



**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.