Prescription Drugs in Medicaid: Navigating Managed Care Requirements

Sponsored by:
AIDS Institute, NYS Department of Health

Presented by:
Empire Justice Center

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Today’s Agenda

- Key terms
- Medicaid & Medicare Recap
- Overview of Medicaid Managed Care
- Special MMC plans
- Describing the Medicaid pharmacy benefit in 2019
  - How does the benefit work?
  - What has changed?
- Navigating Access for Clients
  - Plan formularies
  - Plan restrictions
- Special Client Protections
- Addressing Denials
- Resources
Key Terms

- **Formulary** – List of covered drugs
- **Preferred v. Non-Preferred Drugs** – Non-preferred drugs are not included on the plan’s formulary
- **Carve-in** – process by which NYS brings more services and population in the Medicaid managed care program
- **Medicaid Managed Care** – program now mandatory for most Medicaid enrollees in NYS, clients cannot change plans during the first year (after initial 90 days)
- **Managed Long-Term Care** – managed care for dually eligible adults (i.e., with Medicare and Medicaid) in need of 120 days or more of long-term care services
- **Medicare Part D** – prescription drug coverage for Medicare beneficiaries.
  - Dual Eligibles are expected to obtain drug coverage through Part D plans.
  - Medicaid still covers Part D excluded drugs for duals.
Key Terms (cont’d.)

- **Utilization Controls** – limits to accessing coverage in both fee-for-service Medicaid and in MMC.

- **Prior Authorization** – prescriber required to get approval from the plan before prescription will be paid, generally not needed for refills but required again once refills are exhausted.

- **Step Therapy** – requires client to have tried another (usually preferred) drug be prescribed first for specified time period.

- **Quantity Limit** – limited quantity of drug per fill (usually 30 days).

- **Co-payment** – amount paid directly by the consumer.
Why focus on Medicaid?

- Medicaid remains the single most important source of coverage for nonelderly people with HIV
- Kaiser Frank Foundation data from 2015 – 40% of people with HIV are enrolled in Medicaid
- Compare to 15% for the general population
Medicaid

- Joint Federal/State program
- Two basic types of coverage –
  - MAGI (through marketplace)
  - Non-MAGI (through County DSS)
- Serves people of all ages
- Is means-tested
- More comprehensive benefit package than Medicare or ADAP
- Minimal or no cost-sharing once you meet income/resource limit
First... Non-MAGI Medicaid

- Administered through the Local District Social Services or HRA
- Includes:
  - SSI-related Medicaid
  - ABD Medicaid
  - MSP & MBI-WPD

2019 Income and Resource limits (does not include MSP/MBI-WPD)

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<th>Family Size</th>
<th>Monthly Income Limit</th>
<th>Asset Limit</th>
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Marketplace Medicaid

- Includes MAGI Medicaid
- Established by ACA
- Apply online, by phone, or in person with assistance
  - [https://nystateofhealth.ny.gov/](https://nystateofhealth.ny.gov/)
  - 1-855-355-5777 or TTY: 1-800-662-1220
  - **Navigators**, CAC, or **Broker**
- NYSOH: where individuals can shop for health coverage
  - Allows for comparison of available plan options based on price, services, benefits, quality
- Types of insurance:
  - Qualified Health Plans
  - Essential Plan
  - Expansion Medicaid (MAGI)

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# Eligibility Groups

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<tr>
<th>MAGI</th>
<th>Non-MAGI</th>
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| **Newer Adult Group**: Childless adults, which include individuals that are:  
  • Not pregnant  
  • Age 19-64 (19 & 20 living alone) without Medicare  
  • Could be certified disabled but don’t have Medicare yet | **SSI**:  
  • SSI recipients  
  • State Supplement only |
| **Infants and Children under 19**                                     | **SSI-related Medically Needy**:  
  • Aged, Disabled, or Blind |
| **Parents/Caretaker Relatives**                                       | **ADC-related Medically Needy**:  
  • Under 21 years old  
  • Parent Caretaker Relatives  
  • Pregnant Women |
| **Pregnant Women**                                                    | Medicare Savings Program                                                  |
| **19 & 20 Year Olds Living with Parents**                             | AIDS Health Insurance Program (AHIP)                                     |
| **Family Planning Benefit Program**: if applying through NYSoH & are eligible for FPBP only | Medicaid Buy-In for Working People with Disabilities                     |
| **Child in Foster Care (Chaffee)**: MAGI administered in WMS          | COBRA                                                                    |
Medicare Overview

- **Part A** – inpatient/hospital
  - Includes skilled nursing, home health skilled, hospice

- **Part B** – outpatient/medical coverage
  - Includes DME, home health services, emergency ambulance, preventive
  - Lots of dual eligibles choose to turn down Part B
    - **BEWARE Late Enrollment Penalties!!**
    - Will incur permanent LEPs if move out of state

- **Part D** – prescription drug coverage

- Medicare Advantage (formerly Part C)
  - Medicare private health plans

- **Medicare Savings Programs** (MSPs)
  - Assists client with Parts A and/or B premiums
  - Income/asset limits
  - If client enrolls, will automatically be deemed into Extra Help (Part D costs)
AIDS Drug Assistance Program (ADAP)

- Federal grant administered through NY DOH
- Provide HIV-related prescription drugs to people who have limited or no prescription drug coverage
- Income limit recently increased to 500% of FPL; resource limits eliminated
  - $62,450 for a single person, $84,550 for a couple, or $106,650 for a household of three
- Must be NY resident – no citizenship requirement
Coordinating Medicaid and ADAP

- Medicaid spenddown may be key to activating Medicaid coverage (non-MAGI)

- Expenses paid by ADAP “count” toward Medicaid spenddown
  - Have pharmacist bill ADAP as primary payer. ADAP will mail proof of payment
  - Use ADAP expense to activate Medicaid spenddown coverage
Medicaid Managed Care Plans
Major Change in 2011 (MRT Initiative #11)

**Fee for Service Pharmacy Benefit**
- Clients used Medicaid card - pharmacists paid by NYS for each prescription
- One Medicaid Formulary
- “Preferred v. Non-Preferred” Drugs
- Medicaid paid for all medically necessary drugs

**Medicaid Managed Care Benefit**
- Pharmacy benefit “carved into” Medicaid Managed Care as of 10/1/2011
- Each plan has a formulary
- Plans have varying “utilization restrictions”
- Clients still entitled to all medically necessary drugs
Medicaid Managed Care

- Generally, choose a Managed Care Plan
  - DOH pays insurance companies “per member per month (PMPM)” to cover cost of care
  - The plan will pay for care, rather than “fee-for-service”
  - Must cover Medicaid benefits, at a minimum

- Medicaid can be retroactive for up to 3 months, as long as eligible in those 3 months
  - Pays for comprehensive, medically necessary services
    - Medicine, supplies, durable medical equipment
    - Doctors
    - Hospital inpatient + outpatient
    - Labs + X-rays, etc...
  - Federally, prescription drugs are an optional benefit, but NYS covers both medically necessary + OTC drugs
  - NY Medicaid has “mandatory” generic dispense program: prior authorization required for medication that is not generic
Types of Special Medicaid Managed Care Plans

- **Special Programs in Medicaid Managed Care**
    - Mainstream Managed Care
    - Managed Long-Term Care Plans
    - Health Homes
    - Health and Recovery Plans
    - HIV Special Needs Programs (HIV SNPs)
      - In NYC exclusively
Managed Long-Term Care

- Partially-capitated plan

- For dual eligibles (people who have Medicare + Medicaid) & ALSO need home care for > 120 days

- Either get medical care/drugs through Medicare Parts A (inpatient/hospital) + B (outpatient/medical) + D (drugs), or through Medicare Advantage (Medicare Managed Care).

- **MLTC plan only covers**: long-term care, non-emergency transportation, DME, nursing home care, podiatry, audiology, dental, optometry, home mods, respiratory therapy
  - Examples of services **NOT included** in partially-capitated MLTC: prescription drugs, hospice, assisted living, lab/radiology, hospital inpatient/outpatient, emergency room
Health Homes

- What are Health Homes?
  - Group of health care + service providers working together to make sure you get care/services you need

- HIV+ individuals automatically qualify for HH services

- Care management with:
  - Health providers;
  - Behavioral health & SUD services;
  - Connecting to necessary medications;
  - Housing;
  - Applying/recertifying for social services;
  - Other support services as necessary

- Enrolled through their Managed Care plan in their county: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm
HARP

- **Health and Recovery Plans**
  - For those with significant behavioral health needs or substance use disorder needs
  - Identified as eligible by use of behavioral health usage or by functional impairment
  - Must be Medicaid eligible
    - Those already in a Managed Care plan will be auto-assigned to the sister HARP plan if they are determined eligible and will receive a notice ([more info here](#))
    - Can opt-out if they choose
  - Individuals work w/ care manager to sort through which home & community-based (HCB) needs they will get
  - Coordinates physical + behavioral health care, as well as non-Medicaid support, & meds
    - Can also include behavioral health HCBS
HIV SNP

- **Specialized Medicaid Managed Care plans** (only in NYC) designed to meet needs of those living with HIV/AIDS
  - Can be HIV-negative homeless or transgender
  - Their dependent children can also enroll
  - Covers all Medicaid services; and
    - An HIV specialist primary care physician (PCP)
    - HIV care coordination services
    - Information about HIV medications and side effects
    - Treatment adherence services
    - HIV prevention and risk reductions education for HIV negative members
  - Can choose during Medicaid enrollment to be enrolled in MMC or HIV SNP
  - Clients w/ Medicaid though the Marketplace – enroll in SNPs there
  - Clients w/ Medicaid through HRA – call Medicaid Choice to enroll in SNP
- [Model Contract](#)
Navigating Access to Prescription Drugs
What if your client can’t afford the co-pay?

- Does not apply to dual eligibles
- Medicaid co-payment amounts:
  - $3.00 for non-preferred brand-name drugs
  - $1.00 for preferred, brand-names or generics
  - $0.50 for OTC, non-prescription drugs
  - $1.00 for sickroom supplies.
- Cannot deny medications if patient cannot pay
- Certain beneficiaries cannot be charged copays
  - Children under 21
  - HCBS/TBI waiver participants, and others:
  - [https://www.health.ny.gov/health_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/)
  - $200 annual maximum – beginning April 1st, ending March 31st.
If your client has trouble filling a prescription...

- You need to find out
  - whether your client is in MMC and if so, which plan
  - whether the drug is on the plan’s formulary and if so, whether any restrictions apply

- Your client’s provider (doctor and/or pharmacist) can be an excellent source of information

- Also, be sure to check the NY State Medicaid Managed Care Pharmacy Benefit Information Center
  - Links to plans & contact info
  - Drug search feature compares formularies across plans
  - NYSDOH Helpline: 1-866-881-2809
  - [http://mmcdruginformation.nysdoh.suny.edu/](http://mmcdruginformation.nysdoh.suny.edu/)
Formularies

- Each plan has its own formulary – for people with chronic conditions, such as HIV, it is IMPERATIVE that they know ahead of time that their meds are on the formulary.

- Formularies must be comparable to Medicaid formulary – at least one drug on the Medicaid formulary: [https://mmcdruginformation.nysdoth.suny.edu/](https://mmcdruginformation.nysdoth.suny.edu/)
  - This is all of the Managed care plans, as well as the Medicaid helpline.
  - Info on FFS Medicaid
  - DOH updates this on a quarterly basis

- Plans are able to set their own quantity limits

- Standard Prior Authorization Form for all plans
  - [https://newyork.fhsc.com/](https://newyork.fhsc.com/)

- **Part D Excluded** drugs by state covered under Medicaid
Changing Plans

- Remember, dual eligibles get their drugs through Medicare Part D or Medicare Advantage
  - Duals can switch plan at any time, effective 1\textsuperscript{st} of next month

- For everyone else (including MMC, MLTC, HARP)...
  - If necessary drugs are not covered by your client’s current plan, but are covered by another, changing plans may be an option
    - Within first 90 days after initial enrollment
      - Lock-in for remaining 9 months
    - After 12-month enrollment in plan
      - Remember to verify that your client’s doctor participates in the new plan.
Recap: Medicaid Plan Enrollment
(not for dual eligibles)

First enroll and are approved for Medicaid
You have 60 days to choose a Managed Care Plan
Once in plan, if you need to switch, you have 90 days
Locked in for 9 months

*Those who are dual-eligible may switch once per quarter
Prescriber Prevails

- **Prescriber Prevails**
  - The provider has the final say for the patient on whether certain medications are medically necessary for certain drug classes – even if not on formulary

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<tr>
<th>Atypical antipsychotics</th>
<th>Anti-depressants</th>
<th>Anti-retrovirals</th>
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<tbody>
<tr>
<td>Anti-rejection</td>
<td>Seizure</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Hemotologic</td>
<td>Immunologic therapeutics</td>
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- Can obtain mail order/specialty drugs at any retail network pharmacy, if the retail network pharmacy has agreed to a price that is comparable to the mail order/specialty price
Coverage for Enteral Formula Benefit for those with HIV/AIDS

- AKA MRT Initiative 5901

- Oral fed adults with BMI between 18.5 and 21.9 who have demonstrated at least a 5% weight loss over previous 6 months
  - Oral fed adults with a BMI under 18.5 requiring more than 2-three month authorizations within a 365 day period.
  - Oral fed adult with a permanent structural limitation (tube feeding contraindicated)
Potential Issues

- Your client’s plan is not on the Medicaid Managed Care Pharmacy Benefit website
  - Is it a commercial plan?
  - Is your client Medicare eligible?

- The drug is not on the plan’s formulary, or step therapy or quantity limits apply –
  - Your client will need *prior authorization*
    - All plans must use a *standard PA form*
    - PA should be processed within 48 hours
  - Another option is to *change plans* to one that covers the drug your client needs
Case Example

- Client John shows you a prescription from their doctor for the anti-retroviral drug *Delstrigo*.
- John tells you that their pharmacist says their insurance won’t pay for it.
- John lives in Monroe county and has this card:
- What can you do?

**HINT:** [NY State Medicaid Managed Care Pharmacy Benefit Information Center](https://www.ny.gov/agencies/new-york-state-office-of-medicare-and-medicaid-services/managed-care/pharmacy-benefit-information-center)
Hepatitis C Treatments

- **Viekira Pak** (for HCV genotype 1)
- **Harvoni** (for HCV genotype 1, 4, 5 or 6)
- **Sovaldi** (for HCV genotypes 1 – 4)

Harvoni, Sovaldi, and Viekira Pak Fee for Service Medicaid
Prior Authorization Criteria:

- See: May 2016 Medicaid update:
  - [https://newyork.fhsc.com/providers/pdp_hepatitisc.asp](https://newyork.fhsc.com/providers/pdp_hepatitisc.asp)

MMC plans can use different criteria, although a number use criteria similar to fee for service Medicaid
Addressing Denials
Advocacy Strategies

- Ask doctor to submit prior authorization
  - Anti-retrovirals are subject to “provider prevails”
- Change drug or change plan (if not locked in)
- Appeal the PA denial
  - Internal plan appeal
  - External review
  - Fair hearing
Three Appeal Pathways

**Plan Appeals**

*plan websites & dfs.ny.gov*

- Internal review to plan employed peer reviewers
- External Review to State Division of Financial Services
- *Can be filed simultaneously with Fair Hearing*

**Fair Hearings**

*health.ny.gov*

- Aid continuing available in some circumstances
- In person review with administrative law judge
- *Fair Hearing decision trumps External Review*

**Medicare Part D**

*medicare.gov*

- Coverage determination request (plan level)
- Redetermination of coverage request (plan level)
- Reconsideration by independent contractor (IRE/Maximus)
- Hearing with Administrative Law Judge
- Medicare Appeals Council

**Empire Justice Center**
Resources

- Medicare Rights Center
  - [https://www.medicareinteractive.org/](https://www.medicareinteractive.org/)
  - **800-333-4114** (National Helpline)
- State Medicaid MLTC Complaint Line
  - **1-866-712-7197**
- NY Medicaid Choice
  - **1-800-505-5678** (Individual & Family)
  - **1-888-401-6582** (MLTC)
- Medicare.gov
- Medicaid Managed Care [Pharmacy Benefit Info Center](https://www.medicare.gov/index.html)
- [NY Health Access](https://www.medicare.gov/index.html)
- [HIV SNP info](https://www.medicare.gov/index.html)
Call us for help...

- We can provide advice about appeals and advocacy, or contact NYSDOH about plan errors
- Contact our Health Intake Line
  - Email: health@empirejustice.org
  - Phone: (800) 724-0490 ext. 5822