



QUESTIONS AND ANSWERS RELATED TO THE GUIDANCE ON MEDICARE-APPROVED DRUG DISCOUNT CARD

■ THE MEDICARE-APPROVED DRUG DISCOUNT CARD PROGRAM

Question 1: What are the Medicare-approved drug discount cards used for?

Answer: Medicare-approved drug discount cards offer savings on brand name and generic drugs at retail pharmacies and through certain mail order programs. These Medicare-approved drug discount cards provide significant discounts on mail-order and generic drugs. Anyone in Medicare is eligible to enroll in a Medicare-approved drug discount card program except those who have outpatient prescription drug coverage through Medicaid. Low-income Medicare beneficiaries with incomes no more than 135 percent of the Federal poverty level (FPL) can also get a \$600 credit (Transitional Assistance) on the card annually in 2004 and again in 2005 to be used for the purchase of prescription drugs. The enrollment fee for beneficiaries receiving the \$600 credit is paid by the Federal government.

An individual can recognize a Medicare-approved drug discount card because it will have a seal with the words "Medicare Approved" on it. Some private companies may offer individual discount cards that are not Medicare-approved. If a drug discount card does not carry the Medicare-approved seal, the card isn't Medicare-approved.

Question 2: Who can use the card?

Answer: Only the person with Medicare who applied for the card and enrolled can use the card at participating retail pharmacies and if the beneficiary chooses, through mail order pharmacies when offered. The card is exclusive to the Medicare participant. The cardholder should go to a pharmacy that accepts his/her particular Medicare-approved drug discount card. The cardholder will not be able to use his/her Medicare-approved drug discount card at pharmacies that do not accept his/her particular card.

Question 3: How many Medicare-approved drug discount cards can an individual have?

Answer: Each individual can have one Medicare-approved drug discount card. He/she can use other, non-Medicare approved, drug discount card(s). Medicare advises individuals to use the card that gives them the best deal on their prescription drugs.

Question 4: Who offers the Medicare-approved drug discount cards?

Answer: Private companies offer Medicare-approved discount cards. These private companies apply to the Centers for Medicare & Medicaid Services (CMS), a division of the Department of Health and Human Services, to offer the Medicare-approved drug discount card. To obtain approval, the companies must meet certain standards, such as setting up a process for handling complaints and having experience offering prescription drug discounts. If Medicare approves the private company, the company must make the drug discount card available to every Medicare participant in the State or region that the card covers. Many companies offer nationwide coverage.

The company will decide which prescription drugs will be discounted and the amount of the price discount for those drugs. The company may charge an annual enrollment fee of no more than \$30. Medicare participants will have to pay a new enrollment fee every calendar year.

Question 5: Does everyone have to pay the \$30 annual enrollment fee?

Answer: No, the Federal government will pay the enrollment fee for low-income beneficiaries who qualify for the \$600 credit. States may elect to pay the enrollment fees for beneficiaries who are not receiving the credit and the coinsurance for low-income beneficiaries receiving the credit. However, there is no federal funding to supplement these State expenditures. Lastly, some companies may elect not to charge the \$30 enrollment fee or to charge a lesser amount.

Question 6: Can the \$600 credit be used to buy any prescription?

Answer: According to CMS, all drugs that fit the definition of "covered drugs" as defined by Congress and in CMS regulations are eligible for the \$600 credit. While the vast majority of prescription drugs and certain medical supplies are included, certain classes or categories of drugs are excluded from the definition of "covered drugs". Also, drugs that would otherwise be covered for a particular individual by Medicare Part B would be excluded from the definition of "covered drug" for that individual.

Question 7: Is the Food Stamp Program policy only applicable to the Medicare-approved drug discount card? What about other drug discount cards?

Answer: This Food Stamp Program policy only applies to Medicare-approved drug discount cards.

Question 8: How does this policy conform to the Medicaid spend-down program?

Answer: The food stamp and Medicaid policies are in sync. However, the implementation methodologies may differ slightly due to program differences. Under Medicaid, neither the \$600 credit nor the discount prices will have a negative impact on the eligibility process. The discount and any portion of the \$600 credit used for prescription drugs will be treated as incurred medical expenses for purposes of the Medicaid "spend-down". And there will be no delay in the onset of Medicaid eligibility. CMS will issue guidance on how the Medicaid State agencies will calculate the applicant's level of drug spending to apply to "spenddown".

■ EFFECTIVE DATE/QUALITY CONTROL

Question 9: What is the effective date of this policy?

Answer: This policy became effective with the June 1, 2004 implementation of the Medicare Modernization Act's (MMA) Medicare-Approved Drug Discount Card Program. However, to allow State agencies time to implement the new policy, FNS is requiring State agencies to implement the provisions of the June 18, 2004, policy guidance no later than October 1, 2004.

Question 10: What is the Quality Control (QC) impact?

Answer: These cases will be included in the QC sample and they will be reviewed in accordance with established QC procedures.

Question 11: Is there a hold harmless period? What is it?

Answer: There will be a 120-day QC hold harmless period.

Question 12: When does the hold harmless period begin?

Answer: The 120-day hold harmless period will begin on October 1, 2004, or the date the State agency implements the new policy if the State agency implements the policy after October 1, 2004. In either instance, the hold harmless period will continue through January 28, 2005. If a State agency implements the revised policy prior to October 1, 2004, the 120-day hold harmless period begins on the date of the State agency's implementation and continues for 120 calendar days. The exclusion applies to any variance that occurs in implementing the Medicare-Approved Drug Discount Card and credit during this period.

In addition to the 120-day hold harmless period, State agencies shall also exclude variances that occur between June 1, 2004, and October 1, 2004, or the date the State agency implements the new policy, whichever comes first, under the provisions of 7 CFR 275.12(d)(2)(viii). That exclusion applies until such time as the affected household is recertified or the State agency is otherwise required to act on the household's medical deduction.

Question 13: Does the QC variance apply only to current recipients or will it apply to future applicants as well?

Answer: The variance exclusion applies to all currently certified households, all households that are recertified, households that are newly certified, or households that report updated medical expenses during the 120-day period. The hold harmless period does not apply to future applicants who apply outside of the 120-day exclusionary period.

■ ELIGIBILITY AND VERIFICATION

Question 14: How do you know when an individual gets a Medicare-approved drug discount card?

Answer: It is the obligation of the recipient to inform the State agency that they are participating in the program by providing them with information regarding their participation in this program.

Question 15: Can we assume that if an individual receives the card in 2004 that they will also receive it in 2005?

Answer: Yes, unless there is evidence to the contrary, a State agency should anticipate that individuals who receive the card in 2004 will renew their participation for 2005. The renewal process is automatic for individuals who receive the \$600 credit. Only those individuals who are not eligible for the credit will have to renew and pay the 2005 enrollment fee, if applicable. Once a beneficiary signs up, s/he is signed up for the remainder of the year. Also, the beneficiary may choose another card during the open enrollment period, which is November 15 through December 31, 2004.

Question 16: Since the State agency is allowed to average the credit over the remaining months in 2004, are they required to follow up with the beneficiary in January 2005?

Answer: When a household reports that a member has received the 2004 credit, it is reasonable to anticipate that the same member will receive the full 2005 credit. If the household's new or current certification period would extend into 2005, the local food stamp office would budget the 2005 credit when it budgets the 2004 credit.

Question 17: How do you verify that an individual is receiving the credit?

Answer: FNS believes that virtually all cardholders who document their income for food stamp purposes at no more than the gross income test will receive the subsidy. To simplify administration of the Medicare-Approved Drug Discount Card policy, FNS has determined that States will deem to be

receiving the credit any cardholder whose income is no more than 130 percent of the Federal poverty level. No further verification is necessary.

Question 18: **Are participants going to receive a notice from the Social Security Administration that they have been approved for the credit?**

Answer: The Social Security Administration is not directly involved in the day-to-day operations of this program from a beneficiary perspective. The program is administered by CMS. Because the cards are issued by private corporations most of the notices related to the program should be from the company issuing the participants' cards.

Question 19: **If an individual has a card and they do not tell the eligibility worker that they have it, what does the eligibility worker do? What responsibility does the eligibility worker have to investigate?**

Answer: At the interview, the State agency should direct eligibility workers to ask households with members who are eligible for the excess medical deduction whether they have applied for and received the Medicare-approved drug discount card. However, if the household has in fact received the card, and the case is reviewed by QC, there is the potential for a variance in the case. This would not be the case in States which have a statement on the application form that a household that fails to report a deductible expense will be considered to have rejected the deduction.

Question 20: **If individuals who receive the Medicare-approved drug discount card later apply for and are found eligible for Medicaid (and the associated outpatient prescription drug benefits), are they then ineligible to use their discount card? Should the eligibility worker still apply policies related to the receipt of the Medicare-approved drug discount card?**

Answer: Households are not required to report this change. Moreover, State agencies must take no action on this information until the household's next recertification. CMS will not disable the Medicare-approved drug discount card even if the cardholder subsequently becomes eligible for Medicaid.

Question 21: **Does the drug card policy apply to both applicants and recipients?**

Answer: Yes, this policy should be applied to applicants and recipients alike. States must pick one of the allowable options in budgeting the value of the credit and apply it consistently to both applicants and recipients.

■ CALCULATING THE MEDICAL DISCOUNT

Question 22: **How do State agencies administer the options allowed? May a State agency choose to leave the choice to individual eligibility workers, so that the worker may select the option most beneficial to the individual household?**

Answer: No. The State agency must select an option and apply it uniformly across the State.

Question 23: **Would a State agency that uses the standard expense allowance also allow a medical deduction of \$23 per month, regardless of actual prescription costs for all households that have a discount card?**

Answer: The \$23 per month standard expense allowance that CMS has estimated as the value of the prescription drug discounts received by holders of this card. Therefore, if a State agency selects this option as their method of calculating an individual's benefit amount, they must use the \$23 standard as the amount to add to the individual's out-of-pocket expenses and credit amount to calculate the total medical expense.

If an individual opts to use the actual out-of-pocket prescription expenses that they incurred prior to using the discount card, they have the right to do so. In that case, the State agency would simply calculate the individual's benefit amount using the receipts produced by the individual.

- For example: Prior to using the discount card, the individual incurred prescription expenses of \$300 per month but now pays \$150 per month out-of-pocket using the discount card.

When the eligibility worker calculates the benefit amount using Option 2: They use the following formula:

- $\$150 + \50 (credit) = \$200
- $\$200 + \23 (standard expense) = \$223 (total)

Since this amount is less than the \$300 that the individual incurred before he started using the discount card, if the individual can demonstrate that his expenses totaled \$300 prior to using the card, the eligibility worker can use \$300 when calculating the individual's benefit amount. This is at the option of the individual and based on their ability to produce adequate documentation.

Question 24: **When you apply either the discount factor to actual costs or use the standard expense allowance, if the actual costs of the prescriptions were larger than the amount**

calculated using either formula, are you required to use the larger cost?

Answer:

An individual participating in the program always has the option to claim the actual out-of-pocket prescription expenses that they have incurred prior to using the discount card if those expenses exceed the total amount calculated using either formula for applying the discount option. However, that individual must provide documentation to demonstrate the amount of these actual pre-discount expenses. The purpose of this policy is to insure that an individual does not lose benefits.

For example: Prior to using the discount card, the individual incurred medical expenses of \$300 per month but now pays \$150 per month out-of-pocket using the discount card.

When the eligibility worker calculates the benefit amount using Option 1: They use the following formula:

- o $\$150 + \50 (credit) = \$200
- o $\$200 \times 1.25 = \250 (total monthly expenses)

Using Option 2: They use the following formula:

- $\$150 + \50 (credit) = \$200
- $\$200 + \23 (standard expense) = \$223 (total)

Since this amount is less than the \$300 that the individual incurred before he started using the discount card, if the individual can demonstrate that his expenses totaled \$300 prior to using the card, the eligibility worker can use \$300 when calculating the individual's benefit amount.

Question 25:

If a household has a Medicare discount card, can you disregard the standard \$35 deductible when calculating the household's medical expenses?

Answer:

No, because the provision providing for the deduction of medical expenses to the extent that they exceed \$35 per month is specifically mandated under Section 5(e)(5) of the Food Stamp Act.

Question 26:

If an individual does not pay any out-of-pocket prescription drug expenses, do they still get the deduction?

Answer:

If the individual's prescription drug card covered all the individual's prescription drug expenses, the cardholder would still be eligible for the standard expense allowance.

Question 27:

When applying the discount factor to actual costs, do you apply the discount factor to only one prescription or do you apply it to all prescription expenses for the month?

Answer:

Apply the discount factor to all prescription expenses for the month.

Question 28:

When the State agency assigns a certification period shorter than 12 months, and the State agency has chosen to prorate the credit over the certification period, what will be the effect on the household?

Answer:

In a very short certification period, the State agency would prorate the \$600 credit over two or three months. This household could lose much of the benefit of the deduction, since any deduction that exceeds income is lost. Therefore in choosing which option to take, State agencies should consider this consequence.

Question 29:

Can the \$30 cost of the card be averaged over the certification period?

Answer:

Yes, although most food stamp clients will actually not have to pay for the card because their incomes are so low.

Question 30:

If FNS would have just told States to keep using the pre-discount drug expenses and disregard the \$600 credit as income and resources, the household's food stamp benefits would not have increased. That is simple to implement. Why can't States use this method since food stamp benefits would not decrease?

Answer:

If a client has no change in a prescription, the pre-card cost would be a valid way for the Food Stamp Program to hold the client harmless. But "no change" would mean:

- No change in the medicine's over-all price
- No change in the dose
- No new prescription
- No stopping an old prescription.

However, clients' medicines do often change, so it is necessary to have some way to estimate the credits and discounts. Also, it is more than likely that clients will only be able to document the discounted amount that they will pay out-of-pocket. Finally, the \$600 credit would not necessarily be accounted for in the out-of-pocket expenses if just the pre-card prices were used.

- Question 31:** If a person is eligible for the credit, is the amount always \$600 or can the maximum amount authorized for the person be less?
- Answer:** In 2004, the amount of the credit is \$600 per client per year.
- In 2005, a person who is newly applying for the prescription card loses \$150 with every quarter that passes. Therefore, someone coming in to apply for the card in April, May or June of 2005 will only qualify for a credit of \$450. That amount will continue to decrease every quarter.
- Question 32:** If you find out in 2005 that an individual received the \$600 credit in 2004, can you roll the \$600 from 2004 into 2005?
- Answer:** No. For food stamp purposes, the 2004 credit was made available for 2004.
- Question 33:** If the individual does not pay any out-of-pocket expenses, is the \$600 credit still accounted for in their deduction?
- Answer:** Yes. We assume that most of the clients will actually use the two \$600 credits. We think that it will be easier, then, for a State agency to treat the credits as medical expenses for all those who receive them, rather than trying to anticipate each Medicare client's future actual use.
- Question 34:** Since we are budgeting the \$600 credit whether or not they actually use it, shall we also budget the appropriate 10 percent or 5 percent of the beneficiary's co-pay on that \$600 whether or not they actually use it?
- Answer:** No. The \$600 credit is a benefit that is provided to increase an individual's disposable income. The co-payment is an expense that individuals incur in the purchase of prescription drugs and payment of medical necessities. The rules governing the use of the Medicare-approved drug discount card do not allow for the \$600 credit to cover the beneficiary's co-pay.
- Question 35:** Suppose a new household applies for food stamps in October 2004. A member of the household has received the \$600 credit. The State agency has chosen to prorate the credit over October, November, and December, giving the client a \$200 monthly deductible expense for the credit. In 2005 they are re-enrolled and will receive \$50 per month for 12 months. So, their benefits will decrease, correct?
- Answer:** Yes. This is because the State agency chose to prorate the 2004 credit only over the months that remain in 2004.
- Question 36:** A State has chosen to prorate the credit over 24 months at \$50 a month. If a household applies for food stamps in December, 2004, would the 24 months run from December 1, 2004 to November 30, 2006? Would it matter when the individual applied for or actually received the 2004 credit?
- Answer:** Yes, the proration would cover December, 2004 through November, 2006. The date that the client applied for or received the credit does not affect the actual months of proration for the discount card's credit. The amount prorated would include the full credit amount for 2004 and 2005 for a total of \$1,200.
- Question 37:** When the individual is up for redetermination and has already used the \$600 credit, do you still include that in their budget?
- Answer:** Yes. The options all require some proration of the \$600 credit. None of the options for budgeting the credit involve tracking the client's actual use of the credit. Therefore, actual use is not an issue.
- Question 38:** The option involving prorating the two credits over 24 months seems to offer the least amount of work and be the easiest to administer, but even that is error prone as the worker must track the 12 and 24-month periods which may not be simple, especially if there are breaks in participation. This option does not say anything about not going beyond December 31, 2005 with the \$50 deduction.
- Answer:** First, there is no need to track the 24 month period. The 24-month period would begin when the State agency can include the \$50 in the allotment calculation and then run consecutively through the 24th month. Second, a break in participation would not matter. If, for some reason, the client left the Food Stamp Program, there would be no effect on the \$50 monthly prorated amount. Third, the example in the memorandum specifically refers to budgeting the deductible expense through June, 2006.

■ STATE AGENCY ADMINISTRATION

- Question 39:** Would we have to give each household an option or can we decide statewide which option we want?
- Answer:** The State agency must pick a deduction method and apply it to all the households with cardholders.
- Question 40:** States that choose different options will be giving clients with the exact same circumstances differing amounts of benefits. Is this true?
- Answer:** Yes. But that is true whenever State agencies have options (monthly reporting versus simplified reporting, actual utilities versus mandatory allowances, etc.).
- Question 41:** Who does the State agency need to notify about what option they choose?
- Answer:** The State needs to document their option and send it to their regional office as soon as possible.

- Question 42:** **Is this a data element to add a BENDEX file?**
Answer: No, BENDEX is a system of the SSA and will not provide information regarding Medicare beneficiaries.
- Question 43:** **Are States required to give restored benefits?**
Answer: Yes. Any case that was adversely affected because the new policy was not applied to the medical expense deduction is eligible for restoration of lost benefits. The time frame for restoration would be actions that took place between June 1, 2004, and the date the State agency implements the new policy.
- Question 44:** **If the State agency uses the simplified reporting option, how do households report? Is FNS coming up with this reporting requirement?**
Answer: Under the simplified reporting option as provided under 7 CFR 273.12(a)(1)(vii) and Section 4109 of the Farm Security and Rural Investment Act of 2002 (the Farm Bill), households are required to report only changes that would result in gross income exceeding 130 percent of the Federal Poverty Level. Changes related to the Medicare-approved drug discount card, like all changes regarding the medical expense deduction, would be reportable only at recertification. However, the State agency would be required to act on all changes related to the card that would increase the household's benefits if voluntarily reported by the household.
- Question 45:** **If a State agency has taken on the Farm Bill option not to act on changes, what takes precedence, the option not to act or this policy?**
Answer: We assume that this question refers to Section 4106 of the Farm Bill which permits the State agency to defer action on changes in deductions. We have determined that the implementation of changes in the household's deductible medical expenses related to the implementation of the Medicare-Approved Drug Discount card will take precedence over the option to ignore changes.
- Question 46:** **Why have this complex policy instead of looking at the individual's actual drug expenses?**
Answer: First, by allowing the household to claim only their out-of-pocket costs we would be taking into account the benefits of the credit when determining the individual's benefit amount. This would run contrary to the MMA, which states that the discount and credit shall not be treated as benefits or otherwise considered in determining an individual's eligibility for or the amount of benefits under any other federal program. If an eligibility worker only looks at the individual's actual expenses, the only actual expenses that an individual participating in this program would have are the out-of-pocket expenses they incur after the discount and credit.

Second, the intent of this policy is to allow individuals to break away from having to document actual costs and use a standard. It should be easier for recipients to have this standard rather than trying to figure out their actual expenses.

■ IMPACT OF THE PROGRAM

- Question 47:** **When a State agency gets a waiver from the regulations, program costs cannot increase. Why is it that for this "waiver" from regulations FNS allows the Program costs to increase?**
Answer: First, this is not a waiver of the regulations. Second, Federal law requires that the prescription card's benefits not affect a food stamp household's eligibility or benefit level. While there is legitimate disagreement about the best ways to accomplish this goal, violating Federal law is not an option. If compliance with Federal law results in higher costs, the Food Stamp Program will pay these costs.
- Question 48:** **If a client's certification period extends into calendar year 2006 beyond the credit allowance, what are the expectations for the State agency in removing the amount from the budget? Will FNS consider making any provisions such as allowing 90 days after the period ending?**
Answer: The State agency would remove the credit effective with the first month after the 24th month of proration.

For example, suppose the individual applied for food stamps in September, 2004. The State agency certifies the household for 12 months, from September 1, 2004 to August 31, 2005. The State agency would prorate the two \$600 credits, at \$50 a month, from September 1, 2004, through August 31, 2006. In August, 2005, the State agency recertifies the household and gives the client a 24-month certification period, from September 1, 2005 through August 31, 2007, still using the \$50 monthly prorated credit. That credit will disappear from the allotment calculation for September, 2006, because it was all used up on August 31, 2006.

There would be no reason to give the State agency more time to remove the credit from the prorated calculation. The State agency would have known for two years that the prorated credit expires on August 31, 2006.

- Question 49:** **FNS's guidance, dated June 18, 2004, gives states two options for estimating the amount of a client's prescription discount:**

- **Option 1 - Add together the prorated credit and the verified out-of-pocket expense, then multiply the sum by 1.25 (this automatically includes the discount in the product), or**
- **Option 2 - Deem the discount to be \$23 per client per month. Under either option, the client then has the option of presenting verification that the actual discount is larger.**

Would it be acceptable for a state to use a third option, to verify the normal (undiscounted) price of each prescription drug and not use either of the other options?

Answer:

Yes, but only under the following conditions:

- The household would be required only to provide information regarding participation in the Medicare Prescription Discount Card program, an adequate description of the prescriptions, and the pharmacy where the prescription is filled.
- The state would be responsible for obtaining all necessary verification in a timely manner.
- For verifying these prescriptions' pre-card costs, all regulations that refer to a household's responsibility to obtain verification would not apply.
- All delays in obtaining verification would be state agency-caused delays.

If States use this method, caseworkers must be careful to budget the full retail price of the prescription (the amount that an uninsured person would pay) – not the discounted price.

Question 50:

There are two situations when a food stamp client will use an actual, pre-discount price for a prescription drug that is covered by the Medicare Prescription Drug Card:

- **The state has chosen either the 1.25 method or the \$23 method and the client has verified a higher actual cost, or**
- **The state has chosen to use actual costs for all clients' prescriptions.**

When either of these two situations occurs, does the state also consider the prorated \$600 credit to be a deductible medical expense?

Answer:

No. Whenever the state uses the actual, pre-discount expense, that amount accounts for whatever portion of the credit went towards the purchase.