Dear patient,

Your Medicare Advantage plan has a new program for treating your retina eye disease. This program, which began on Jan. 1, 2019, is called **step therapy**. In the step-therapy program, your ophthalmologist must use the drug Avastin as the first step in treating your retinal disease.

Because we treated you with Avastin as part of the step-therapy program, your Medicare Advantage Plan is required to offer you additional new benefits. We want to make sure you know about these benefits listed here:

- You can participate in a new program that helps manage and coordinate your drugs. This is called a **Drug Management Care Coordination Program**. The program gives you information about your medications.

- If you participate in the Drug Management Care Coordination Program, your Medicare Advantage Plan must offer you a reward at completion (such as a gift card or other item of value). Because you were treated with Avastin instead of a more expensive drug, the reward could be substantial (i.e., it should equal at least 50% of what the Medicare Advantage Plan saved with this less expensive drug).

If you did not want to participate in the step-therapy program, you were supposed to be able to change your Medicare plan or participate in a different one. Changes in plan participation were allowed from January 1 to March 31, 2019.

After March 31, Medicare Advantage Plan participants are locked into their plan for the rest of the coverage period. (Remember that there will be an open enrollment period later this year when you can change your plan options for 2020.)

If you have not been offered the additional benefits listed above from your Medicare Advantage Plan, call your health plan directly to ask about them. Also, please let us know if you have already gotten these benefits from the Medicare Advantage Plan or if your plan refuses to offer them to you.

Thank you.

Sincerely,

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: September 17, 2012

TO: Medicare Advantage Organization, Section1876 Cost Contractors, Section 1833 Health Care Prepayment Plans and PACE Organizations

FROM: Danielle R. Moon, J.D., M.P.A.
Director

SUBJECT: Prohibition on Imposing Mandatory Step Therapy for Access to Part B Drugs and Services

The purpose of this memorandum is to remind Medicare Advantage Organizations (MAOs), Section 1876 Cost Contractors, Section 1833 Health Care Prepayment Plans, and PACE Organizations that the imposition of additional requirements for access to certain Part B drugs or services, such as step therapy requirements, is not permitted unless also required through Original Medicare.

Medicare health plans coordinate and manage care for their enrollees through a variety of techniques, such as provider/network contracting, plan authorization processes, provider referrals, case management, and disease management programs. CMS regulations at 42 C.F.R. §§ 417.414(b) and 422.101(a) and (b) require all Section 1876 cost plans and MAOs to "provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare…and that are available to beneficiaries residing in the plan's service area." The sections also require MAOs to comply with all national coverage decisions (NCDs); local coverage decisions (LCDs) written by Medicare contractors with jurisdiction for Medicare claims in the MAO or plan's service area; and coverage instructions and guidance in Medicare manuals, instructions and other guidance documents.

In addition, by virtue of §1934(b) of the Social Security Act, PACE organizations are required to provide all benefits covered under Original Medicare. This means that MAOs, PACE and cost plan enrollees must have, at minimum, equal access to items and services covered by Original Medicare in their service area. While plans may create coverage policies in the absence of an NCD or LCD, those policies may not be more restrictive than what Original Medicare allows and may not impose barriers to Parts A and B services, including, as described above, the imposition of step therapy requirements for Part B drugs and services (see Chapter 4 Medicare Managed Care Manual, sections 10.2 and 10.4). Finally, Section 1833 plans must also follow Original Medicare coverage criteria for the Part B services they furnish their members (see 42 C.F.R. §§ 417.800 and 417.801).

If you should have any questions regarding the information outlined in this memorandum, please contact Marty Abeln at Marty.Abeln@cms.hhs.gov or 410-786-1032.