REVISED

NYS Medicaid Pharmacy Program

Executive Budget Changes

SFY 2011-2012

Key Points & FAQs

2011-2012 Enacted Budget Key Points

☑ Medicaid Redesign Team Proposal #11

Bundle Pharmacy into Managed Care

- **Effective October 1, 2011:** Beneficiaries who are currently enrolled in managed care plans will also receive pharmacy benefits through their plans.

☑ Medicaid Redesign Team Proposal #15 (A-L)

Comprehensive Fee-for-Service Pharmacy Reform

- **Effective April 1, 2011:**
  - The State will accelerate the collection of supplemental drug rebates by adding small or single classes to the Preferred Drug list (PDL) as "all preferred" until such time that the Pharmacy &Therapeutics Committee (P&TC) may review, and will take advantage of changes to legislative language that provides additional leverage in direct rebate negotiations;
  - the ability for pharmacists to override the early fill edit due to lost or stolen medication is eliminated and will be replaced with the requirements that prescribers contact Medicaid to initiate such a request;
  - the HIV specialty pharmacy designation which provides a higher reimbursement is eliminated;
  - pharmacy reimbursement rates for brand name drugs will be reduced to AWP-17%;
  - dispensing fees for generic drugs will be reduced to $3.50; and
  - The Commissioner of Health is authorized to set pharmacy reimbursement rates and establish benchmark pricing. Future changes to pharmacy reimbursement must include sixty days advance notice to the Legislature.

- **Effective May 1, 2011:** Several administrative changes will be made to streamline the P&TC process and effectuate greater savings;
  - □ The Commissioner will designate a state staff member to chair the P&TC;
  - □ State staff will make recommendations to the P&TC.

- **Effective August 25, 2011:**
  - □ Prior authorizations under the PDP will be based on the effective date that a drug becomes non-preferred rather than on the date the prescription was written; and
  - □ Reimbursement for clotting factor will be changed to pay at the lesser of acquisition cost or the Medicaid State Maximum Allowable Cost (SMAC).

- **Effective October 1, 2011:**
  - □ wrap-around coverage for antidepressants, antiretrovirals, atypical antipsychotics and immuno-suppressants for dual eligibles will be eliminated;
  - □ prior authorization exemption under the Preferred Drug Program (PDP) for antidepressants, antiretrovirals, atypical antipsychotics and immuno-suppressants will be eliminated; and
  - □ opioids will be limited to four prescriptions every thirty days.

- **Effective January 26, 2012:**
  - □ A voluntary mail order program will be implemented
- **Effective January 1, 2013:**
  - □ Long-term care pharmacies will be required to dispense drugs in smaller quantities [per provisions in the Affordable Care Act (ACA) for Medicare Part D plans]; and
  - □ Requirements will be established related to re-dispensing and appropriate crediting of returned meds.

Frequently Asked Questions (FAQ)

☑ Bundle Pharmacy into Managed Care

Q1. How will beneficiaries know whether their prescriptions are covered by their managed care plan or Medicaid?
Medicaid and Family Health Plus beneficiaries that are currently enrolled in a managed care plan will receive prescription drugs through their plans beginning on October 1, 2011. Beneficiaries impacted by this change will be notified by letter.

Q2. Will there be a change to the drugs beneficiaries take now?
While managed care plans will be required to provide coverage for those categories of drugs currently included in the Medicaid fee-for-service program, managed care plans will have their own list of covered drugs, so it is possible there may be changes to a beneficiary's current medications. Starting in August/September, communications will be sent by Medicaid and managed care plans that will provide more information regarding covered drugs along with guidance on how to ensure continued access to medications through the managed care plan.

Q3. What pharmacy benefits will be bundled into the managed care plans?
The following items will be included in the pharmacy benefit:

For Medicaid managed care beneficiaries: prescription and certain non prescription (OTC) drugs, medical supplies, hearing aid batteries, enteral formulae.

For Family Health Plus beneficiaries: prescription drugs, vitamins when necessary to treat an illness or condition, insulin and diabetic supplies (e.g. insulin syringes, blood glucose test strips, lancets, alcohol swabs), smoking cessation agents including OTCs, select over-the-counter medications included on the Medicaid Preferred Drug List (e.g. antihistamines, and emergency contraception), hearing aid batteries and enteral formulae.

Q4. Will there be a change in co-payments?
There will be no change in co-pay amounts.

Q5. Will beneficiaries be able to stay with their current pharmacy?
Beneficiaries that are currently receiving medications from pharmacies that also participate with their managed care plan can continue to get their medications at their current pharmacy. Look for communications starting in August/September that will provide more information regarding how to determine a pharmacy's participation status with a particular plan.

Q6. Will beneficiaries have to change doctors?
As long as they are seeing doctors that currently participate with their managed care plan, beneficiaries can continue to use the same doctors. Beneficiaries should be advised to check with their plan to verify whether their doctor participates in their managed care plan.

Q7. How many managed care plans are in each county/region?
There is a choice of managed care plans in most counties; however a few counties have only one plan. You can get more information on managed care plans by county on the DOH website: http://health.ny.gov/health_care/managed_care/pdf/cnty_dir.pdf
Plans will be required to ensure access to pharmacy benefits in all areas of the State.

Q8. Will every pharmacy be allowed to enroll in the managed care plans? How will this change affect my pharmacy practice?
Managed care plans will manage the enrollment and credentialing of their providers.

If your pharmacy does participate with the managed care plans then effective October 1, 2011, pharmacy claims should be billed to a beneficiary's managed care plan. Beneficiaries will be required to present their health plan benefit card to the pharmacy, rather than their Medicaid card. An extensive transition plan is being developed to ensure access to necessary medications during the transition period. Additional information and guidance will be provided to pharmacies prior to the implementation date.

Added 7/5/11 **Q9. Will the managed care plans be reissuing new identification cards? If beneficiaries are not issued new cards and/or they do not bring their new cards to the pharmacy; how will the pharmacy know where to bill the claim?**
Most plans will be reissuing identification cards. However, it is expected that not all beneficiaries will remember to bring their new cards to the pharmacy. Therefore, a future Medicaid Update article will include the plan specific information pharmacies will need to submit claims such as the BIN number, Processor Control Number (PCN), Pharmacy Benefit Manager (PBM), and the plan's customer service phone number.

Q10. Will the pharmacy benefit be uniform for all managed care plans?
Managed care plans will be provided with guidance regarding coverage, plan formularies, and exception processes. Plans will establish their own formularies and prior authorization processes. However, formularies must include all categories of drugs included on the NYS Medicaid formulary. Plans will also be required to maintain an internal and external review process for exceptions.

Q11. Will pharmacy reimbursement rates be set by Medicaid or by the managed care plans?
Reimbursement rates will be set by the managed care plans and/or their PBM.

Q12. Will there be additional information available prior to October 1st?
Additional information on the upcoming change will be provided through the Medicaid Update, updates to the DOH website and through direct notifications to providers and beneficiaries. An extensive transition plan is being developed to ensure access to necessary medications.

Q13: What role will the plans have in auditing pharmacies? What will OMIG's role be in auditing pharmacies?
Plans will be responsible for managing and auditing their pharmacy networks. If there is a suspicion of fraud or abuse, OMIG will work with the plan and/or provider to review and evaluate the situation.

Updated 7/5/11 **Q14: Will the OMIG card swipe requirement apply to managed care beneficiaries?**

No, the card swipe requirement will not apply to managed care beneficiaries. The plans will set policy and/or guidance regarding identity verification and/or signature requirements.

Added 7/5/11 **Q15: What is OMIG's strategy for expanding the card swipe program?**

The expansion of the program has been redirected to transportation and personal care services using a mobile card swipe terminal. It is anticipated that approximately 1900 mobile terminals will be deployed to personal care and transportation providers by the conclusion of the expansion.

While there will be no expansion of the program to pharmacies beyond the twenty (20) that were recently added, it will continue during the course of the transition of beneficiaries into managed care. Once the transition is complete, the program and the remaining fee-for-service population will be re-evaluated.

MRT #154-7 (Mandate Participation by Certain Pharmacies in the Card Swipe Program) was created prior to the decision to roll pharmacy services into managed care. Therefore, OMIG has redirected the focus of the card swipe program to other Medicaid program areas.

Q16: How will manufacturer rebates be administered and collected once the pharmacy program is bundled into Managed Care?

New York State will continue to invoice and collect federal level rebates under the National Drug Rebate Agreement by accessing pharmacy claims data, which will be provided by the managed care plans. The plan will be responsible for any additional rebates, over and above federal level rebates. The value of these additional rebates will be incorporated into the plans' capitated rates.

Q17: Can providers use 340B drugs when the pharmacy program is bundled into Managed Care?

Yes. The 340B drugs are not subject to federal rebate requirements; therefore plans will be responsible for identifying all claims paid as 340B drugs within the encounter data provided to the state.

Q18: Will clotting factor products be bundled into the managed care plans?

Clotting factor products will remain as a Medicaid fee-for-service benefit for a limited period of time. The state intends to bundle these products into the managed care plan in the near future. Pharmacies billing for these services should bill Medicaid using the alpha numeric Client Identification Number (CIN) on the health plan card.

Q19: Will Fidelis Care New York provide the family planning benefit?
No. A beneficiary enrolled in Fidelis Care New York will continue to receive family planning as a Medicaid fee-for-service benefit. Pharmacies billing for these services should bill Medicaid using the alpha numeric Client Identification Number (CIN) on the Fidelis card.

Added 7/5/11 **Q20: Is the movement of the pharmacy benefit from Medicaid fee-for-service to the managed care plan considered "good cause" to switch managed care plans?**
The pharmacy benefit changes are not considered good reason (good cause) to change plans and the beneficiary must remain in the current plan.Within the first 90 days of joining the health plan, beneficiaries may leave and join another plan. However, once the 90 days are over, the beneficiary is "locked in" to that plan for the rest of the year (the next nine months). After the first 12 months of enrollment, a beneficiary may switch plans at anytime.

☑ Comprehensive Fee-for-Service Pharmacy Reform

Updated 7/5/11 **Q1. If pharmacy is being moved into Managed Care, why is there an initiative to reform the Medicaid fee-for-service program?**
While pharmacy benefits for the majority of Medicaid beneficiaries will be moved to Managed Care effective October 1, 2011, approximately 1.5 million beneficiaries (of which approximately 750,000 are Medicare/Medicaid dual eligible), will continue to access pharmacy benefits through the fee-for-service program until such time that they are moved into Managed Care. Therefore, several initiatives are being enacted to optimize rebate opportunities, reduce waste, rationalize drug coverage and reimbursement and remove statutory limits that drive cost in the fee-for-service program. There are various implementation dates for these initiatives.

Q2. Are there specific populations that will remain in the pharmacy fee-for-service program?
Beneficiaries that are not currently enrolled in a managed care plan and those beneficiaries that are also enrolled in Medicare Part D plans (dual eligibles) will continue to obtain pharmacy benefits from Medicaid until such time that they are moved into Managed Care.

Q3. How will this reform affect the Medicaid fee-for-service pharmacy benefit?
While many of the changes will have no effect on beneficiaries, there are some that may have an impact. These include:

- A change in the early fill policy for lost or stolen medications that will limit Medicaid reimbursement for lost or stolen meds to one event per year and will require prescribers to contact Medicaid for approval;

- beneficiaries will be able to obtain maintenance medications through enrolled mail order pharmacies;
- Medicaid will no longer provide supplemental coverage for drugs in the following classes for beneficiaries who are also enrolled in a Medicare Part D plan: antidepressants, antiretrovirals, atypical antipsychotics and immuno-suppressants;
- non-preferred drugs in the following classes will no longer be exempt from prior authorization requirements: antidepressants, antiretrovirals, atypical antipsychotics and immuno-suppressants; and
- prescriptions for medications in the opioid class will be limited to four every thirty days.

Q4. How will this reform affect pharmacy practice?
There are several reform initiatives that will have a direct effect on pharmacy providers. Information on each of the initiatives will be provided to providers prior to specific implementation dates. Changes that will have an impact on pharmacy providers include:

- Reimbursement rates for brand name drugs will be reduced, as will dispensing fees for generic drugs;
- reimbursement rates for clotting factor will be paid at the lower of acquisition cost or SMAC;
- the HIV specialty pharmacy designation is eliminated;
- the ability for pharmacists to override the early fill edit due to lost/stolen meds is eliminated and will be replaced with the requirement that beneficiaries contact Medicaid to initiate such a request; and
- dispensing requirements for long-term-care pharmacies will be changed to replicate provisions regarding short cycle dispensing in the federal Affordable Care Act (ACA) for Medicare Part D.

For billing purposes, beneficiaries remaining in the fee-for-service program will continue to present their Medicaid card at the pharmacy.

Q5. Will an approved state plan amendment be required before the reimbursement rate and dispensing fee changes can be implemented? I understand that the pharmacy reimbursement and dispensing fee changes are effective 4/1/2011. When will these changes be implemented and will notice be provided to pharmacies?
Yes, a CMS approved state plan amendment will be required before the reimbursement and dispensing fee changes can be implemented. Once the state plan amendment has been approved by CMS, pharmacies will be provided with at least 14 days notice.

Remittances will be prospectively adjusted to account for the retroactive time period between the effective date of the change (4/1/2011) and the implementation date of the change in reimbursement rate and dispensing fees.

☑ General Questions

Q1. Are there plans to transition pharmacy benefits for all Medicaid beneficiaries into Managed Care?

The ultimate plan is for all beneficiaries to be enrolled in some level of Managed Care or care management within three years. This will be accomplished in phases, with pharmacy benefits being impacted and/or transitioned in accordance with the transition to Managed Care or care management. In the mean time, beneficiaries remaining in the fee-for-service pharmacy program will continue to obtain their prescriptions from Medicaid.

Q2. How does Managed Care differ from care management?

Information on the differences between managed care and care management can be found at:

http://health.ny.gov/health_care/medicaid/redesign/docs/medicaid_redesign_team_questions_and_answers.pdf

Q3. What types of plans would be considered a care management program?

There are several different types of care management programs, including health homes, patient-centered medical homes, waiver services and behavioral health organizations, integrated service delivery systems and Special Needs Plans (SNP). Beneficiaries will be enrolled in care management plans that best suit their needs.