Medicare Part D 2024 Update

Fall Medicare Training for Professionals
October 11, 2023

Ginger Rogers
Medicare Part D Program Coordinator

SHIP
State Health Insurance Assistance Program

disabilityrights WISCONSIN

Acknowledgement

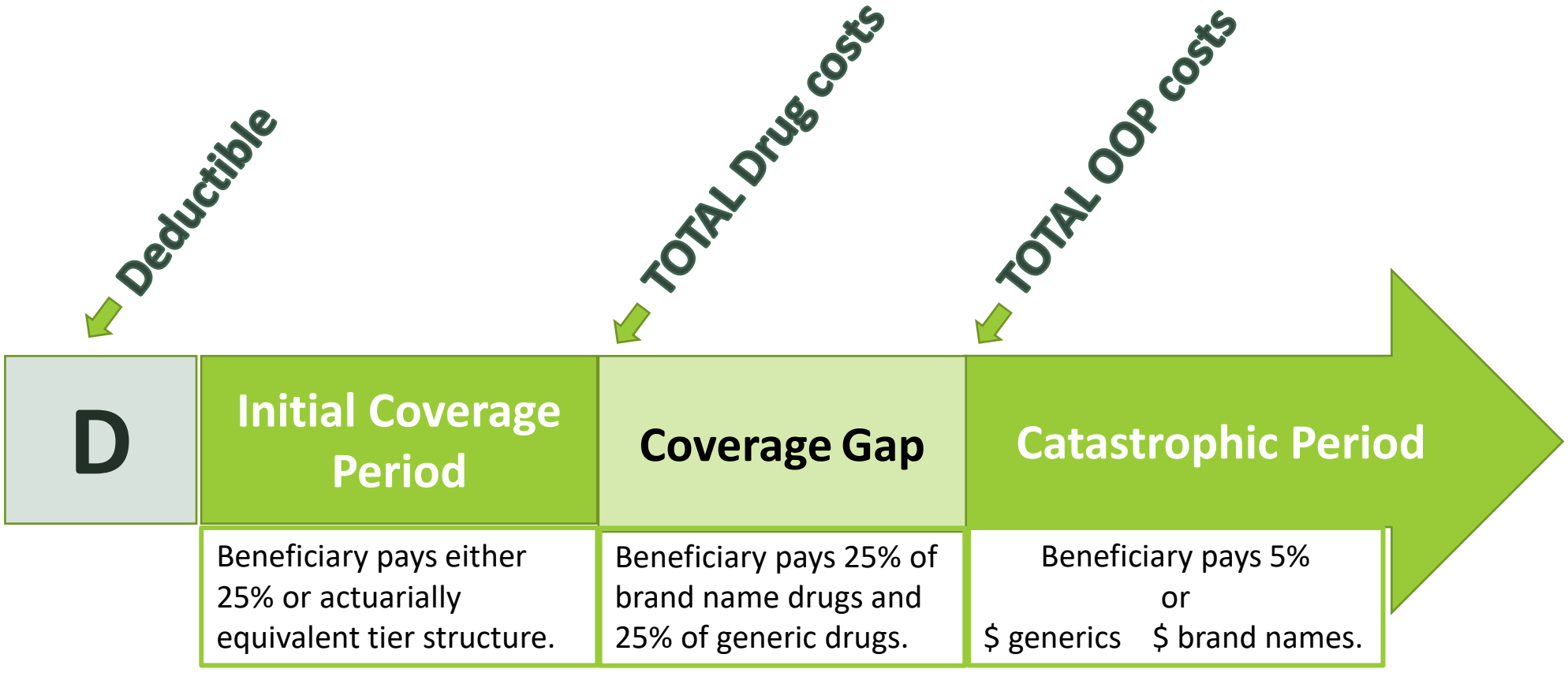
“This project was supported by the Wisconsin Department of Health Services with financial assistance, in whole or in part, by grant number 90SAPG0091, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.”

Objectives

- Part D structure for 2024
- Benchmarks for 2024
- 2024 Prescription Drug Plans
- Inflation Reduction Act for 2024
- Advanced Topics

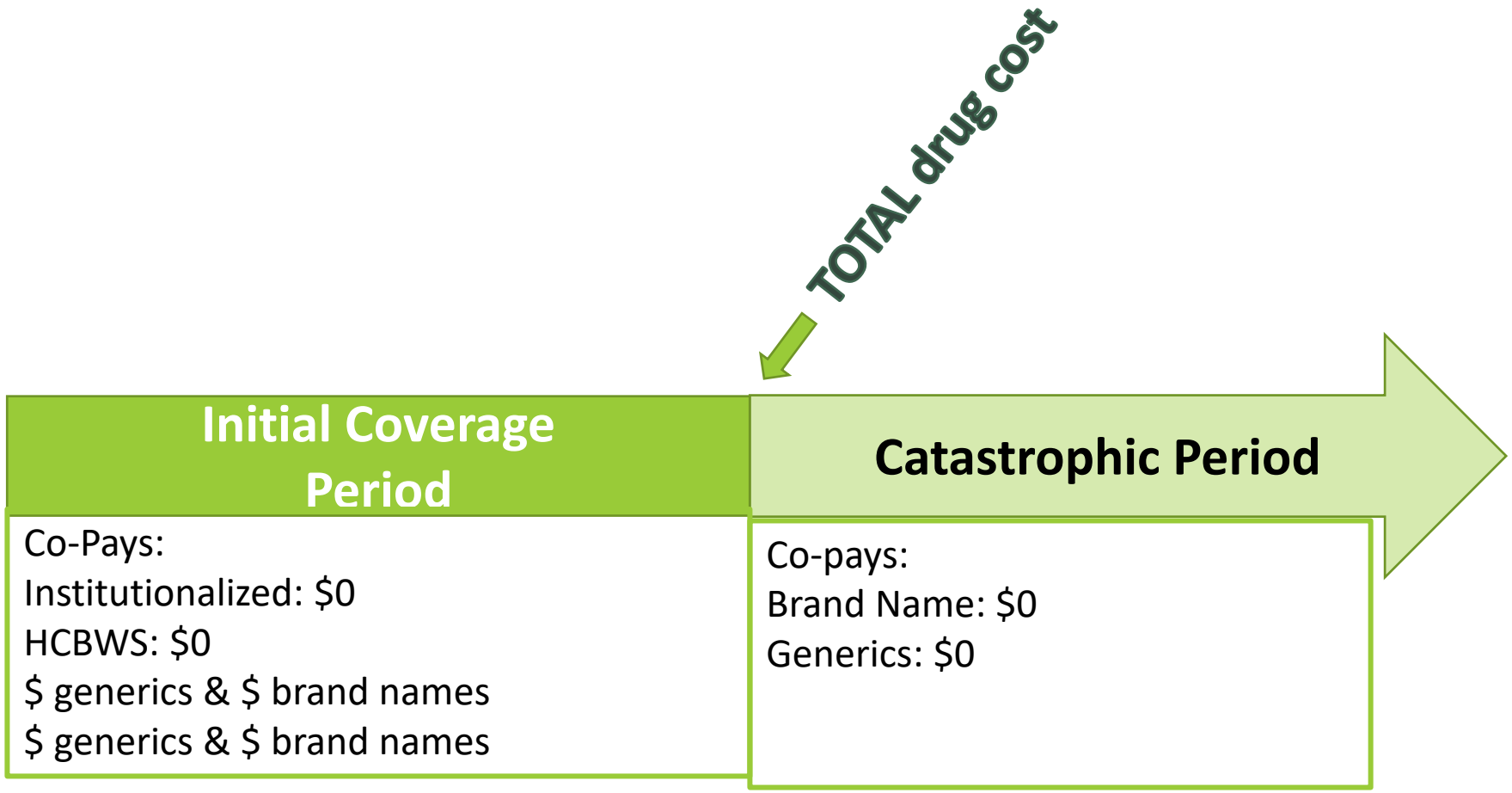
Part D Standard Structure

Medicare Part D Standard Structure



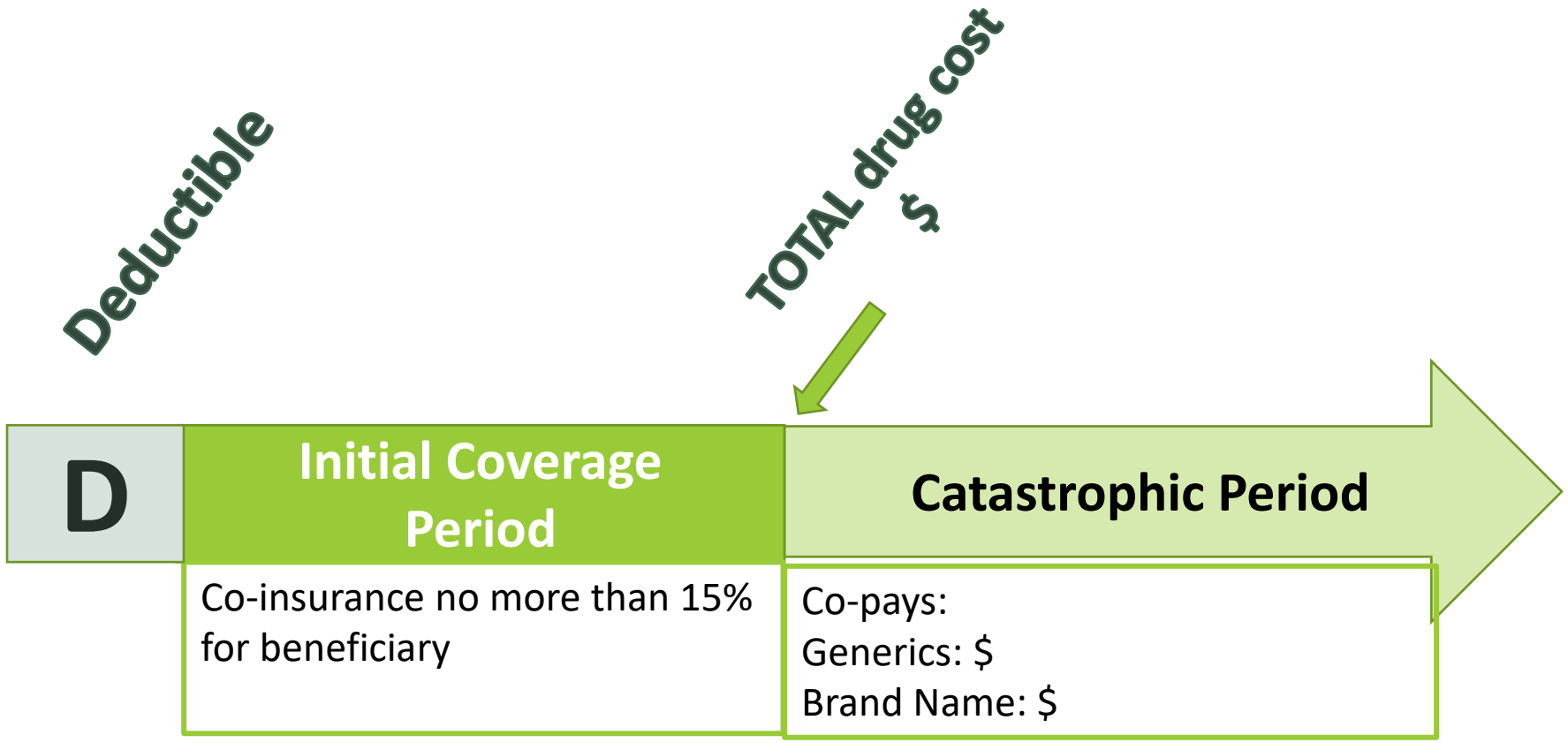
Effective January 1, 2006 – December 31, 2023

Medicare Part D LIS Structure



Effective January 1, 2006– December 31, 2023

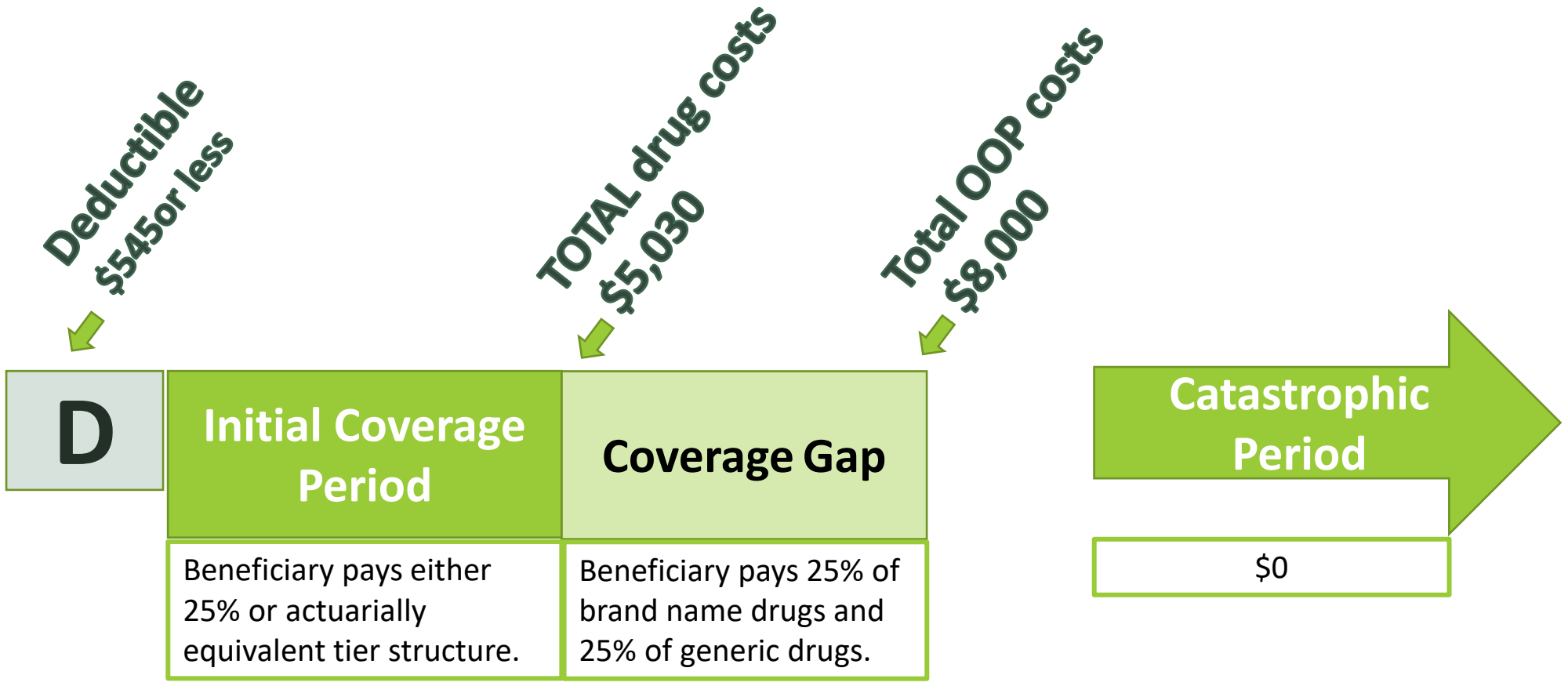
Medicare Part D Partial LIS Costs – Extra Help



Effective January 1, 2006 – December 31, 2023

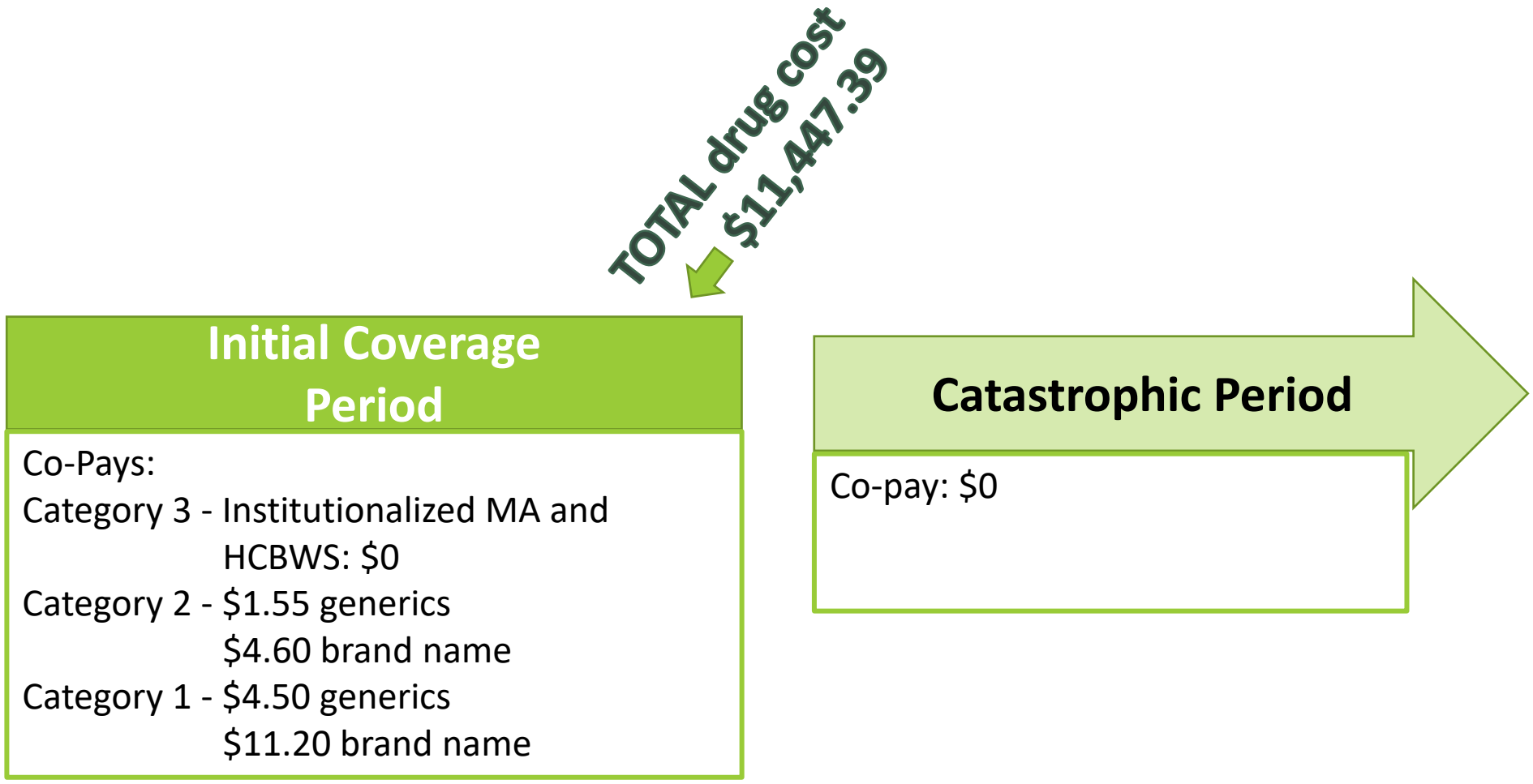
Standard Structure 2024

2024 Medicare Part D Standard Structure



Effective January 1, 2024 – December 31, 2024

2024 Medicare Part D LIS and Extra Help Structure



Effective January 1, 2024 – December 31, 2024

Changes to SSA Extra Help

- Partial extra help will no longer be available January 1, 2024
- All who are currently on partial extra help will become full extra help eligible
  - Those with partial extra help income 136%-149% FPL
- Will get all the benefits as full LIS
- Will receive notice of the change in LIS
  - **Orange letter should be mailed by October**

SSA Extra Help and Low Income Subsidy

- SSA Extra Help application is not the same as deemed LIS through Medicaid
  - Deemed eligibility through Medicaid overrides SSA Extra Help
- Check continuing eligibility for Medicaid
  - Forward Health or CARES
- Do not apply for Extra Help if Medicaid will continue

Counselor Tip:

Not sure if Medicaid is continuing? Client applied for Extra Help and has Medicaid? Call for assistance.

2024 Part D Benchmarks

- National Base premium = $34.70
  - Averaged PDP premiums from all states
- WI Regional LIS subsidy (benchmark) = $48.07
  - Averaged basic premium in Wisconsin
- De minimus = $2.00
  - Basic plans can voluntarily waive up to $2 over the regional benchmark premium
  - No de minimus plans in Wisconsin for 2024

Counselor Tip:
National Base Premium is used to determine LEP. WI Regional LIS subsidy is used to determine low cost plans.

2024 Prescription Drug Plans

Prescription Drug Plans

Low Cost (Benchmark) Plans

CY2024 Medicare Part D Stand-Alone Prescription Drug Plans

Data as of September 05, 2023. Includes CY2024 approved contracts/plans. Employer sponsored plans (800 series) are excluded. Plans under sanction are not shown.

Notes: Data are subject to change as contracts are finalized. For CY2024, enhanced alternative plans may offer additional cost-sharing reductions in the gap on a sub-set of the formulary drugs, beyond the standard Part D benefit.

State	Company Name	Plan Name	Benefit Type	Benefit Type Detail	$0 Premiu	Monthly Drug Pr	Annual Drug D	Contract ID	Plan ID	Summary Star Rating
Wisconsin	Wellcare	Wellcare Classic (PDP)	Basic	AE	x	$44.50	$545.00	S4802	097	
Wisconsin	Wellcare	Wellcare Value Script (PDP)	Enhanced	EA		$0.00	$545.00	S4802	132	
Wisconsin	Wellcare	Wellcare Medicare Rx Value Plus (PDP)	Enhanced	EA		$78.90	$0.00	S4802	219	
Wisconsin	Anthem MediBlue Rx (PDP)	Anthem MediBlue Rx Standard (PDP)	Basic	BA		$83.60	$545.00	S5596	056	
Wisconsin	Anthem MediBlue Rx (PDP)	Anthem MediBlue Rx Plus (PDP)	Enhanced	EA		$89.50	$0.00	S5596	057	
Wisconsin	Aetna Medicare	SilverScript Choice (PDP)	Basic	AE	x	$45.60	$545.00	S5601	032	
Wisconsin	Aetna Medicare	SilverScript Plus (PDP)	Enhanced	EA		$98.70	$200.00	S5601	033	
Wisconsin	Aetna Medicare	SilverScript SmartSaver (PDP)	Enhanced	EA		$9.80	$280.00	S5601	191	
Wisconsin	Cigna	Cigna Secure Rx (PDP)	Basic	AE	x	$48.00	$545.00	S5617	223	
Wisconsin	Cigna	Cigna Extra Rx (PDP)	Enhanced	EA		$79.60	$145.00	S5617	261	
Wisconsin	Cigna	Cigna Saver Rx (PDP)	Enhanced	EA		$22.60	$545.00	S5617	366	
Wisconsin	UnitedHealthcare	AARP Medicare Rx Preferred from UHC (PDP)	Enhanced	EA		$100.70	$0.00	S5820	015	
Wisconsin	Humana	Humana Basic Rx Plan (PDP)	Basic	AE	x	$48.00	$545.00	S5884	139	
Wisconsin	Humana	Humana Premier Rx Plan (PDP)	Enhanced	EA		$106.60	$200.00	S5884	162	
Wisconsin	Humana	Humana Walmart Value Rx Plan (PDP)	Enhanced	EA		$35.30	$545.00	S5884	195	
Wisconsin	UnitedHealthcare	AARP Medicare Rx Basic from UHC (PDP)	Basic	AE	x	$41.60	$545.00	S5921	361	
Wisconsin	UnitedHealthcare	AARP Medicare Rx Walgreens from UHC (PDP)	Enhanced	EA		$54.20	$410.00	S5921	397	
Wisconsin	Clear Spring Health	Clear Spring Health Value Rx (PDP)	Basic	AE	x	$34.30	$545.00	S6946	013	
Wisconsin	Mutual of Omaha Rx	Mutual of Omaha Rx Plus (PDP)	Basic	AE	x	$46.30	$545.00	S7126	015	
Wisconsin	Mutual of Omaha Rx	Mutual of Omaha Rx Premier (PDP)	Enhanced	EA		$77.80	$349.00	S7126	085	
Wisconsin	Mutual of Omaha Rx	Mutual of Omaha Rx Essential (PDP)	Enhanced	EA		$22.10	$545.00	S7126	118	

2024 Prescription Drug Plans (PDPs)

- 21 plans in Wisconsin
  - Available in all counties
- **NEW** $0 premium plan
  - Wellcare Value Script
- Highest premium plan - $106
  - Humana Premier Rx Plan
- Reduced premium for 2024
  - United Health Care AARP Medicare Rx Preferred
  - Mutual of Omaha Rx Plus

2024 Prescription Drug Plans, Continued

- 7 low cost plans
  - **New** low cost plan - Mutual of Omaha Rx Plus
- Name Change
  - United Health Care AARP Medicare Rx Plus

    Changed to
  - United Health Care AARP Medicare Rx Basic

2023 Plans Not Available in 2024

- Elixir Rx Secure – Low Cost plan for 2023
  - Plan terminated - no crosswalk
  - SEP to change plan because of termination is effective November 1 – January 31
  - SEP for Involuntary Loss of Creditable coverage is available starting January 1, 2024- February 28
  - Don’t forget LINET!
- Notices
  - Dual Eligible auto/facilitated enrolled will receive a blue reassignment notice
  - Choosers will receive blue notice of non renewal and should pick a new plan
  - Random reassignment for auto/facilitated

Counselor Tip: Notices will be sent in November. The first notice will tell the client the plan will not renew, and the second will information on the new plan for 2024. Choosers will not be reassigned

Plan not available in 2024, continued

- Clear Spring Premier Rx
  - Consolidated into Clear Spring Health Value

Counselor Tip:

Consolidation does not allow for a SEP. Part D regulations allow two plans to merge as long as they have the same contract number. Annual Notice of Change is used to notify plan members of the merger.

Inflation Reduction Act (IRA) Insulin and Vaccine Cost Sharing Continues for 2024

Senior Savings Model

Cost Sharing Cap on Insulin

Cost Sharing Cap Adult Vaccines

Part D Senior Savings (PDSS) Model

- Still available until December 31, 2023
  - IRA did not eliminate the model

Counselor Tip:

Newly eligible Medicare beneficiaries October through December who are on insulin will need careful plan comparison. Make sure to look at both the 2023 plan and the same 2024 plan, if available, for similarities.

Vaccine and Insulin Plan Cost Sharing Continues

Cost sharing for vaccines for 2024 will remain $0 for vaccines and $35 or less for insulin

- Plan Finder will show costs for insulin and vaccines as approved in the 2024 individual plan bid
- Plans cannot charge more than the statutory limit for vaccines and insulin
  - If plan member is charged for a vaccine administration fee, must be reimbursed
- Out of Network claims
  - Cannot charge more than the statutory limit

Insulin Coverage under Part B and D

- Must be an insulin product
  - Includes combination products that include insulin and other non-insulin products
  - If not on plan formulary, ask for a coverage determination
- Insulin delivered through covered Part B durable medical equipment (DME), i.e., insulin pump, is also aligned with the $35 cost sharing
  - No Part B deductible

Counselor Tip:

Prescription drugs, including injectable drugs, that are not insulin products or combination products that combine an insulin product with another drug are **not** covered by the $35 cost-sharing cap. E.g. Ozempic, Victoza. Jardiance

Cost Sharing Cap on Insulin - How it Works

- Prescribed two vials of the same insulin monthly
  - Cost share is $35
  - Two different insulins, $35 each
- Prescribed 3 month supply of insulin
  - Cost share is $105
- Prescribed one package of insulin pens in one month
  - Cost share is $35
- Prescribed another type insulin in the same month
  - Cost share is $35

Part D Vaccine Coverage and Access

Adult Immunization Schedule by Vaccine and Age Group | CDC

- Part B preventive vaccines have been free of charge since ACA 2010
  - Covid-19 (2020 and 2023)
  - Influenza
  - Pneumococcal
  - Hepatitis B
- Recommended Advisory Committee on Immunization Practices (ACIP) adult vaccines, e.g.
  - Shingles
  - Tetanus

Counselor Tip:
There is a B v D difference between a tetanus booster and a tetanus vaccine because of injury. Part B vaccines v Part D vaccines can be tricky, ask for assistance if not sure.

In-Network Access to Part D Vaccine

MLN908764 – Medicare Part D Vaccines (cms.gov)

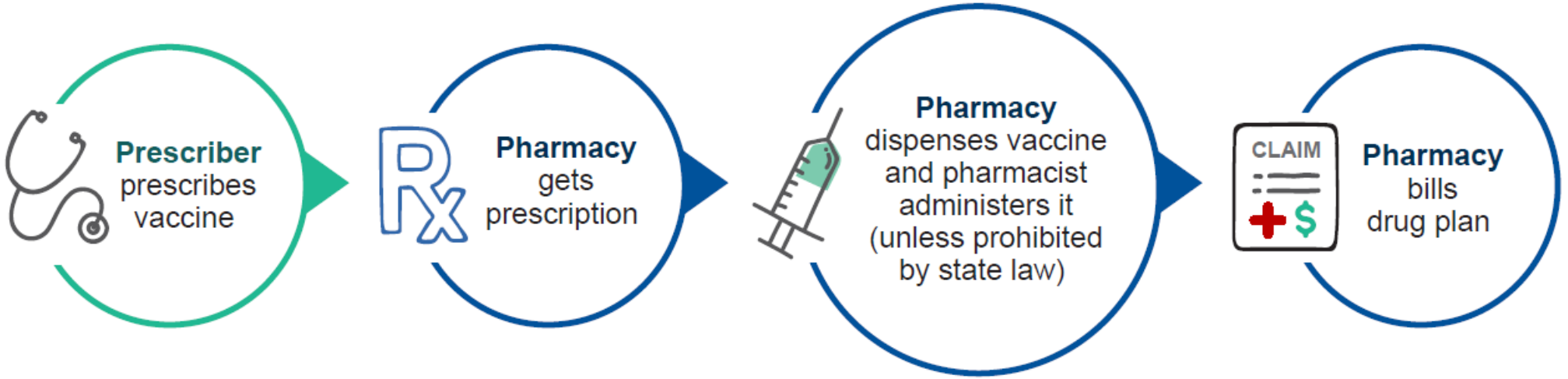


Figure 1. In-Network Pharmacy Administers Vaccine*

*Most prescribed vaccines are ACIP-recommended. If a prescriber suggests their patient get a vaccine that isn't ACIP-recommended, the drug plan may charge the patient coinsurance or a copayment.

Pharmacy Provides Vaccine and Prescriber Bills Administration – Out of Network

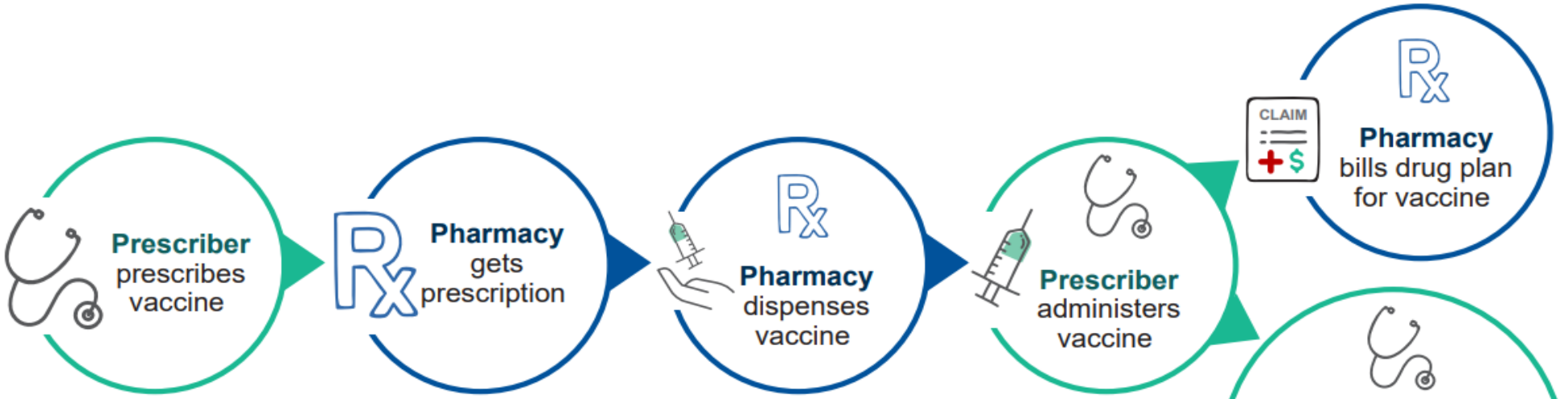


Figure 2. In-Network Pharmacy Provides Vaccine* to Prescriber to Administer

**Vaccine administration in prescribers' offices is considered out-of-network because sponsors' networks are defined as pharmacy networks only.

QUESTIONS?

Break – 5 minutes

To help you track when we will resume, each bar takes 1 minute to disappear from the slide…

Additional Update Topics - Advanced

Medicaid v Medicare Drug Coverage
Off Label Usage
Coverage Determinations
LINET and Retroactive LIS
Best Available Evidence
Auto and Facilitated Plan Enrollment

Covered Part D Drug

- A drug, approved by the FDA that may be dispensed only upon a prescription,
- A biological product,
- Insulin,
- Medical supplies associated with the delivery of insulin,
- A vaccine licensed under section 351 off the Public Health Service Act and its administration, and
- Included in a Part D sponsor's formulary or treated as included as the result of a coverage determination.

Medicaid v Medicare Drug Coverage

- Medicaid stops covering medications when Medicare starts
  - Effective month of Medicare eligibility
- Medicaid may cover Part B drug coinsurance
  - Original Medicare
  - Medicare Advantage
- Medicare Part D excluded medications will be covered by Medicaid
  - If the drug is covered by Medicaid

Counselor Tip:

If you are not sure about drug coverage, ask for assistance. Remember, not on formulary **does not** mean excluded from coverage. The terms are not interchangeable.

Medicare v Medicaid Rx Coverage
Forward Health Provider Online Handbook Topic 1947

BadgerCare Plus and Wisconsin Medicaid deny claims for Medicare Part D-covered drugs for dual eligibles. Claims and PA requests for Medicare Part D-covered drugs for dual eligibles must be submitted to the appropriate Medicare Part D PDP.

Drugs Excluded from Coverage by Medicare Part D

Providers may submit claims for drugs that are covered by BadgerCare Plus and Medicaid but are excluded from coverage by Medicare Part D. All other claims will be denied and the pharmacy provider will be instructed to submit the claim to the Medicare Part D PDP. Providers will receive an EOB code for this denial.

Medicare Part D excluded drugs include OTC drugs; agents that are used for the symptomatic relief of cough and cold; prescription vitamins and mineral products (**except** prenatal vitamins and fluoride); and weight loss agents.

PA requests for drugs covered by Medicare Part will be denied because these drugs will be covered by a Medicare Part D PDP.

Online Handbook Display (wi.gov)

Medications Excluded from Part D

- Agents when used for anorexia, weight loss, or weight gain (even if used for a non cosmetic purpose (i.e., morbid obesity)).
- Agents when used to promote fertility.
- Agents when used for cosmetic purposes or hair growth.
- Agents when used for the symptomatic relief of cough and colds.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Nonprescription drugs

Excluded Medications that are Medically Necessary (not Excluded)

- Prescription drug products used for AIDS wasting and cachexia due to a chronic disease either used for weight gain or agents used for cosmetic purposes.
- Part D drugs indicated for the treatment of psoriasis, acne, rosacea, or vitiligo are not considered cosmetic.
- Vitamin D analogs such as calcitriol, doxercalciferol, and paricalcitol when used for a medically-accepted indication
- Prescription-only smoking cessation products.
- Cough and cold medications are eligible to meet the definition of a Part D drug in clinically relevant situations other than those of symptomatic relief of cough and/or colds.

Part D Drug Off Label Usage

- Part D limits coverage of medications to medically accepted indications
- Medication Off Label usage
  - Any medication use not approved by the FDA and not listed on the label
    - Lidocaine Patches – approved for herpetic pain (Shingles) only
  - Off label use is covered only if identified as safe and effective in the officially recognized compendia
- Pharmaceutical companies are not allowed to promote medications for off label use
- Difficult, if not almost impossible, for beneficiary to get this information

Off Label Usage, cont.

- Considered Off Label usage if given in a different manner
  - Dispensed only in a capsule, but prescribed as a solution
  - Approved for one dose each day, but prescribed 2 doses each day

Counselor Tip: These types of off label usage may be covered in certain circumstances. Get thorough information on the reason for the change in dispensation of the drug. Ask for assistance to determine next steps in the exception/appeal process.

LCD - Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394) (cms.gov)

Coverage Determinations
Aka, Coverage Request, Exception Request

- Request for coverage of a medication that is on or not on formulary
- Multiple types of coverage determinations
  - Tiering (cost sharing)
  - Medical Necessity
  - Out of Network
  - Satisfaction of Utilization Management requirements
- Plan time frame for determination
  - Standard – 72 hours to determine coverage
  - Expedited – 24 hours to determine coverage

Coverage Determinations

Important to remember the time frame and the need for information from prescriber

- Clients can call the plan to start the process
- Plans must assist the client to get information needed
  - Includes contacting the prescriber
- An expedited determination must be requested by the prescriber

Counselor Tip: Clock starts ticking for the plan decision when it receives all the information needed.

Complaints and Grievances

- Guidance is combined for Medicare Advantage and Medicare Part D Parts C&D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance (cms.gov)
- Complaints and Grievances are not the same
- Plans are required to distinguish the difference and reply to the plan member in a timely manner

Grievance

- An expression of dissatisfaction about plan provision of services or benefits
  - Operation, Activities, Behavior
- Examples of a Grievance
  - Plan benefit design
  - Premium or payment increase
  - Call wait time
- Grievances must be resolved within 30 days
  - Answer must be in writing
  - Not appealable

Complaint

- CMS considers a complaint as a higher level of grievance
  - CMS does not define complaint
  - Not an appeal
- Complaints are usually filed after an adverse event
  - Enrollment and marketing issues/problems
  - Plan is not processing premium payments
  - Medicare beneficiary rights and protections are not being followed
    - Network inadequacy
- Complaints are used to determine how well a plan is complying with Medicare Health and Drug plan regulations
  - Can affect star ratings
  - Complaint Tracking Module

Complaint Tracking Module (CTM)

- CMS tracks the problems plan members are having with the plans
  - Plans are required to enter complaints into the complaint tracking module
- Wisconsin SHIP uses the information from the complaints filed to make sure that we know the issues in our beneficiary community.
- Complaints are resolved and overseen by CMS
  - Plan level
  - CMS level

Wisconsin CTM Process

- SHIP counselor points of contact to file a complaint
  - Jill Helgeson- Jill.Helgeson@wisconsin.gov - Medigap Helpline
  - Alyssa Kulpa - Alyssa.Kulpa@gwaar.org - GWAAR
  - Ginger Rogers - Ginger.Rogers@drwi.org - Medicare Part D Helpline
- Complaint must be valid
  - Only Medicare Advantage and Medicare Part D
- We can only see what we file
  - Ask your client if they previously filed a complaint on the issue
  - Wisconsin cannot access a complaint has been filed by 1-800-Medicare

Steps to File a Complaint

- Get the information from the client on what happened and when
  - Discuss with client what you are doing and why a complaint should be filed
  - Client makes the decision to go forward
- Contact the plan-Complaint will **not** be filed without this contact first!
  - Ask the plan to correct the issue
  - Document the contac
    - Date, time and persons you spoke to and, if client called, when and to whom they spoke
    - Include information if you were transferred to another department
- Summarize the issue and all actions taken in writing
  - Include the resolution expected
- Contact a point of contact
  - DBS and EBS must contact program attorney first
- If valid, the complaint will be filed
  - CMS can take up to 30 days for resolution

CTM, continued

- If the complaint is a marketing issue
  - Get the agent's name
  - Get the 800 # called if on TV
  - Additional complaint filed with Office of the Commissioner of Insurance (OCI)
- Complaints can be filed:
  - By calling 1-800-MEDICARE
  - Calling the plan directly
  - Representative can file complaint on behalf of beneficiary
  - By Wisconsin Point of Contact

Counselor Tip:
SHIP counselors who are not Benefit Specialists should contact their supervisor and a Helpline for assistance.

LINET

LI NET currently operates as a demonstration program that provides immediate and retroactive Part D coverage for eligible low-income beneficiaries who do not yet have prescription drug coverage. The LINET program as of January 1, 2024 becomes a permanent part of Medicare Part D, as required by section 118 of the Consolidated Appropriations Act(CAA).

LINET – Limited Income Newly Eligible Transition program

- Administered by Humana
  - Since 2010
- Current coverage for dual eligible and extra help eligible
  - Provides immediate coverage for those without Part D
  - Usually eligible for 1 -2 months
  - Open formulary with some exceptions
    - Opioid edits
    - Excluded Part D drugs are not covered
- Retroactive eligibility is available in certain circumstances
  - Coverage is available by submitting a direct member reimbursement form

LINET Retroactive Coverage

- Available to those who are SSI eligible
  - Usually with retroactive disability determination
- Available to those with retroactive Medicaid
  - Effective date of Medicare eligibility if new to Medicare
  - Effective date of Medicaid eligibility if already on Medicare
    - Up to 36 months
- If already paid out of pocket during a LINET eligible period
  - can submit a receipt for reimbursement

docushare-app (humana.com)

LINET and Dual Eligible New to Medicare

- Let CMS do the work for your client
  - Facilitated enrollment
- Your client will benefit
  - No deductible
  - No premium
  - Automatic LIS (category 1)
  - No BAE (Best Available Evidence) submission wait time
- Plan can always be changed if not a good fit
  - Quarterly SEP

New to Medicare Dual Eligible and Enrollment in Part D

Tell your client the following:

- Enroll in LINET at the Point of Sale (POS) at the pharmacy counter
  - Give/email 4 steps for Pharmacy Providers Medicare's LINET Pharmacy Resources - Humana, or
  - Fax to Pharmacy
- Will receive a letter and card from Humana @ 2 weeks
  - May be facilitated enrolled in Humana, so make sure your client understands
- Will receive a yellow letter from CMS that will give them the **date** and **plan** in which they will be enrolled
  - Plan facilitated enrollment is usually effective 2 months after eligibility for LIS
  - LINET will continue to cover medications until new plan starts
- Will receive a new card and welcome materials from plan
- **Make an appointment to see you before taking any action to change coverage.**

Best Available Evidence (BAE)

Submission to current plan or LINET information needed to substantiate LIS

- State of Wisconsin Medicaid only updates to CMS once per month
- Plans are required to accept evidence of eligibility for LIS
- Plan must provide access to covered Part D drugs at a reduced cost sharing level
  - Category 1
  - Category 3 if institutionalized
- Update plan system within 48-72 hours of receipt of documentation
- Must assist members if cannot produce documentation
- Must develop appropriate member services and pharmacy help desk to identify BAE cases

Acceptable BAE

- A copy of a state document that confirms active Medicaid status
- A printout from Forward Health Interchange enrollment file
- A screen shot from CARES or Forward Health showing Medicaid status
- Other state documentation
  - Notice of decision
- SSA award letter for extra help

How to Submit BAE

- Call the plan BAE contact
  - You do not have to be a SHIP counselor
- Fax
- Email

Here is the link for BAE contacts. :
Part D Contacts | CMS

Counselor Tip:
Include a statement about your client, outlining FBDE status effective date, if the client has 3 or less days of medication or none, what you want the plan to do and that you will follow up in 2 days. Contact a helpline for assistance.

Auto and Facilitated Enrollment

- Auto Enrollment
  - The process by which full benefit dual eligible individuals who have not elected a Part D plan are enrolled into a Part D Plan by CMS
  - SSI only beneficiaries
- Facilitated Enrollment
  - The process by which non full benefit dual eligible and non dual eligible LIS beneficiaries eligible for the low income subsidy who have not elected a Part D plan are enrolled in a Part D plan.
  - MSP only, Extra Help.

Counselor Tip: Auto enrollment is often used interchangeably for both types of enrollment

Auto and Facilitated Enrollment

- CMS will randomly enroll a LIS eligible beneficiary
  - Low cost plans only
- Facilitated Enrollment is effective 2 months after CMS is notified of LIS eligibility
- Auto enrollment for SSI only and effective the month of Medicare eligibility
  - All other random LIS enrollment is facilitated
- Will receive a yellow letter
  - With name of plan and effective date
- Client has the right to accept the randomly assigned plan or choose another

Plan Enrollment and Ranking during OEP and IEP

- During the OEP and before January 1
  - Can change any elected plan effective January 1, until Dec. 7
    - Last plan choice will be the plan effective January
  - Dec. 8 – Dec. 31 can elect to withdraw the application
    - Will go back to current plan, PDP or MA/MAPD, if continuing in the new plan year
- Ranking for those who become Medicare eligible during the OEP

1. IEP for Part D
2. SEP
3. AEP

Counselor Tip: One the IEP is used, it cannot be used again. For those who are in their IEP, make sure the plan choice is available next plan year, or select an additional plan to be effective January 1.

CMS Notices and Plan Mailings

CMS Notices

- Grey Notice - Loss of LIS
- Blue Notice - Reassignment
- Yellow Notice - Auto Enrollment
- Purple Notice - LIS
- Orange Notice - Change in LIS status

Plan Mailings

- ANOC and Summary of Benefits in September and October
- Creditable coverage notice in November

Resources

- Special Enrollment Chart
  - Microsoft Word - SEP-Chart.doc (medicareinteractive.org)
- CMS Consumer Mailings
  - Guide to CMS consumer mailings.
- LINET
  - Resources for Medicare LINET Beneficiaries - Humana
- Prescription Drug Manual
  - Prescription Drug Benefit Manual | CMS

Final Thoughts

Part D changes 2025 - CMS has already started releasing some information and we anticipate the changes will be finalized by the end of the 1st quarter 2024

- $2000 cap on Medicare Part D covered prescription costs
  - Part D structure will not look or work the same
- New ways for clients to pay drug costs
  - Medicare Prescription Payment Plan
- New marketing
- New educational materials

All of us will be working diligently behind the scenes to make sure you are kept informed. Stay tuned!

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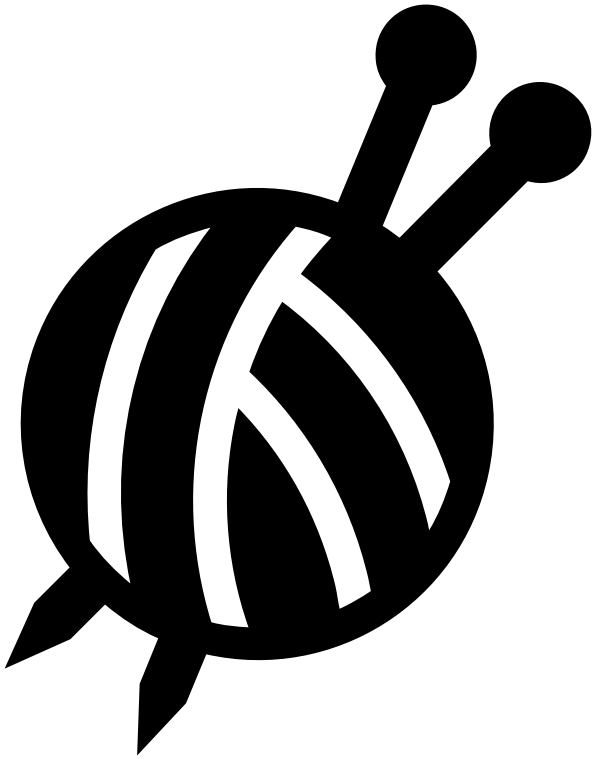

QUESTIONS?