DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
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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.