

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0978**. The time required to complete this information collection is estimated to average **1 hour** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Dear State Official:

As you know, the Centers for Medicare & Medicaid Services (CMS) clarified our non-discrimination policy in the 2008 Call Letter to explicitly permit States to adopt reasonable coordinating criteria that will allow the SPAPs and Part D sponsors to provide quality coordination of care and benefits in the interest of our beneficiaries. Our revised approach allowed SPAPs with authorized representative status to enroll on behalf of their members into plans that agree to the State-specific coordination criteria, such as offering similar formularies, expanding pharmacy networks, and sharing historical claims data.

For calendar years 2008 and thereafter, we require SPAPs to submit information on their programs using the attached template (or an alternative format) to CMS, which will allow CMS to approve its coordination criteria prior to the beginning of the calendar year. For 2009 and thereafter, we have revised the template slightly to request information regarding the timing of States' enrollment activities relative to their authorized representative status (See section III. Enrollment). This will allow CMS to anticipate beneficiary inquiries to its call centers about enrollments that occur outside of the annual open-enrollment period. CMS is currently accepting the SPAP templates and SPAP information for CMS review for calendar year 2009.

To reiterate our current policy, the coordinating criteria adopted by an SPAP must serve the purpose of either easing the transition of SPAP members into the Part D benefit, or establishing reasonable administrative requirements. CMS will carefully review an SPAP's proposed criteria to ensure that it serves these legitimate purposes, and are not a pretext for steering beneficiaries towards one or more preferred plans. In addition, the coordinating criteria may not be unduly burdensome so as to deter a significant number of Part D plans from coordinating with the SPAP; rather, all Part D plans must have a real opportunity to coordinate with an SPAP on an equal basis. Finally, the SPAP must permit an SPAP member to enroll in a Part D plan that does not meet the SPAP's coordinating criteria, without negatively impacting the beneficiary's SPAP benefits.

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Attached is the standardized template and instructions for calendar year 2009. SPAPs are required to submit information regarding its program in the attached template (or an alternative format) by August 1 in order to expedite CMS's approval of its coordination criteria prior to the calendar year. CMS will review the state's template within 30 days. We believe this process will give the states enough time to issue a request for proposal (RFP) prior to the Part D benefit year. CMS's review of the state's template will be based upon the guidance we have provided in regulation at 42 CFR 423.464, Chapter 14 of the Medicare Prescription Drug Manual, and the 2007 SPAP Qualified Guidelines.

States should submit their scanned and signed template to the following email box: **SPAP_Plans@cms.hhs.gov**.

If you have questions regarding the instructions, please contact Christine Hinds on (410)786-4578 or Debbie Hunter on (410)786-0625.

Sincerely,

Abby L. Block
Director
Center for Beneficiary Choices

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Revised June 2008

SPAP Plan to Wrap-Around Part D

State _____

Program Name _____

I. Eligibility

Who is eligible for your state's SPAP benefits? Please provide applicable poverty and asset thresholds. If eligibility is linked to a specific disease or condition, LIS application status, and/or Part D enrollment status, please note that as well:

II. Financial Assistance

a) Is the SPAP adopting one of the lump sum approaches outlined in Chapter 14 of the Medicare Prescription Drug Benefit Manual? Please check at least one box.

1. Yes.
2. No, a lump sum approach is not being adopted.

b) If Yes to a., please check which approach you intend to use:

1. Risk-based
2. Non-risk based

c) If Yes to a., attach the RFP and indicate proposed publication date for RFP.

d) If you are not adopting a lump-sum approach, please check at least one box below, and describe the type of financial assistance to be provided with respect to wrapping around the Part D benefit:

1. Premium Assistance Only. (Provide description. For example – Providing premium assistance limited to \$30 per beneficiary, per month). _____

2. Cost-sharing assistance at point-of-sale (Provide description of type of cost sharing assistance and the limit on such cost sharing assistance. For example – SPAP pays for cost sharing of covered Part D drugs up to \$5 copay per

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prescription).

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3. ___ Both premium assistance and cost sharing. Provide Description.

III. Enrollment

a) Does your program intend to make Part D enrollment elections on behalf of your members as their authorized representative under state law? Please check at least one box below.

1. ___ No.
2. ___ Yes. **If yes, please respond to questions b & c below.**

b) What is the state's enrollment/assignment process? Please check at least one box below.

1. ___ Random assignment. You intend to enroll your members (spouses or members of the same household) randomly among:

- ___ All plans in state's region.
- ___ Plans at or below your region's low-income benchmark premium amount.

2. ___ Non-random assignment. You intend to enroll your members, using a member's unique characteristics such as prescription drug utilization. **Please attach a detailed description of the algorithm the state will use, including all of the steps you will use to arrive at the plan assignment.**

c) Do you intend to limit enrollment in particular plans based on established coordination criteria? Please check at least one box below.

1. ___ No.

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2. ___ Yes. **Please attach a detailed description of the coordinating criteria that the State will use, including the date that the RFP will be published.**

d) Please provide the approximate dates of when the SPAP will enroll its members into coordinating plans:

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NOTE: As required by our revised policy, SPAP benefits (premiums and cost sharing financial assistance) must apply if a beneficiary chooses to opt out into another plan outside of those that have agreed to coordinate benefits with the state, unless the state is limiting wrap-around benefits to beneficiaries joining certain plans in accordance with the risk-based lump sum approach noted in section II.

IV. Assurance

1. **___ I certify that at least annually, the State will submit a revised template by August 1. If the information contained in this template changes during the year, the State will submit a revised template for CMS approval.**
2. **___ The above information is correct and in accordance with 42 CFR 423.464, Chapter 14 of the Medicare Prescription Drug Manual as it applies to SPAPs, and enrollment guidance provided in the Qualified SPAP Guidelines.**

Signature: _____

Print Name: _____

Title: _____

Agency: _____

Date Submitted: _____ **Date approved by CMS:** _____

Signature of CMS Approving Official _____

Typed Name of CMS Approving Official _____

*Please submit your signed and scanned template to the following email box:
SPAP_Plans@cms.hhs.gov.*