

Q&A Session for CMS Medicaid and CHIP Managed Care Final Rule- Guidance to Medicaid Managed Care Plans on Pharmacy

Date: Friday, March 09, 2018

Q1: Do we know what kind of DUR programs CMS wants us to implement this year so that it will be available for reporting in 2019? Is there any guideline or draft available?

A: <https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/index.html>

See these areas:

- Medicaid Drug Utilization Review (DUR) Annual Reports
- The FFY 2016 DUR annual reports are now posted and can be viewed at Drug Utilization Review Annual Report.
- FFY 2016 Drug Utilization Review
- The fee-for-service data from the FFY 2016 DUR reports have been compiled and presented in a similar format to last year in one State Comparison/Summary Report FFY 2016 (PDF 830.38 KB).

To help address the opioid abuse epidemic, please note that states have actively implemented several management control measures such as: using quantity limits and days' supply limits for short-acting and long-acting opiates, applying statewide prescription drug monitoring programs and utilizing morphine daily dose alerts to prevent drug overdose. More guidance will be given from CMS; as the information becomes available it will be shared with the plans.

Q2: Can the state please clarify if there is any flexibility or areas of interpretation regarding making determinations of coverage within 24 hours. This is a substantial change in timeframe and it would be good if the state had ideas on how best to comply.

A: The 24-hour review applies only to authorization requests for covered outpatient drugs as defined by SSA §1927. The review clock starts when a completed prior authorization form is sent in. Where the provider has accepted the responsibility of letting the member know the status of the request, and the plan receives an incomplete prior authorization form, the plan can notify the provider the form needs to be completed and re-submitted without starting the 24 - hour review clock. Once the prior authorization form is complete, the plan has 24 hours to ask for any additional info (lab reports, chart notes, or any clinical information) and make a determination. The provider and enrollee are to be verbally notified of the determination within the 24-hour timeframe. Written notice will be provided as per NYS PHL §4903.

Q3: What are the timeframes for the pharmacy related appeals? standard and expedited? I have received information that I need to confirm.

A: The timeframes are the same as for any service appeal. Additional information can be found on this site: https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm

Q4: Although not in the current contract, the encounter data that gets reported currently includes the 340B identifiers. Does the State agree that the only real change for managed care plans in this area is the 45 days TAT regarding encounters, is that right?

A: Yes, this is correct.

Q5: Do you have any specifics relative to the coverage of compounds? Can there be limits, etc.?

A: Coverage of compounds has not change. FFS coverage of compounds can be found here on page 29.

https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Policy_Guidelines.pdf

Please refer to the Medicaid FFS formulary file for drugs that are covered under FFS.

<https://www.emedny.org/info/formfile.aspx>

Q6: Should the printed formularies be in font size of 12? This is regarding the 438.10(d)(5)(II) section.

A: Yes, all member materials need to comply with the font size in requirement of 42 CFR 438.10.

Q7: What are NY guidelines regarding DUR Board? (Individual plan board or State run board?)

A: Please see the following webpage for information on the Medicaid FFS DUR board.

https://www.health.ny.gov/health_care/medicaid/program/dur/

The MCO's have their own DUR/P&T boards/committees. The Medicaid FFS DUR Board does have MCO representation and the information presented is webcasted as well as shared with the MCO's post meeting. Please see: Social Services Law, Sections 369-AA through 369-CC.

Q8: Has there been a change to pharmacy network time and distance?

A: Per the current contract, plans should be following Medicare Part D time and distance standards. This will not change.

Q9: For the Pharmacy network, are we allowed to have out of State locations in the Medicaid network? Does the state allow out of state locations to get a NY Medicaid ID?

A: Please see the FAQs related to provider enrollment, which can be found at the followingsite:https://www.emedny.org/info/ProviderEnrollment/ManagedCareNetwork/FAQs.aspx?cat=*

Q10: May an MCO operate a closed formulary or must plans make all outpatient drugs available? May an MCO exclude drugs that are covered by FFS?

A: Yes, MCOs may operate a closed formulary and exclude drugs on the formulary that are covered under FFS, however if a medication is available on the FFS formulary it must be made available through the exception process when medically necessary.

Q11: May an MCO adhere to a step therapy program?

A: Yes, if it complies with the statutory language and guidance. See: Chapter 512 of the Laws of 2016, Insurance Law §4900(g-9) and Public Health Law § 4903(7-f-3). These are the FAQ's currently available: http://www.dfs.ny.gov/insurance/health/step_therapy_legislation_qa.htm . Additional guidance on step therapy protocol override determinations is forthcoming.

Q12: Does the MCO need to provide an exceptions process to allow direct access to the high tier drug?

A: Yes, the plan must have an exception process.

Q13: Is it permissible for the MCO to require use of generics when available?

A: Yes, pursuant to the NYS Mandatory generic law (Public Health Law § 206(o)); however, if a brand medication is medically necessary and available on the FFS formulary, the plan must review the request through the exception process.

Q14. What must an MCO do to determine that a drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs over other drugs? What 'population' must be considered in making such a determination? May an MCO make such a determination when the state has not made the same determination?

A: Medicaid FFS does not currently exclude any drug in accordance with section 1927(d)(4)(C) of the Federal Social Security Act. If or when Medicaid FFS decides to invoke this exclusion we will make the Managed Care plans aware of the criteria.