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Office of Medicaid Management
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Medicare Prescription Drug Benefit to Start January 1, 2006



Special Edition!

Please Read and Save for Future Reference

This edition of the Medicaid Update provides detailed information regarding the impact of the Medicare Part D prescription drug program on Medicaid providers and full benefit dual eligible recipients (recipients with both Medicare and Medicaid services). All of the information provided in this edition is also available on the Department of Health website at www.health.state.ny.us

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Starting January 1, 2006, Medicare, not Medicaid, will be the primary payor of drugs for dual eligible recipients.

For the first time, prescription drug benefits will be provided by Medicare to their beneficiaries through approved Part D prescription drug plans (PDP).

*This includes Medicare beneficiaries who also have Medicaid (called **dual eligibles**).*



Dual eligible Medicaid recipients will be changed from the Medicaid fee-for-service program to a Medicare prescription drug plan. They will need to use drugs on their plan's formulary and use their plan's pharmacy network. They may need help to assure their medications are fully covered by their Medicare prescription plan. Many of your patients may come to you seeking advice. The information in this Medicaid Update is designed to assist you and your patients through this transition.

Dual eligibles (duals) MUST be enrolled in a Medicare prescription drug plan as of January 1, 2006, or they may lose all of their New York State Medicaid benefits, including healthcare coverage!

Medicare Drug Plan Information and Contacts

The Medicare Program offers detailed Medicare prescription drug plan information on their websites. We encourage providers to visit these websites, or call the Medicare toll-free number, for information.

Medicare: 1-800-MEDICARE

www.medicare.gov (for recipients)

www.cms.hhs.gov/medicarereform/pdbma (for providers)

TTY 1-877-486-2048

In addition, HIICAP (Health Insurance Information Counseling Assistance Program) provides free counseling to individuals and groups about the new Medicare drug benefit and can help your patient compare and choose plans. For more information, call HIICAP at **1-800-333-4114**.

Section 1: Medicare and Its Impact on Providers and Dual Eligible Recipients

Assignment and Enrollment by the Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) have randomly auto-assigned duals to 15 different PDPs. If recipients do nothing, they will be automatically enrolled into the CMS assigned PDP on January 1, 2006. CMS letters, which were printed on yellow paper for easy identification, were mailed to recipients in November 2005. These letters advise recipients as to which plan they have been auto-assigned.

Recipients should be reminded to keep all their Medicare and Medicaid prescription drug information in one place. This information can be used to help the recipient, or others assisting the recipient, in understanding and maximizing their drug benefit.

Enrollment Options for Dual Eligible Recipients

The “auto-assigned” prescription drug plan may or may not be the best match for an individual, based on a recipient’s drug needs and the pharmacies which they currently use. Recipients can change plans at any time and may obtain assistance in finding a plan to better match their needs by calling 1-800-MEDICARE (1-800-633-4227) or going to the CMS website at www.medicare.gov/mpdpf.

CMS has identified 15 PDPs in New York State as “benchmark” plans (please see page 22). Dual eligible recipients should be encouraged to join these plans. If they change their plan to another benchmark plan, they will not be responsible for any additional monthly premiums. If they choose to join any “non-benchmark” plans, they may be responsible for monthly premium payments.

Choosing a Plan

Only the recipient or their legally authorized representative can actually enroll the recipient in a PDP. However, anyone can help the recipient choose a plan. The Medicare Prescription Drug Plan Finder at www.medicare.gov/mpdpf is the best way to find out what plans will meet a particular person’s needs. You can also call 1-800-MEDICARE for information and assistance.

Pharmacy Benefits Through a Preferred Drug Plan (PDP)

Whether a recipient chooses their own plan or remains in the plan that was assigned by CMS, they will receive a Medicare prescription drug card in the mail. They must use this card at the pharmacy to receive prescription drugs beginning January 1, 2006. In some cases, Medicare prescription drug cards may not be available from the plans by January 1, 2006. PDPs may issue letters to their enrollees that confirm the recipient’s participation in their plan until the plan cards are issued. These letters should be taken by the recipient to the pharmacy when filling a prescription.

NYS Medicaid recipients are expected to fully maximize the benefits of the PDP plans. Recipients must utilize the PDP network pharmacies and formularies. If a drug is not covered by the plan, the exception and appeal process must be used to obtain coverage for the non-formulary drug. The prescriber may also change the prescription to a drug covered by the plan if medically appropriate.

What Does The New Medicare Drug Benefit Look Like?

The Medicare prescription drug benefit is provided through commercial prescription drug plans which include the following features:

Formularies

Covered items under the Medicare Part D Drug Benefit include:

- ✓ Prescription drugs
- ✓ Biologicals
- ✓ Insulin and insulin related supplies defined as syringes, needles, gauze and swabs
- ✓ Certain vaccines

Plan formularies must include all, or substantially all, of the drugs in the following drug classes in 2006:

- ✓ Antidepressants
- ✓ Antipsychotics
- ✓ Anticonvulsants
- ✓ HIV/AIDS drugs
- ✓ Immunosuppressants
- ✓ Antineoplastics

Each plan will have their own formulary which may include a variety of utilization management tools such as: prior authorization, step therapy, and/or quantity limitations. These formularies can change; however, plans are required to notify their enrollees who use an affected drug, at least 60 days prior to the change.

Transition Supply

Plans must provide for an appropriate transition supply for new enrollees to access their prescribed drugs that are not on the enrollee's PDP formulary. Each plan has its own transition process and the supply of drugs provided to the enrollee during the transition process also varies among plans.

Exceptions and Appeals

Although there may be certain restrictions on the use of particular drugs, all medically necessary drugs must be available under the Medicare prescription drug plan benefit, whether or not they are on the plan's formulary. Drug plans must provide exception and appeal processes for drugs not on the formulary.

The recipient, their appointed representative, or the prescriber can request an exception or appeal. An exception is also called an initial coverage determination. It is the first time that the recipient or their prescriber goes back to the plan with medical justification to request that a drug be covered by the plan. **We encourage prescribers to assume this role.** The prescriber will need to decide whether another drug covered by the recipient's PDP can meet their patient's medical need. If so, a new prescription for the covered drug can be written and no additional action is needed. Otherwise, the prescriber will need to file an exception request or appeal request by contacting the recipient's plan. Be prepared to provide medical justification for your request.

- An expedited exception may be requested, requiring the plan to make a decision within 24 hours or less, dependent on the patient's medical condition. Only the prescriber can request an expedited exception.
- If an expedited exception is not requested, the plan has 72 hours to make a determination.

Remember that PDPs are required to cover all medically necessary drugs even if the drugs do not appear on their formularies. When appropriate medical justification is provided to support the prescription, the request for an exception must be approved.

If the exception is approved, the exception applies to the initial fill and refills. If the exception request results in a denial, PDPs are required to complete and issue a "Notice of Denial of Medicare Prescription Drug Coverage" to the recipient and their prescriber every time the plan denies an exception request/coverage determination. This form is labeled "Form No. CMS-10146" in the lower left hand corner. Please be sure to keep a copy of this denial notice in the patient's record.

The prescriber, the recipient, or their appointed representative is expected to continue the appeal process to get the recipient's drug covered by their plan when an exception is denied. The prescriber, recipient, or their appointed representative should contact the plan to determine how to proceed with the appeal process.

Co-payments and Cost Sharing

Dual eligible recipients will be required to pay a small co-payment (**\$1 for generics and \$3 for brand and specialty drugs**) even though a plan may have higher or tiered co-payments for their other members.

This means that a dual eligible will not be responsible for paying more than a maximum \$3 co-payment each time the prescription is filled.

Duals in long term care facilities (nursing homes) **are not subject to** co-payments.

Dual eligibles will have no other out-of-pocket expenses.

Unlike Medicaid, co-payments must be paid by the recipient to obtain their drug. Medicare co-payments cannot be waived by the pharmacy unless done so on an individual, unadvertised basis.

Pharmacy Networks

Each plan has a preferred pharmacy network. *Recipients should verify that the pharmacy they intend to use is in their PDP network to ensure that their prescriptions will be covered.*

- ✓ They can do so by contacting their pharmacy.
- ✓ They can also review a list of other participating network pharmacies by contacting their drug plan or Medicare.

If an enrollee attempts to fill a prescription at a non-network pharmacy, they may need to pay the full price of the drug and be partially reimbursed by the plan at a later time.

Section 2: Transition and How You Can Help!

Moving from the Fee-For Service Medicaid Pharmacy Benefit to the Medicare Prescription Drug Program

Medicare PDPs are required to have an appropriate transition process when the patient has been stabilized on a medication at the time they join the plan. This includes dual eligibles. Each PDP's transition process may vary. Some plans may require the pharmacist or prescriber to contact the plan by phone or fax to verify that a patient has been stabilized on a drug before allowing an initial prescription to be processed. Most plans will allow a short term initial supply of a non-covered drug to allow time for the prescriber to re-evaluate the patient's drug needs and change the prescription or initiate an exception request. Plans may institute prior authorization or step therapy for subsequent refills. Plans may require new prescriptions if the recipient changes to another pharmacy.

Note: CMS has instructed plans that they must give special attention to recipients already stabilized on drugs so that there is no gap in coverage in the following six classes-- antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant and HIV/AIDS.

Transition is a Time For Action!!

- **Prescribers** are encouraged to take action to ensure that recipients will continue with their necessary drug regimen. This may entail switching a recipient to a covered formulary drug or initiating step therapy, if appropriate, or obtaining an exception authorization through the PDP.
- **Pharmacists** are encouraged to pay attention to any special messaging they may receive through the claims processing system. Some of these messages may include information regarding the need for prior authorization or the need to take some other action (calling a plan's hotline to ensure the processing of a transition supply of drug). The pharmacist must also provide information to the recipient regarding the exception and appeal process if a drug is not covered by the plan. Pharmacists may be asked by the recipient to assist them with this process.
- **Recipients** are encouraged to choose a plan that best meets their needs. They may need help checking with their plans for information on drug coverage, any drug utilization requirements such as prior authorization or step therapy, and whether their current pharmacy is in their plan's network.

How Providers Can Help

Providers, along with their staff, may be key contacts for recipients who have questions about these changes. New educational materials for you and your staff are available by contacting Medicare at 1-800-MEDICARE or by going to their web site at:

<http://www.cms.hhs.gov/medlearn/drugcoverage.asp> for training and educational materials.

We encourage you and your staff to become familiar with the information from Medicare and in this supplement to be responsive to your patient's questions.

Make Sure:

- The recipient and their family/caregivers are aware that the Medicare prescription drug benefit replaces their Medicaid drug coverage.
- The recipient is aware that Medicare PDP enrollment is a condition of Medicaid eligibility. If the beneficiary refuses to enroll in a PDP, they may lose all of their health care benefits.
- The recipient retains and does not throw away any mail from Medicare or Medicaid concerning their drug benefit.
- The recipient has received and saves the **yellow** letter from CMS which identifies the plan to which they have been initially assigned.
- The recipient's pharmacy is in the network of their assigned plan.
- The recipient's drugs are covered by the assigned plan formulary.
- The plan's utilization controls don't create a barrier for the beneficiary to easily access their drugs.
- The recipient's prescribing provider is aware of the drugs included in their patient's Part D plan and action is taken, if necessary, to assure the recipient receives their drugs (either by requesting an exception or by the prescriber writing a new prescription for a drug that is covered by the plan).

PDPs can answer questions about the following:

- Drug formularies* and coverage including prior authorization, quantity limits, and/or step therapy
- Coverage determinations
- Exception/Appeal process
- Pharmacy Network: preferred pharmacies, mail order and use of out-of-network pharmacies
- Drug co-payments
- Issuance of a new card
- Transition process

*1-800-Medicare can also be contacted for this information or the Medicare formulary finder (www.medicare.gov/MPDPF) may also be used.

Medicare or HIICAP can answer questions about the following:

- Determining which plan a recipient is in
 - ✓ The recipient's auto-assignment (**yellow**) letter will contain the name of the plan to which they were auto-assigned.
 - ✓ Information from a recipient's Medicare Part A/B Health Insurance card is necessary to find out which plan a recipient has been assigned to.
- Enrollment in a plan
- Changing a plan
- Assistance with changing a plan
- More information about which plan(s) may be a better match for the recipient

Pharmacies may also be able to assist in the following:

- Determining which plan a recipient is in
 - ✓ through their eligibility/claims processing system or the Medicare Plan Finder at www.medicare.gov/MPDPF
- Helping the recipient identify plans that include their drugs
- Providing written information to the recipient on the exception and appeal process
- Discussing other drug alternatives with prescribers when their patients' drugs are not on the plans' formularies

Section 3: The Medicare Prescription Drug Plan and Medicaid's Role

Drug Coverage Under Medicare Part B

Drugs and items that are covered by Medicare Part B will continue to be reimbursed under Part B.

- Rules for Medicare Part B billing have not changed.
- Part B should be billed first for covered Part B drugs and supplies.
- Medicaid's cost sharing role for Part B covered drugs and supplies will not change. If Part B denies the drug claim, the PDP can be billed. Medicaid can be billed for supplies denied by Part B.

Coverage of Drugs in Federally Excludable Drug Categories

The NYS Medicaid program will continue to cover **benzodiazepines, barbiturates, and certain over-the-counter drugs.**

These products are excluded from Medicare Part D coverage and should be billed directly to Medicaid.

Limited Wrap-Around Benefit

The PDP is now the primary payor for prescription drugs. However, in limited circumstances, Medicaid will provide an additional "wrap-around" benefit for drugs not covered by the PDP in addition to the federally excludable drug categories noted above.

This will only occur after the prescriber has **requested an exception request with the PDP and has received a denial.**

To assure that the Medicare prescription benefit has been maximized prior to billing NYS Medicaid, the **Medicare Verification System (MVS)** was developed.

Section 4: The Medicare Verification System

The Medicare Verification System (MVS) is a means for providers to confirm to the Medicaid program that Medicare coverage has been sought from, and denied by, the PDP.

It is a fully automated system, available 24 hours a day, 7 days per week.

A prescriber, or their agent, may call only after their patient's PDP has made a determination to deny coverage of a particular drug based on lack of medical necessity or insufficient medical information. Prescribers will be required to respond to a short series of questions verifying that a coverage request was made and denied.

Medicare Verification System Process:

- This process must be completed for Medicaid coverage and payment of a PDP denied drug.
- The prescriber or their agent must have filed an exception request with the recipient's Medicare prescription drug plan to demonstrate medical necessity for the specific drug.
- If the request is denied by the PDP, the prescriber can call the Medicare Verification System (MVS) at 1(800) 292-7004 and respond to a short series of questions. The prescriber will then receive a MVS number which must be included on the prescription.
- The dispensing pharmacist must call 1(800) 292-7004 and respond to a short series of questions and use the MVS number on the claim at the time of claim submission.
- Benzodiazepines, barbiturates and OTC products do **not** require verification.

Medicare Verification System Requirements and Guidelines:

The Medicare Verification System allows prescribers and pharmacies to seek Medicaid coverage and payment when a medication has been denied coverage by the PDP due to lack of medical necessity or insufficient medical justification.

- Every attempt should be made to maximize the Medicare Part D PDP coverage through the PDP's exception/appeal process. Medicaid remains the payor of last resort.
- The MVS number must be written on the face of the prescription and the dispensing pharmacist must call 1(800) 292-7004 to complete the MVS process.
- Dispensing must occur on or after the date the MVS or joint MVS/prior authorization number is issued.
- An MVS number is effective for the life of the prescription only (up to five refills within six months). Note that other State laws and Medicaid requirements still apply to these prescriptions.
- Multiple MVS numbers for multiple patients may be obtained in a single phone call.
- Pharmacy claims payment is subject to patient eligibility and other Medicaid guidelines.

- For orders written by an unlicensed intern or resident, the supervising physician's MMIS ID number or their license number must be entered. Hospital, clinic or other health care facility MMIS ID numbers cannot be used.
- Phone and fax orders are allowed. Remember that the MVS number must be provided to the pharmacist when phoning in or faxing the prescription.
- The toll-free MVS call line may also be used to cancel a previously obtained MVS number only if the drug was not dispensed.
- Prescribers are expected to continue with the PDP's appeal process even though an MVS number is obtained. This gives the prescriber an opportunity to provide additional medical justification to the plan supporting the specific prescription while Medicaid assures there is no gap in coverage.
- The "Notice of Denial of Medicare Prescription Drug Coverage" (Form No. CMS-10146) must be kept in the patient's record.
- MVS cannot be used to obtain:
 - ✓ early refills,
 - ✓ refills for lost or stolen drugs,
 - ✓ extended or vacation supplies, or
 - ✓ extension of quantity limits
- Medications subject to existing Medicaid prior authorization programs will continue to require prior authorization before Medicaid payment. Currently, drugs requiring prior authorization include:
 - ✓ Zyvox,
 - ✓ Serostim,
 - ✓ prescription second generation antihistamines,
 - ✓ prescription proton pump inhibitors, and
 - ✓ brand name drugs when a generic equivalent is available (Mandatory Generic Drug Program).

Information regarding Medicaid prior authorization requirements can be provided by the prescriber at the end of the MVS call and **will not require** a second phone call to the Medicaid prior authorization call line.

Prescribers will not be required to repeat their identifying information but should have the appropriate prior authorization worksheet completed so they can respond to the appropriate prior authorization questions. *This worksheet must also be retained in the medical record.*

After completion of the joint Medicare verification and prior authorization process, **one** eleven digit number (MVS number) will be issued by the system.

The *Medicare Verification Prescriber Worksheet and Instructions* and the *Medicare Verification Pharmacy Worksheet and Instructions*, included on pages 13-15, provide step-by-step assistance for the prescribers and pharmacist to complete this process.

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**NEW YORK STATE MEDICAID PROGRAM
MEDICARE VERIFICATION SYSTEM (MVS) PRESCRIBER INSTRUCTIONS**

Medicare Verification System Call Line 1-800-292-7004

A voice interactive call line is utilized to obtain Medicare Verification or joint Medicare Verification/prior authorization.

PRESCRIBER PROCEDURE:

- ◆ The prescription claim was billed to and denied by patient's Prescription Drug Plan (PDP).
- ◆ The prescriber submitted an exception request to the patient's PDP and provided the medical justification.
- ◆ The PDP has denied coverage of the medication.
- ◆ The prescriber or agent calls **1-800-292-7004**. Information can be entered either by voice or by using the phone keypad.
- ◆ The prescriber or agent will be prompted to answer questions verifying that an exception request was made to the PDP and the request was denied.

A. VERIFICATION: Respond to the following questions:

- a. Does the patient have a Medicare prescription drug plan?
- b. Did you request an exception from the patient's specific prescription drug plan?
- c. Was this exception denied by the patient's specific prescription drug plan?
- d. Coverage determination denial was based on:
 1. Lack of medical necessity
 2. Insufficient medical information

B. PRIOR AUTHORIZATION:

Does this drug require prior authorization by the NYS Medicaid program?

C. PRESCRIBER IDENTIFIER: Choose Prescriber Option

Unlicensed residents and physician assistants must use the MMIS/license number of their supervising physician. Do not use a hospital/clinic or group MMIS number.

- ◆ Enter your personal Medicaid identification number (MMIS)

OR

- ◆ License Number
 - Choose '1' for Physician/Physician Assistant/Resident
 - Choose '2' for Optometrist
 - Choose '3' for Nurse Practitioner/Midwife
 - Choose '4' for Dentist
 - Choose '5' for Podiatrist

D. CLIENT IDENTIFICATION NUMBER: Enter the patient's Medicaid client identification number (2 letters, 5 numbers, 1 letter). Follow the prompts.

E. PRESCRIBER TELEPHONE NUMBER: Enter your ten-digit telephone number (area code/number).

- ◆ A Medicare Verification System number will be returned; write it legibly on the face of the prescription.
- ◆ Do not fax a copy of this worksheet; it may be kept in the patient's medical chart for future reference. If prior authorization is also required, you must complete a prior authorization worksheet and also keep the worksheet in the patient's record.
- ◆ The Medicare Verification Worksheet should be reproduced for future prescribing.

**For billing questions, contact 1-800-343-9000.
For clinical concerns or policy questions, contact the
Pharmacy Policy and Operations Staff at (518) 486-3209.**

**NEW YORK STATE MEDICAID PROGRAM
 MEDICARE VERIFICATION SYSTEM (MVS) PRESCRIBER WORKSHEET
 MVS Call Line 1-800-292-7004**

- ◆ Beginning January 1, 2006, prescriptions not covered by the patient's Medicare Prescription Drug Plan (PDP) will require a Medicare Verification System (MVS) Number to be covered and paid for by Medicaid.
- ◆ Benzodiazepines, barbiturates and OTC items do **not** require verification.
- ◆ Products covered by existing NYS Medicaid prior authorization programs will continue to require prior authorization. Information regarding prior authorization can be provided by the prescriber at the end of the Medicare Verification System call and will not require a second phone call. Only one number will be issued.

Be prepared to respond to these questions when you call.

<p>A. VERIFICATION</p> <p>a. Does the patient have Medicare Part D? Yes ___ No ___</p> <p>b. Did you request an exception from the patient's specific PDP? Yes ___ No ___</p> <p>c. Was this exception denied by the patient's specific PDP? Yes ___ No ___</p> <p>d. Plan denial of coverage was based on (select number)</p> <p style="padding-left: 20px;">1. Lack of medical necessity</p> <p style="padding-left: 20px;">2. Insufficient medical information</p>	<p>Yes ___ No ___</p> <p>Yes ___ No ___</p> <p>Yes ___ No ___</p> <p>_____</p>
<p>B. PRIOR AUTHORIZATION</p> <p>Does this drug require Prior Authorization by NYS Medicaid program?</p> <p>◆ If yes, you will be prompted to select one of the following and the call will be transferred appropriately. You should have a completed prior authorization worksheet available to respond to the prior authorization questions:</p> <ul style="list-style-type: none"> ○ Zyvox, Serostim, Brand Name drugs, 2nd generation antihistamines or prescription proton pump inhibitors 	<p>Yes ___ No ___</p>
<p>C. PRESCRIBER IDENTIFIER</p> <p>Ordering Practitioner Medicaid ID number</p> <p>OR license</p> <p>NYS Physician/PA/Resident</p> <p>NYS Optometrist</p> <p>NYS Nurse Practitioner/Midwife</p> <p>NYS Dentist</p> <p>NYS Podiatrist</p> <p>OR</p> <p>Out-of-State Prescriber License</p>	<p>Complete <u>one</u> of the following prescriber identifiers:</p> <p>MMIS ID Number</p> <p>_____</p> <p>OR license</p> <p>0 0 _____</p> <p>U _____ or</p> <p>V _____</p> <p>F _____</p> <p>0 0 0 _____</p> <p>0 0 0 0 _____</p> <p>OR</p> <p>_____</p> <p>(Use your state abbreviation in the first two spaces.)</p>
<p>D. CLIENT IDENTIFICATION NUMBER (2 letters, 5 numbers, 1 letter)</p>	<p>_____</p>
<p>E. PRESCRIBER TELEPHONE NUMBER (_____) _____ - _____</p>	
<p>Record the Verification number here for your records and on the face of the patient's prescription.</p>	<p>_____</p>

For billing questions, contact 1-800-343-9000.

For clinical concerns or policy questions, contact the Pharmacy Policy and Operations Staff at (518) 486-3209.
INSTRUCTIONS ON REVERSE SIDE

**NEW YORK STATE MEDICAID PROGRAM
MEDICARE VERIFICATION SYSTEM PHARMACY INSTRUCTIONS**

MVS Call Line 1-800-292-7004

The prescriber must initiate the Medicare verification or joint Medicare verification/prior authorization process. A voice interactive call line is utilized to complete the Medicare verification or joint Medicare verification/prior authorization process.

Pharmacy Procedure:

- ◆ The pharmacist calls **1-800-292-7004** prior to dispensing. Information can be entered either by voice or by using the phone keypad.
- ◆ The pharmacist chooses option '6' for Pharmacy.
- ◆ The pharmacist responds "Yes" to the recipient having Medicare prescription drug coverage.
- ◆ The pharmacist chooses "Yes" or "No" regarding the drug prior authorization status. (If prior authorization is required, the pharmacist will need to choose the appropriate prior authorization selection.)
- ◆ The pharmacist enters their identifying and prescription drug information.
- ◆ The pharmacist enters the MVS number into the prior authorization number field when submitting the claim to Medicaid.

A. Medicare Verification or Joint Medicare Verification prior authorization: Enter 11 digit number.

B. Client Identification Number: Enter the client identification number (2 letters, 5 numbers, 1 letter).

C. Pharmacy MMIS Number: Enter your eight-digit Medicaid MMIS number.

D. Pharmacy Category of Service: Enter category of service (COS).

Free-standing pharmacies (and nursing home institutional pharmacies for purposes of the Medicare Prescription Drug Benefit Program) usually have a COS of 0441. Hospital-based pharmacies should use COS 0288.

E. Pharmacy Telephone Number: Enter the ten-digit telephone number with area code.

F. NDC: Enter the 11-digit NDC of the drug you are dispensing.

G. Quantity: Enter the quantity of a single fill.

H. Number of Refills: Enter the number of refills ordered.

- ◆ You will hear a message that you have authorization to dispense the drug.
- ◆ Pharmacists may enter multiple authorizations during one telephone call.
- ◆ Use the same Medicare Verification number on claims for refills – you do not need to call the Medicare verification line again for refills of this prescription.

SUBMITTING A CLAIM:

- ◆ After the Medicare verification or joint Medicare verification/prior authorization process is complete there will be a slight delay while the information is transmitted to our fiscal agent. Until that transfer occurs, the prescription cannot be adjudicated on-line. We recommend you wait approximately two minutes before you begin your electronic claim submission.
- ◆ When billing a prescription electronically, the MVS number must be entered into the prior authorization code field.
- ◆ No more than two claims requiring MVS numbers can be submitted for payment in one claim's transmission. Refer to the ProDUR/ECC Provider Manual for complete instructions.
- ◆ Medicare Verification or the joint Medicare verification/prior authorization does not guarantee payment. Payment is subject to patient eligibility and other Medicaid guidelines.
- ◆ Technical questions regarding electronic on-line claims adjudication – call 1-800-343-9000.

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For clinical concerns or policy questions, contact the
Pharmacy Policy and Operations Staff at (518) 486-3209.**

**NEW YORK STATE MEDICAID PROGRAM
MEDICARE VERIFICATION SYSTEM (MVS) PHARMACY WORKSHEET**

MVS Call Line 1-800-292-7004

- ◆ Beginning January 1, 2006, prescriptions not covered by the patient's Medicare Prescription Drug Plan (PDP) will require a MVS Number.
- ◆ Benzodiazepines, barbiturates and OTC products do **not** require verification.
- ◆ Completion of the MVS process does not guarantee payment. Payment is subject to patient eligibility and other Medicaid guidelines.
- ◆ Pharmacists must call the MVS call line to validate the 11 digit MVS or joint MVS/prior authorization number or the claim will not be paid. Only **one** number will be issued.

Be prepared to respond to these questions when you call.

Does the patient have a Medicare prescription drug plan?	Yes___ No ___
Does the drug require prior authorization?	Yes___ No ___
A. Medicare Verification or Joint Medicare Verification/ Prior Authorization number (11 digits)	_____
B. CLIENT IDENTIFICATION NUMBER (2 letters, 5 numbers, 1 letter)	_____
C. PHARMACY MMIS NUMBER	_____
D. PHARMACY CATEGORY OF SERVICE (COS) – (0161, 0441, 0288)	_____
E. PHARMACY TELEPHONE NUMBER (with area code)	____-____-_____
F. NDC (11-digit)	_____
G. QUANTITY (per fill)	_____
H. NUMBER OF REFILLS	_____

**For billing questions, contact 1-800-343-9000.
For policy questions, contact the
Pharmacy Policy and Operations Staff at (518) 486-3209.**

INSTRUCTIONS ON REVERSE SIDE

Section 5: Information for Long Term Care Facilities

The Medicare Prescription Drug Plan Program will have a significant impact on NY's long term care facility population. People who receive both Medicare and Medicaid (full duals) and reside in Long Term Care Facilities (LTCFs) such as nursing homes, ICF/MRs (Intermediate Care Facilities/Mentally Retarded), and residential psychiatric treatment centers will receive their prescription drug coverage from the plan and **will not pay a premium, a deductible or co-payments**.

Some special rules apply.

LTCFs should be receiving more detailed information about the Medicare prescription drug program and how it affects their Medicaid population from the appropriate DOH, Office of Mental Health (OMH), or Office of Mental Retardation/Development Disabilities (OMRDD) offices.

The following information pertains to **DOH regulated nursing homes only**.

Enrollment/Eligibility

- Dual eligibles residing in nursing homes have been randomly auto-assigned to fifteen Medicare plans. If no action is taken to change plans, recipients will be auto-enrolled in that plan effective January 1, 2006.

While recipients can change plans on a monthly basis, nursing homes cannot direct residents into specific plans. Only the resident, or their legally authorized representative, can determine and enroll the resident in their choice of plans.

However, nursing home staff can advise and help their residents understand which pharmacies are participating and which plans cover most or all of their current medication.

CMS has identified 15 PDPs in New York State as "benchmark" plans (please see page 22). Dual eligible recipients should be encouraged to join these plans. If they change their plan to another benchmark plan, they will not be responsible for any additional monthly premiums. If they choose to join any "non-benchmark" plans, they may be responsible for monthly premium payments.

- For a resident who is admitted to a nursing home **with a Medicare prescription drug plan and is Medicaid pending**, the Medicare prescription drug plan will pay the cost of the drugs and the resident is responsible for meeting their cost sharing responsibilities.

If the resident is paying their own Medicare PDP premium and other PDP cost sharing, they should apply for "extra help" (the low income subsidy) while Medicaid is pending. This will reduce their out-of-pocket expenses. Once they become Medicaid eligible, the resident will not have cost sharing. The resident stay should be billed retroactively to the Medicaid eligibility date using the rate that excludes the drug component.

- For a resident who is admitted to a nursing home **without Medicare Part D and is Medicaid pending**, the current rules apply. Medicaid will pay the nursing home retroactively back to the Medicaid eligibility date using the rate that includes the drug component.

Plan Formularies

- Recipients will be subject to their plan's formulary and formularies may differ from plan to plan. Prescription drug plans can use pharmacy management tools, including prior authorization, step therapy, quantity limits and other tools.
- Dual eligibles residing in nursing homes do not pay co-payments. As such, pharmacy management tools that use a tiered co-payment do not apply to dual eligibles, including residents in LTCFs.

Transition

- Plans must cover an "emergency supply" or "first fill" of non-formulary PDP drugs for a long term care facility resident as part of their transition process to ensure that there is no gap in coverage while an exception or appeal is being processed.
- **The transition period is a time for action.**
 - ✓ Confirm that the resident is in a plan that includes the long term care pharmacy that services your facility.
 - ✓ The patient's drug regimen should be reviewed and any necessary changes made to conform to the plan's formulary.
 - ✓ When medically necessary, an exception for use of a non-formulary drug may be requested to the recipient's plan by the prescriber.

Medicare PDP Excludable Drugs

- Medicaid will continue to pay for barbiturates and benzodiazepines on a fee-for-service basis. These drugs should be billed directly to Medicaid.
- Over-the-counter (OTC) drugs remain in the nursing home rate and cannot be billed separately.

Pharmacy Networks

- Long term care institutions are encouraged to select one or more eligible network pharmacies who participate in the largest number of Part D plans. In-house or institutional pharmacies must be in the residents' plan networks to receive reimbursement from the PDP. They must also be enrolled in Medicaid to receive payment for the Medicare excludable drugs and the limited Medicaid wrap-around benefit.
- Remember that the facility chooses the LTC pharmacy but the resident chooses the plan. Nursing homes cannot direct residents into plans. Nursing home administrators and their staff, however, may assist residents in understanding what plans cover most or all of their current medications.

Section 6: Frequently Asked Questions and Answers

Provider Questions

Q. How can I find out which plan a recipient is enrolled in?

A. Contact Medicare at 1-800-MEDICARE, refer to the CMS Plan Finder at www.medicare.gov/mpdpf or refer to the yellow auto assignment letter sent to the beneficiary by CMS in November for enrollment information. Information from the recipient's Medicare card will be necessary. This includes: name, DOB, effective dates of Medicare Part A & B and the beneficiary's Medicare ID #. Pharmacies may also be able to help.

Q. Who can assist recipients with enrollment in a Medicare prescription drug plan?

A. Recipients may obtain assistance in finding a plan to better match their needs by calling 1-800-MEDICARE (1-800-633-4227) or by going to the CMS website www.medicare.gov/mpdpf or by contacting HIICAP at 1-800-333-4114. Only the recipient or their legally authorized representative can actually enroll the recipient in a PDP but anyone, especially their physician or pharmacist, can help them understand and choose their plan.

Q. Will all prescription drug plans have a standard formulary?

A. Each plan will have their own formulary which may include a variety of utilization management tools such as: prior authorization, step therapy, and quantity limitations. These formularies can change; however, plans are required to notify their enrollees who use an affected drug, at least 60 days prior to the change.

Q. My patient has been stabilized on a drug that is not on their plan's formulary. Can my patient still get the drug while I evaluate other options?

A. Yes. Medicare PDPs are required to have an appropriate transition process when the patient has been stabilized on a medication at the time they join the plan. This transition process differs from plan to plan and you, or the patient's pharmacist, may have to contact the plan for additional information. Plans must also provide coverage for all, or substantially all, drugs in the following drug categories: antidepressants, antipsychotics, anticonvulsants, HIV/AIDS drugs, immunosuppressants, and antineoplastics.

Q. What needs to be done if a medically necessary drug is not on a PDP's formulary or requires prior authorization? Is there an exception or appeal process?

A. The prescriber always has a choice to change the prescription to another medically appropriate medication that is covered by the PDP. However, drug plans must provide an exception/appeal process for drugs not on their formulary. To file an exception or appeal, contact the recipient's plan. If a beneficiary has a prescription for a drug that requires prior authorization, the PDP must also be contacted.

Q. How long does it take for a plan to make a decision on my exception request?

A. An **expedited** exception requires the plan to make a decision **within 24 hours or less**, dependent on the patient's medical condition. **Only the prescriber can request an expedited exception.** If an expedited exception is not requested, the plan has 72 hours to make a determination.

Q. Who notifies the provider and recipient about the requirements of the PDP appeal process and the outcomes of any reconsiderations or exceptions?

A. A plan must provide their enrollees with information regarding their exception and appeals process. Pharmacies are also required to provide written information on how a recipient can request an exception and appeal. However, it is likely that you, or your patient, will need to contact the plan to find out the specific requirements to request an exception and coverage determination.

In general, the plan is responsible for notifying the provider and recipient of the outcomes of exception and appeal requests. All negative decisions must be provided to the recipient in writing.

Q. What if a Medicare PDP denies a prior authorization or an exception request?

A. Medicaid will provide a limited "wrap-around" benefit for drugs not covered under the PDP, but only after the prescriber has requested an exception from the Medicare drug plan and has received a denial. See additional information regarding the Medicare Verification System (MVS) starting on page 8.

Q. How will billing for Medicare Part B drugs or drugs that are administered in my office be affected by the Medicare prescription drug program? Will anything change?

A. Rules for Medicare Part B billing have not changed. Drugs that are covered under Medicare Part B will continue to be covered under Medicare Part B. Providers should continue to utilize Part B as they have in the past, consistent with Medicare Part B billing instructions.

Q. Where can my patient go for more information?

A. They can call Medicare at 1-800-MEDICARE (TTY 1-877-486-2048) or access their website at www.medicare.gov. For the Medicare Prescription Drug Plan Finder or the Medicare Formulary Finder, they can go to www.medicare.gov/MPDPF. They can also contact the New York State Health Insurance Information Counseling Assistance Program (HIICAP) at 1-800-333-4114 for individual assistance in understanding and choosing their plan.

Q. Will I have to write new prescriptions for my patients?

A. This depends on the plan. If your patient has to change pharmacies, a new prescription may be required. You may also have to write a new prescription if your patient's current medication is not on their plan's formulary and you prescribe an alternate, medically appropriate drug covered by the plan.

Recipient Questions

Q. How do I know what plan I'm in?

A. Contact Medicare at 1-800-MEDICARE, refer to the CMS Plan Finder at www.medicare.gov/mpdpf or refer to the **yellow** auto assignment letter sent to you by CMS in November for enrollment information. Information from your Medicare card will be necessary. This includes: name, DOB, effective dates of Medicare Part A & B and the beneficiary's Medicare ID #.

Q. Will my drug plan cover all of my medications?

A. With the exception of barbiturates, benzodiazepines and some OTC drugs, all other medically necessary prescriptions should be covered under the Part D plan. Remember you must also use a pharmacy that participates with your drug plan.

Q. How do I know if my drugs are covered?

A. Each plan has their own formulary or drug list. You should get a copy of the formulary from your plan. This information may also be available in the information packet sent to you by your plan. You should discuss your current medications with your doctor when you receive this information.

Q. What if I don't want to stay with my current Medicare Prescription Drug Plan?

A. You can change plans. You can obtain assistance in finding a plan to better match your needs by calling 1-800-MEDICARE or by going to the CMS website at www.medicare.gov/MPDPF or by contacting HIICAP at 1-800-333-4114. However, you need to be enrolled, except for very special circumstances, in a Medicare prescription drug plan to keep your Medicaid benefits.

Q. Can I use my Medicaid card after December 31st to get my drugs?

A. No, except under limited circumstances. Medicaid will continue to pay for benzodiazepines, barbiturates, and some over the counter drugs. Medicaid may also pay for some drugs not covered by your plan but your prescriber will need to obtain special permission to get them.

Q. Will I get a Medicare drug card?

A. Yes. As of January 1, 2006 you must use your Medicare PDP card to obtain your drugs. You may not receive a card by January 1. In this case, you can use the letter from your plan that states you are enrolled in their plan until you receive your new card.

Q. I am getting a lot of information from Medicare and Medicaid about my drugs. Do I need to keep it?

A. Yes, keep this information in a safe place. If you don't understand this information, take it to someone you trust that can help explain it. You can also contact Medicare at 1-800-MEDICARE or call a HIICAP counselor at 1-800-333-4114 for help.

Q. Do I have to pay my Medicare co-pay?

A. Yes, you must pay a \$1 or \$3 co-payment for each prescription filled. Medicaid cannot pay your co-payment for you. If you live in a nursing home, you do not have to pay co-payments.

Q. Will Medicaid pay my Medicare prescription co-payments?

A. No.

Q. What if my drug isn't covered?

A. Contact your physician or ask your pharmacist what you should do next. Your physician may change your drug to a drug that is covered under your plan. If your physician wants you to stay on your drug, your drug plan must have a process for you to get drugs not on their formulary. This is called an exception or appeal process. To file an exception or appeal, contact your plan and your physician.

Q. How do I know if my pharmacy is in my plan?

A. Each plan has a pharmacy network. You should verify that the pharmacy you usually use is in your PDP's network. You can call your pharmacy and ask if they are in your plan's network. You can also review the list of participating network pharmacies by checking with your plan or by contacting Medicare.

Pharmacist Questions

Q. Will Medicaid continue to cover any drugs for people in a Medicare prescription drug plan (PDP)?

A. The NYS Medicaid program will continue to cover certain drugs that are excluded from the Medicare PDP coverage. These include barbiturates, benzodiazepines, and certain over the counter medications covered under Medicaid. Pharmacists can bill Medicaid for these drugs as they have in the past.

Q. How can I tell that a claim has been denied because the recipient is a dual eligible (eligible for both Medicaid and Medicare) and their prescription should be billed to the Medicare prescription drug plan?

A. If a claim is submitted to Medicaid for a dual who is enrolled in a Medicare Part D plan, a message will be transmitted indicating that "recipient has Medicare Part D". The drug claim should be submitted to the PDP for payment.

Q. Will duals have to meet deductibles and pay co-payments?

A. Dual eligible Medicaid recipients have no deductibles. However, they are required to pay a nominal co-payment (\$1 for generics and \$3 for brand and specialty drugs) for each prescription. Duals in long term care facilities are not subject to co-payments.

Q. Can Medicaid be billed for Medicare PDP co-payments?

A. No. The Medicaid program does not have authority to pay for Medicare pharmacy co-payments. The pharmacy may, on an individual and unadvertised basis, waive the co-payment. Pharmacies should be aware of any contractual issues with a plan prior to the waiving of co-payments.

Q. What if a recipient does not have a Medicare prescription drug card or does not know what plan they are in?

A. The pharmacist can refer to the **yellow** auto assignment letter sent to the beneficiary by CMS in November, if available. They can also contact Medicare at 1-800-MEDICARE or refer to the CMS Plan Finder (information from the recipient's Medicare Part A/B Health Insurance card will be necessary to complete this).

Additional Q & As can be found on the Department's website at www.health.state.ny.us

Section 7: Medicare Prescription Drug Benchmark Plans

New York State Part D Medicare Prescription Drug Plans

For people with both Medicare and NYS Medicaid

The following is a list of the Medicare Prescription Drug Plans available to persons with both Medicare and New York State Medicaid. The specific plans under "Plan Name" are available at no cost. Other plans offered by the companies may require an additional monthly premium payment. Contact information was updated as of 11/30/05.

Company Phone #	Website	Benchmark Plan Name
<u>American Progressive Insurance Co.</u> (800) 825-8200 or (866) 566-3049	http://www.rxpathway.com/	Prescription Pathway Bronze Plan (Reg. 3)
<u>Excellus Health Plan, Inc.</u> (800) 659-1986	https://www.excellusbcbs.com/	Simply Prescriptions
<u>First Health</u> (800) 588-3322	http://www.firsthealthpremier.com/	First Health Premier
<u>Group Health Incorporated (GHI)</u> (800) 611-8454	http://www.ghi.com/	GHI Medicare Prescription Drug Plan
<u>Health Net Insurance of NY</u> (800) 547-8734	https://www.healthnet.com/	Healthnet Orange
<u>Humana Insurance Company of NY</u> (800) 281-6918	http://www.humana.com/	Humana PDP Standard
<u>Pacificare Insurance Company</u> (800) 943-0399 (800) 943-0399	http://www.prescriptionsolutions.com/	Pacificare Saver Plan Pacificare Select Plan
<u>Silverscript Insurance Company</u> (866) 552-6106	http://www.silverscript.com/	Silverscript
<u>Unicare</u> (866) 892-5335	http://www.unicare.com	Medicare Rx Rewards
<u>United Healthcare Insurance Co of NY</u> (888) 556-7052 (888) 556-7052 or (888) 867-5564 (888) 556-7052	http://www.uhc.com/	United HealthRx AARP MedicareRx Plan United Medicare MedAdvance
<u>Wellcare Health Plans</u> (888) 423-5252	http://www.wellcare.com/medicare	Wellcare Signature