

Attachment 2: 2017 SPAP template

Program Name and State:

Contact Information:

(SPAP Agency Official, Mailing Address, Email, and Phone):

(SPAP RxBIN/RxPCN/RxGroup ID, as applicable):

SPAP Processor Contact Information:

(SPAP Processor, Contact Name, Mailing Address, Email, and Phone):

I. Eligibility

A. Provide who is eligible for your state's SPAP benefits (specifying income and asset thresholds, and/or specific diseases/conditions):

B. SPAP eligibility conditioned upon LIS application?

- Yes
- No

C. SPAP eligibility conditioned upon Part D enrollment?

- Yes
- No

II. Financial Assistance/Benefits

A. Does the State use a lump sum approach (outlined in Chapter 14 of the Medicare Prescription Drug Benefit Manual)? Please check at least one box.

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

B. If yes to A., please check what type of approach you intend to use and attach the request for proposal (RFP) and indicate proposed publication date of RFP:

- Risk-based
- Non-risk based

Proposed publication date of RFP: _____

C. If not adopting lump-sum approach, indicate type of coverage provided:

- Premium only
- Cost sharing only
- Both

D. Describe the premium assistance provided by the SPAP, including a description of the member's premium obligation after the SPAP benefit is applied:

E. Describe the cost sharing assistance provided by the SPAP, including a description of the member's cost sharing obligation after the SPAP benefit is applied:

III. Enrollment

A. Indicate if State can enroll on behalf of your members as their authorized representative under State law.

- Yes. **If yes, please respond to questions B & C below.**
- No

B. Provide State's enrollment/assignment process? Please check at least one box below.

- Random assignment. State enrolls 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.
- Non-random assignment. State enrolls 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.**
- Limit enrollment to particular plans based on established coordination criteria.

C. Indicate when the State intends to enroll its members into Part D plans for the upcoming year:

Assurances

- **I certify that at least annually, the State will submit a template by August 5. If the information contained in this template changes during the year, the State will submit a revised template for CMS approval and will update the NCPDP SPAP-ADAP BIN/PCN Spreadsheet to reflect any changes.**
- **The information contained in this template is correct and in accordance with 42 CFR 423.464, Chapter 14 of the Medicare Prescription Drug Benefit Manual as it applies to SPAPs, and enrollment guidance provided in the Qualified SPAP Guidelines.**
- **I certify that the SPAP adheres to the coordination of benefits (COB) process as adopted by industry, has signed a data sharing agreement with CMS, and uses the**

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same unique 4Rx information (RxBIN/RxPCN/RxGroup) used to process claims secondary to Part D as what is reported on the monthly coordination of benefits (COBC) file submitted to CMS' contractor.

Signature of SPAP

Official: _____ **Date:** _____

Signature of CMS

Official: _____ **Date:** _____

Amy Larrick Chavez-Valdez, Director, Medicare Drug Benefit and C&D Data Group

Signature of CMS

Official: _____ **Date:** _____

Arrah Tabe-Bedward, Director, Medicare Enrollment & Appeals Group

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