FOR PROZAC,

AN ANTI-DEPRESSANT.

IT'S A NON-FORMULARY  
MEDICATION,

BUT THE GENERIC VERSION,  
FLUOXATINE,

IS ON THE FORMULARY.

SHE IS A CONTINUING  
MEMBER OF THE PDP.

OK, SO FIRST DISCUSSION--  
PROZAC IS--WAS NON-FORMULARY

IN THE PREVIOUS PLAN YEAR

AND IT CONTINUES TO BE  
NON-FORMULARY.

IS THE BENEFICIARY ENTITLED  
TO A TRANSITION SUPPLY?

[AUDIENCE LAUGHTER]

>> IT'S OK. I DON'T BITE.  
I WON'T BITE.

>> NO.

>> NO. I HEAR ANYONE SAY "YES"?

WHO SAYS "NO"?

THIS IS THE AFTERNOON WAKEUP.

OK, YEAH, I SEE.  
SOMEONE HAS 2 HANDS.

OK. AND YOU WOULD BE CORRECT

BECAUSE THE DRUG WAS NOT  
IN THE PLAN'S FORMULARY IN 2006.

THIS AGAIN WOULD BE--IF  
YOU NEED MORE INFORMATION

ABOUT THIS, AGAIN, I REFER YOU  
TO CHAPTER 6, SECTION 30.2.5.

WHERE THE PLAN SPONSOR  
CAN REALLY HELP HERE IS

WITH APPROPRIATE MESSAGING.

APPROPRIATE MESSAGING WOULD BE  
NCPDP ERROR CODE NUMBER 70,

PRODUCT SERVICE NOT COVERED,  
WITH THE SECONDARY MESSAGE

ON WHERE THAT PHARMACY  
STAFF PERSON CAN GET MORE

INFORMATION, CALL  
THE PLAN AT 1-800-OUR-PLAN.

AND THAT WOULD BE  
ACCEPTABLE AND APPROPRIATE.

LESS APPROPRIATE WOULD JUST  
BE TO HAVE THE PRIMARY NCPDP

REJECTION CODE WITH  
NO SECONDARY MESSAGING.

NOW SCENARIO 2--REMEMBER  
THIS IS A CONTINUING MEMBER

OF THE PDP,

GOING ON JANUARY 2,

SHE'S DROPPING OFF  
A PRESCRIPTION FOR PROZAC.

BUT, UNLIKE THIS DISCUSSION,

THE PLAN IS REMOVING  
THE BRAND-NAME PROZAC

FROM THEIR FORMULARY  
FOR JANUARY 1.

IN DISCUSSION 2,

IS THAT BENEFICIARY ENTITLED  
TO A TRANSITION SUPPLY?

[APPLAUSE IN BACKGROUND]

>> VERY--THEY APPLAUDED YOU!

[LAUGHTER]

>> YOU GUYS ARE GREAT.  
THIS IS GREAT.

JOHN, YOU DID A GOOD JOB.

UH, NO, YES, THEY ARE.

BECAUSE, AGAIN, THIS WAS  
SOMETHING THAT THE BENEFICIARY

HAD BEEN ON, IT WAS ON THE  
PLAN'S FORMULARY, AND, AGAIN,

YOU NEED TO OFFER  
A TRANSITION SUPPLY.

AGAIN, APPROPRIATE MESSAGING  
IS NCPDP ERROR CODE 70,

WITH THE SECONDARY MESSAGING  
GIVING THE PHARMACY

MORE INFORMATION  
ON WHERE TO CALL.

AGAIN, LESS APPROPRIATE WOULD

BE THAT SAME ERROR MESSAGE

WITH NO SECONDARY MESSAGE.

SO THOSE ARE OUR SCENARIOS.

AS PROMISED, I'M GOING  
TO TOUCH VERY BRIEFLY

ON THE MEDICARE COVERAGE  
GAP DISCOUNT PROGRAM

THAT STARTS IN 2011.

BUT, FIRST, IN 2010, WE WILL  
BE, AS YOU'RE WELL AWARE,

BENEFICIARIES WHO REACHED  
THE COVERAGE GAP THIS YEAR

WILL GET A \$250  
REBATE CHECK FROM CMS,

AND WE'RE IN THE PROCESS

OF ISSUING THOSE CHECKS  
NOW AS WE SPEAK.

THE SECOND--OR ADDITIONALLY--

THE COVERAGE GAP  
DISCOUNT PROGRAM--

WE TALKED A LITTLE  
BIT ABOUT THE COVERAGE

OF GENERICS  
IN THE COVERAGE GAP

AT THE 7% LEVEL IN 2010...

IN 2011, THE LEGISLATION  
REQUIRES MANUFACTURERS

IN ORDER FOR THEIR BRAND-NAME  
DRUGS TO BE COVERED

UNDER PART D, TO HAVE IN EFFECT  
AN AGREEMENT WITH CMS,

WHICH WILL GIVE  
BENEFICIARIES ACCESS

TO BRAND-NAME DRUGS  
AT A 50% DISCOUNT.

CERTAIN BENEFICIARIES  
ARE NOT ELIGIBLE FOR THOSE,

INCLUDING ENROLLEES WHO ARE  
IN RETIREE DRUG SUBSIDY PLANS,

AND LOW-INCOME  
SUBSIDY INDIVIDUALS.

CMS EXPECTS THAT ALL  
MANUFACTURERS WILL SIGN

THE AGREEMENT SO THAT THEIR  
DRUGS WILL CONTINUE TO MEET

THE DEFINITION  
OF A PART D COVERED DRUG.

AND, AS I'M SURE MANY OF  
YOU ARE AWARE, CMS PUBLISHED

A DRAFT MANUFACTURER AGREEMENT  
IN THE FEDERAL REGISTER,

AND THERE IS A MEETING  
TODAY TO DISCUSS

THAT WITH  
INTERESTED STAKEHOLDERS.

THE ACTUAL COVERAGE  
GAP DISCOUNT PROGRAM,

FINAL GUIDANCE--IT SAYS  
HERE THAT THERE

WAS A DRAFT GUIDANCE  
ON APRIL 30.

WE ISSUED THE FINAL  
GUIDANCE ON MAY 21.

AND SO I WOULD REFER YOU  
TO THAT MEMO FOR MORE DETAILS

ON HOW WE'LL BE  
ADMINISTERING THAT.

BUT THOSE 2 THINGS WORK  
HAND IN HAND--THE 7%

ON GENERICS AND  
THE 50% DISCOUNT

ON THE BRAND-NAME DRUGS FOR  
THE COVERAGE GAP IN 2011.

FINALLY, SO, WHAT  
ARE WE WORKING ON?

WELL, WE'RE WORKING ON  
THE REGULATION TO IMPLEMENT

THE AFFORDABLE CARE ACT  
AND THAT PROPOSED REGULATION

WILL BE OUT  
IN THE FALL OF 2010.

SO WITH THAT, UH...

WE WILL TAKE ANY QUESTIONS  
FROM ANY OF YOU.

YES. IF YOU CAN JUST SPEAK LOUD  
ENOUGH SO WE CAN ALL HEAR YOU,

WE WON'T--

>> I JUST HAVE A QUESTION  
ON THE \$250 REBATE.

>> YES.

>> I'M QUESTIONING  
WHETHER OR NOT A PERSON

HAS TO BE JUST  
INTO THE GAP

OR IF THEY HAVE  
TO SPEND \$250?

>> AS I--I ASKED THAT QUESTION,



AND WHAT I WAS TOLD  
WAS THEY'RE ONE PENNY

INTO THE GAP,  
THEY GET THE CHECK.

SO THAT'S A GREAT QUESTION,  
BECAUSE I HAD IT.

NO, JUST KIDDING. YES?

>> WHAT ARE SOME OF THE BEST  
THINGS THAT WILL GO--

WILL [INDISTINCT] IN 2010?

>> WELL, I KNOW THAT  
WE HAVE, AND I THINK

IT WAS RELEASED  
TO OUR PARTNERS.

WE HAVE A BROCHURE  
THAT WAS RELEASED.

INCLUDED IN THE CHECK

WILL BE A LETTER  
IDENTIFYING

THE PURPOSE  
OF THE CHECK.

AND THE CONTRACTOR  
THAT WE DID HIRE

TO DISTRIBUTE THE MONIES

WILL BE DOING  
A FOLLOW-UP

A MONTH LATER TO ENSURE

THE CHECKS  
HAVE BEEN CASHED.

>> THE REASON  
I ASKED IS BECAUSE

I'M TRYING TO FIGURE OUT  
WHETHER THE DISTRIBUTION

OF THE REBATE WILL HAVE  
ANY IMPACT ON OUR COSTS

AND...[INDISTINCT DIALOGUE]

>> WELL, IF ANYONE  
IS CONTACTING

THE PLAN REGARDING  
THEIR REBATE CHECK,

THEY SHOULD BE DIRECTED  
TO CALL 1-800-MEDICARE.

>> OTHER QUESTIONS?

WELL, THANK YOU AGAIN  
ALL FOR COMING,

AND FOR COMING  
TO THIS SESSION,

AND FOR WORKING  
WITH CMS TO TAKE CARE

OF OUR BENEFICIARIES.  
THANK YOU.

[APPLAUSE]

>> THANK YOU ALL.