20 - Definitions

(Rev. *14*, Issued: *10-01-18*, Effective Date: *10-01-18;* Implementation Date: *10-01-18*) Unless otherwise stated in this chapter, the following definitions apply:

Annual out-of-pocket threshold: The point in the Part D benefit when a beneficiary enters the catastrophic coverage phase. Detailed description is found in chapter 5, section 20.3.1 of this manual.

Applicant: The Part D eligible individual applying for the low- income subsidy with either the Social Security Administration (SSA) or the State Medicaid agency.

Basic prescription drug coverage: Refer to chapter 5, section 20.1 of this manual for the description of this term.

Best Available Evidence *(BAE)*: Documentation used by the Part D sponsor to support a favorable change to a low-income subsidy eligible beneficiary's LIS status.

Complaint Tracking Module (CTM): *a module that is part of the Health Plan Management System which provides Sponsors with a method for submitting BAE assistance requests to CMS.* (*For more information see 70.5.3 - Part D Sponsors Responsibility When BAE is not available).*

Copayment Amounts: Applicable calendar year copayment/coinsurance amounts are provided in *the Annual Call Letter* for full subsidy and partial subsidy eligible individuals.

Coverage Gap: The Part D benefit phase above the initial coverage limit and at or below the annual out-of-pocket threshold described at 42 CFR 423.104(d)(4) (and in chapter 5, section 20.3.1 of this manual).

Covered Part D drugs: Refer to chapter 6, section 10.2 of this manual for the description of this term.

Deductible Amounts: Applicable deductible amounts provided in *the Annual Call Letter* for partial subsidy eligible individuals.

Deemed Eligible Individual: An individual who is deemed as meeting the eligibility requirements for full subsidy eligible individuals if the individual is entitled to Medicare and:

- A full benefit dual eligible individual (eligible for full Medicaid benefits);
- A recipient of Supplemental Security Income (SSI) benefits; or
- Eligible for full Medicaid benefits, and/or the Medicare Savings Program as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI) under a State's Medicaid plan.

Dual Status: Entitlement to Medicare and concurrent eligibility for a Title XIX benefit (i.e., Medicaid or a Medicare Savings Program).

Extra Help: The low-income subsidy (LIS) or subsidy.

Family Size: Includes the applicant, the spouse, if any, living in the same household and the number of individuals, if any, related to the applicant(s) living in the same household, and dependent on the applicant or the applicant's spouse for at least one-half of their financial support.

Federal Poverty Level (FPL): The income standard for poverty that is updated annually by the
U.S. Department of Health and Human Services and generally used as the basis for determining the low-income subsidy level. For more information regarding specific FPLs, see section 40.1.1.

Full Benefit Dual Eligible *(FBDE)* Individual: An individual who is entitled to Medicare and is eligible for comprehensive Medicaid benefits and meets the requirements of the definition at 42 CFR 423.772.

Full Subsidy: The amount of reductions to a full subsidy eligible individual's costs under a Part D plan, including:

- 100% subsidy of the monthly premium for basic prescription drug coverage up to the regional low-income premium subsidy amount;
- Elimination of the annual deductible;
- Reduced cost-sharing if the copayment under the basic or enhanced portion of the plan's benefit package is more than the applicable LIS copayment amounts provided in the annual Call Letter for Part D covered drugs (further explained in section 60.4);
- Elimination of the coverage gap;
- Elimination of cost-sharing above the annual out-of-pocket threshold; and,
- Waiver of late enrollment penalty.

Full Subsidy Eligible Individual:

- A subsidy eligible individual whose income is below 135 percent of the FPL applicable to the individual's family size and whose resources do not exceed the resources described in 42 CFR 423.773(b)(2)(ii). For current year resource limits see; and
- An individual deemed eligible as a full subsidy eligible individual.

Generic: A drug for which an application under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(j)) is approved.

Income: Money received in cash or in-kind by the applicant or a spouse who is living with the applicant that can be used to meet their needs for food and shelter. This definition includes the income of the applicant and spouse who is living in

the same household, if any, regardless of whether the spouse is also an applicant. Income for support and maintenance in kind is not counted as income to the applicant.

Individual Receiving Home and Community-Based Services (HCBS): A full-benefit dual eligible individual who is receiving services under a home and community-based waiver authorized for a State under section 1115 or subsection (c) or (d) of section 1915 of the Social Security Act or under a State plan amendment under subsection (i) of such section or if such services are provided through enrollment in a Medicaid managed care organization with a contract under section 1903(m) or under section 1932 of the Social Security Act.
Institutionalized Individual: A full-benefit dual eligible individual who is an inpatient in a medical institution or nursing facility for which payment is made under Medicaid throughout a calendar month, as defined in section 1902(q)(1)(B) of the Social Security Act.

Low-Income Subsidy (LIS) Individual's Premium Amount: The premium paid by the low- income subsidy beneficiary for basic prescription drug coverage after the premium subsidy amount is applied.

MA-PD plan: A plan offered by a Medicare Advantage (MA) organization that provides qualified prescription drug coverage.

Medicare Savings Program (MSP): For purposes of the Medicare Part D full subsidy eligibility, the Qualified Medicare Beneficiary (QMB) benefit, the Specified Low Income Medicare Beneficiary (SLMB) benefit, or the Qualifying Individual (QI) benefit under title XIX of the Social Security Act.

Multiple source or multi-source drug: A drug defined in section 1927(k)(7)(A)(i) of the Social Security Act.

Part D sponsor: A prescription drug plan (PDP) sponsor, MA organization offering an MA-PD plan, a Program for All-inclusive Care for the Elderly (PACE) organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage.

Partial Subsidy: Partial reductions in a beneficiary's costs imposed under a Part D plan, including:

- Reduction to the deductible when the deductible is greater than the maximum deductible amounts for partial subsidy eligible individuals (See *Annual Call Letter* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf)

- 25% to 100% subsidy of the monthly premium for basic prescription drug coverage up to the regional low-income premium subsidy amount;

- Reduction to 15% coinsurance per prescription for covered Part D drugs, up to the annual out-of-pocket threshold, and copayments of not more than the maximum copayments for Partial subsidy eligible individuals above the annual out-of-pocket threshold (*See Annual Call Letter* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf);
- Elimination of the coverage gap; and,
- Waiver of late enrollment penalty (LEP).

Partial subsidy eligible individual: Referred to as other low-income subsidy eligible individuals at 42 CFR 423.773, or a subsidy eligible individual who has:

- Income less than 150% of the Federal Poverty Level (FPL) applicable to the individual's family size; and
- Resources that do not exceed the amounts described in section 30.2. of this chapter (see current year resource limitations).

Personal representative: For purposes of this chapter, (1) an individual who is authorized to act on behalf of the applicant; (2) if the applicant is incapacitated; or incompetent, someone acting responsibly on their behalf, or (3) an individual of the applicant's choice who is requested by the applicant to act as his or her representative in the application process.

Preferred drug: A covered Part D drug on a Part D sponsor's formulary for which beneficiary cost-sharing is lower than for a non-preferred drug on the sponsor's formulary.

Preferred multiple source drugs: A drug that is both a preferred drug and a multiple source drug, meaning that one version of that drug is placed on the sponsor's formulary with lower cost sharing than for a non-preferred drug.

Prescription Drug Plan (PDP): Prescription drug coverage that is approved under 42 CFR 423.272 and that is offered by a PDP sponsor that has a contract with CMS.

Reference Month: The month in the previous calendar year as identified by CMS for the calculation of the low-income benchmark premium amount. See 423.780(b)(2), 422.258(c)(1).

Resources: With the exception of the value of the individual's life insurance policy, the liquid resources of an LIS applicant (and, if married, his or her spouse who is living in the same household), such as checking and savings accounts, stocks, bonds, and other resources that can be readily converted to cash within 20 days, that are not excluded from resources in section 1613 of the Act, and real estate that is not the applicant's primary residence or the land on which the

primary residence is located. The value of any life insurance policy is not counted as a resource to the applicant.

Regional low-income premium subsidy amount: The greater of the PDP region's low-income benchmark premium amount or the lowest monthly beneficiary premium for a PDP that offers basic prescription drug coverage in the PDP region as defined in section 50.2.1.

State: Each of the 50 States and the District of Columbia.

Subsidy: The low-income subsidy.

Supplemental drugs: Drugs that would be covered Part D drugs but for the fact that they are specifically excluded as Part D drugs under 42 CFR 423.100, and as described in chapter 6, section 20.1 of this manual. Because such drugs must have otherwise qualified as covered Part D drugs (as defined in chapter 6, section 10.2 of this manual) in order to be covered as a supplemental benefit, and because only prescription drugs are included in the definition of a Part D drug, over-the-counter drugs cannot be supplemental drugs, as discussed in chapter 6, section 10.10. Supplemental drugs may be included as a supplemental benefit under enhanced alternative coverage, as described in chapter 5, section 20.4.2 of this manual.

Transaction Reply Report (TRR): A report that CMS provides to Part D sponsors containing details of the rejected and accepted enrollment transactions that CMS has processed for a Part D sponsor's contract(s) over a specified time period. There are two types of TRRs: the Weekly TRR that covers the processing week (typically Sunday through Saturday) and the Monthly TRR that covers the payment processing month.

True Out-Of-Pocket costs (**TrOOP) –** See chapter 5, section 30 of this manual for the description of this term.