Prescription Drugs in Medicaid: *Navigating Managed Care Requirements*

Sponsored by:
AIDS Institute, NYS Department of Health

Presented by:
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Today's Agenda

- Key Terms
- Medicaid & Medicare Recap
- Overview of Medicaid Managed Care
- Special MMC plans
- Navigating the Pharmacy Benefit
  - Plan formularies
  - Plan restrictions
- Potential Issues
- Addressing Denials
- Changes Coming in 2023
- COVID-19 PHE
- Resources

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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 populations into 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.

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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 first for specified time period
- ***Quantity Limit*** – limited quantity of drug per fill (usually 30 days)
- ***Co-payment*** – amount paid directly by the consumer

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Why focus on Medicaid?

- Medicaid remains the single most important source of coverage for nonelderly people with HIV
- Kaiser Family Foundation data from 2018 – Medicaid is estimated to cover 40% of adults with HIV
- Compare to 15% for the general population
- 2020 KFF Issue Brief – Insurance Coverage and Viral Suppression Among People with HIV
- 1.5 million additional Medicaid enrollees in NYS since the public health emergency began

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Medicaid

- Joint Federal/State program
- Two basic types of coverage –
  - MAGI (through marketplace)
  - Non-MAGI (through County DSS, lower income limit + resource test)
- Serves people of all ages
- Means-tested
- More comprehensive benefit package then Medicare or ADAP
- Minimal or no cost-sharing once you meet income/resource limit

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First... Non-MAGI Medicaid

- Administered through the Local District Social Services or HRA
- Includes:
  - 65 or older
  - Blind or determined disabled (SSA)
  - Receive SSI, MSP, AIDS Health Insurance Program, or Medicaid Buy-In for Working People with Disabilities
- 2022 Income and Resource limits

Family Size	Monthly Income Limit	Asset Limit
1	$934	$16,800
2	$1,367	$24,600

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Marketplace Medicaid

- MAGI Medicaid established by ACA
- Income level of 138% FPL applies to most adults who are not disabled and who do not have Medicare
- No resource limit for MAGI!
- Apply online, by phone, or in person with assistance
  - https://nystateofhealth.ny.gov/
  - 1-855-355-5777 or TTY: 1-800-662-1220
  - Navigators, CAC, or Broker

Family Size	Monthly Income Limit (2022 estimate)
1	$1,563*
2	$2,105*

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Other Marketplace options

- NYSOH: where individuals can shop for health coverage
  - Allows for comparison of available plan options based on price, services, benefits, quality
- Essential Plan
  - New York residents age 19-64 AND ineligible for other affordable insurance
  - $0 premium and all plans include dental and vision
- Qualified Health Plans
  - Comprehensive private plans certified by NYSOH
  - Premium depends on plan, tax credits available

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Eligibility Groups

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

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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 Plans (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)

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Name of Program	Benefit (What Medicaid Pays)	Monthly Income Eligibility*		Resource Limits		Retroactive?
		Individual	Couple	Individual	Couple	
Qualified Medicare Beneficiary (QMB) (100% FPL)	Medicare premiums, deductibles, coinsurance	$1,133*	$1,526*	None	None	NO – effective in m following month o application
Specified Low Income Medicare Beneficiary (SLMB) (120% FPL)	Medicare Part B premium	$1,359*	$1,831*	None	None	YES – 3 months be month of applicati
Qualified Individual (QI) (135% FPL)	Medicare Part B premium	$1,529*	$2,060*	None	None	YES – 3 months, bu same calendar yea
Qualified Disabled + Working Individual (QWDI) (200% FPL)	Medicare Part A premium	$2,265*	$3,052*	$4,000	$6,000	YES – 3 months be month of applicati
Non-MAGI Medicaid (LDSS)		$904	$1320	$15,900	$23,400	YES – 3 months of or unpaid medical
MAGI Medicaid (NYSoH)		$1,563*	$2,105*	None	None	YES – 3 months of pa unpaid medical bills

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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 500% of FPL; no resource limit
  - $67,950* for a single person, $91,550* for a couple
- Must be NY resident – no citizenship requirement
- HIV-infection or at risk of acquiring

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Coordinating Medicaid and ADAP

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

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Medicaid Managed Care Plans

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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

Major Change in 2011 (MRT Initiative #11)

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Medicaid Managed Care

- Generally, choose a Managed Care Plan
  - DOH pays insurance companies per member per month 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

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Care Coordination in MMC

- Managed Care plans must provide care coordination for enrollees with high needs such as
  - Chronic illnesses, HIV, or physical/developmental disabilities
  - long-term services and supports (LTSS)
- The plan must have adequate case management systems to identify the service needs, including enrollees with chronic illness and disabilities
  - Plan should be screening based on claims data provider
  - Appropriately train staff to function as case managers for special needs populations (or subcontract for case management)
  - Inform enrollees about services, including referral to Health Home
- *Member Services* is frequently the care coordination unit for the managed care plan
- Encourage self referral and/or speak to trusted provider

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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)

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Managed Long-Term Care

- MLTC plans approved by NYSDOD - MLTC plan directory
- Mandatory enrollment for dual eligibles (people who have Medicare + Medicaid) AND need home care for > 120 days
- Partial-capitation
- **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

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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

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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 services (HCBS) they will need
  - Coordinates physical + behavioral health care, as well as non-Medicaid support, & meds
    - Can also include behavioral health HCBS

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HIV SNP

- Specialized Medicaid Managed Care plans designed to meet needs of those living with HIV/AIDS
  - Only available in NYC
  - For individuals living with HIV/AIDS or are homeless or are transgender – 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

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Navigating Access to Prescription Drugs

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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
- 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/
  - $200 annual maximum – beginning April 1st, ending March 31st

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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

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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
- Managed Care formularies must be comparable to FFS Medicaid formulary – at least one drug in each class on the Medicaid formulary
- 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
- Plans are able to set their own quantity limits
- Standard Prior Authorization Form for all plans

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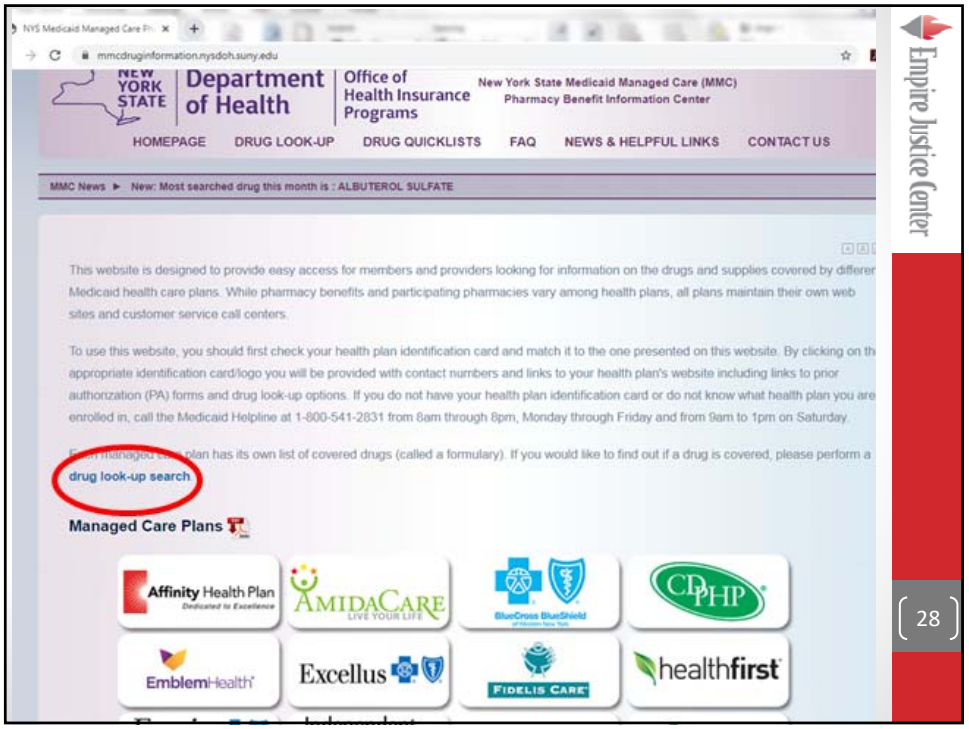

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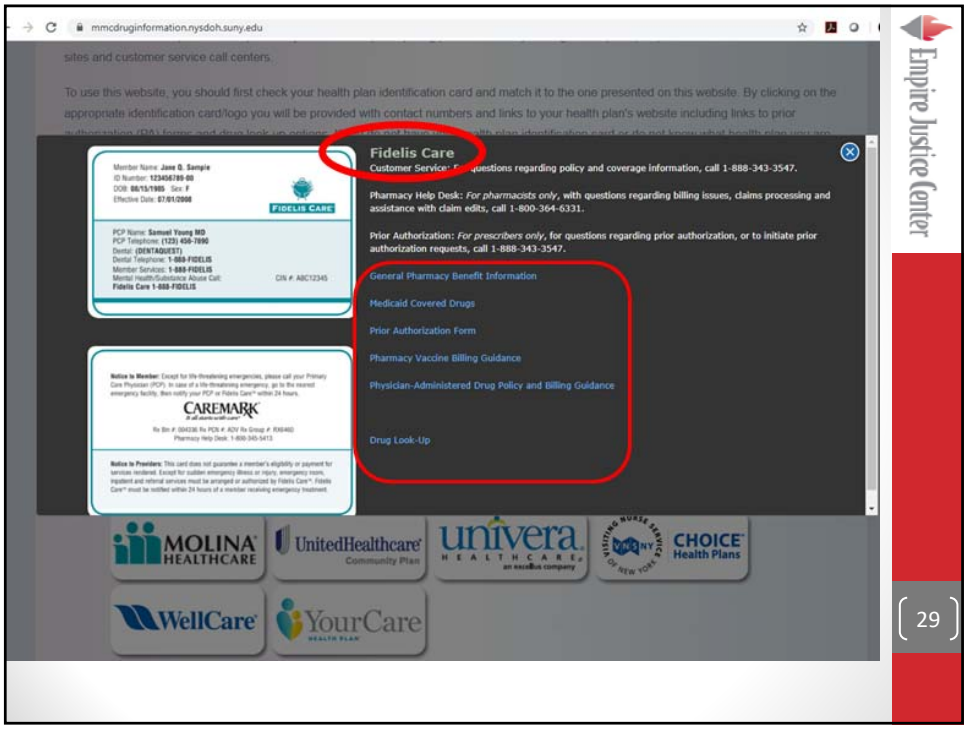
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sites and customer service call centers.
To use this website, you should first check your health plan identification card and match it to the one presented on this website. By clicking on the appropriate identification card/logo you will be provided with contact numbers and links to your health plan's website including links to prior
Fidelis Care
Customer Service: questions regarding policy and coverage information, call 1-888-343-3547.
Pharmacy Help Desk: For pharmacists only, with questions regarding billing issues, claims processing and assistance with claim edits, call 1-800-364-6331.
Prior Authorization: For prescribers only, for questions regarding prior authorization, or to initiate prior authorization requests, call 1-888-343-3547.
General Pharmacy Benefit Information
Medicaid Covered Drugs
Prior Authorization Form
Pharmacy Vaccine Billing Guidance
Physician-Administered Drug Policy and Billing Guidance
Drug Look-Up
MOLINA HEALTHCARE
UnitedHealthcare Community Plan
univera HEALTHCARE
CHOICE Health Plans
WellCare
YourCare
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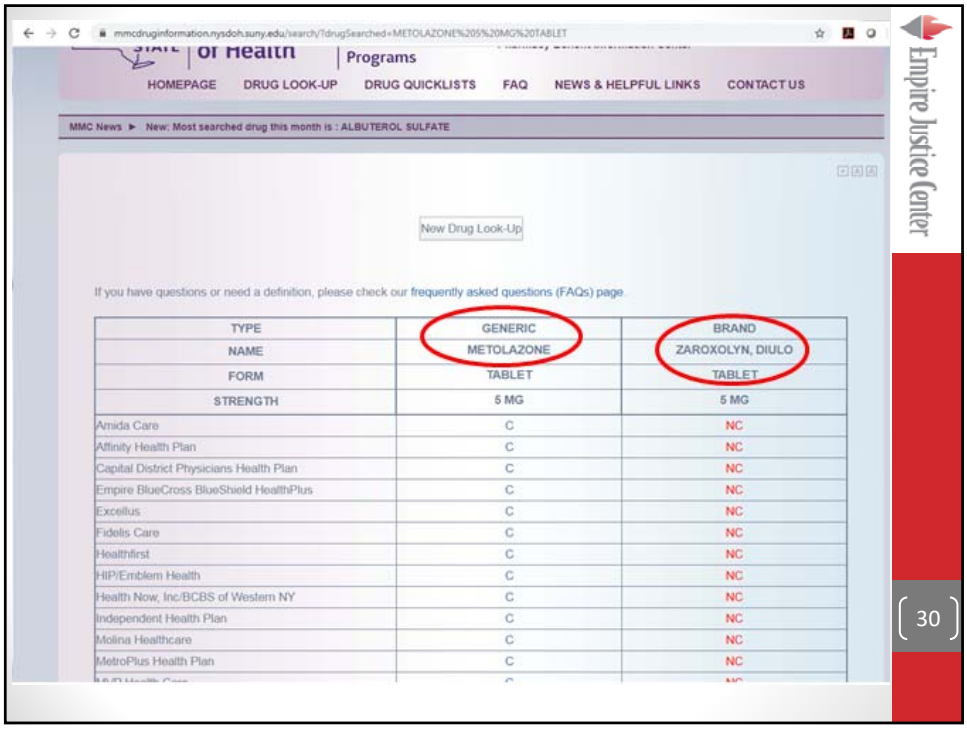
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of Health | Programs
HOMEPAGE DRUG LOOK-UP DRUG QUICKLISTS FAQ NEWS & HELPFUL LINKS CONTACT US
MMC News ► New: Most searched drug this month is : ALBUTEROL SULFATE
New Drug Look-Up
If you have questions or need a definition, please check our frequently asked questions (FAQs) page.
TYPE GENERIC BRAND
NAME METOLAZONE ZAROXOLYN, DIULO
FORM TABLET TABLET
STRENGTH 5 MG 5 MG
Amida Care C NC
Affinity Health Plan C NC
Capital District Physicians Health Plan C NC
Empire BlueCross BlueShield HealthPlus C NC
Excellus C NC
Fidelis Care C NC
Healthfirst C NC
HIP/Emblem Health C NC
Health Now, Inc/BCBS of Western NY C NC
Independent Health Plan C NC
Molina Healthcare C NC
MetroPlus Health Plan C NC
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Medication Assisted Treatment (MAT) Formulary

- Effective October 1, 2021, NYS Medicaid has enacted a single statewide MAT Formulary
- MMC plans and FFS will follow a single formulary for Opioid Antagonists and Opioid Dependence Agents
  - preferred products and coverage parameters are consistent across the Medicaid program
- List of Medication Assisted Treatment Agents
- MMC enrollees will continue to access medications by presenting their plan card to pharmacy
- Prior Approval is required for all non-preferred agents

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Changing Plans

- Remember, dual eligibles get their drugs through Medicare Part D or Medicare Advantage
  - Duals can switch plan once per calendar quarter, effective 1st of next month, for the first 9 months of the year
- 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

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When can you change plans?

- Within first 90 days after initial enrollment
  - After 90 day, **locked-in** for following 9 months
- After 12-month enrollment in plan, can change plans for any reason
- Changing plans during lock-in period?
  - See 18 NYCRR 360-10.6
  - "Good cause" for changing or disenrolling - failed to furnish accessible and appropriate medical care, services or supplies
- Remember to verify that your client's providers participate in new plan
- Note: if eligible for HIV SNP or HARP, individual may transfer at any time

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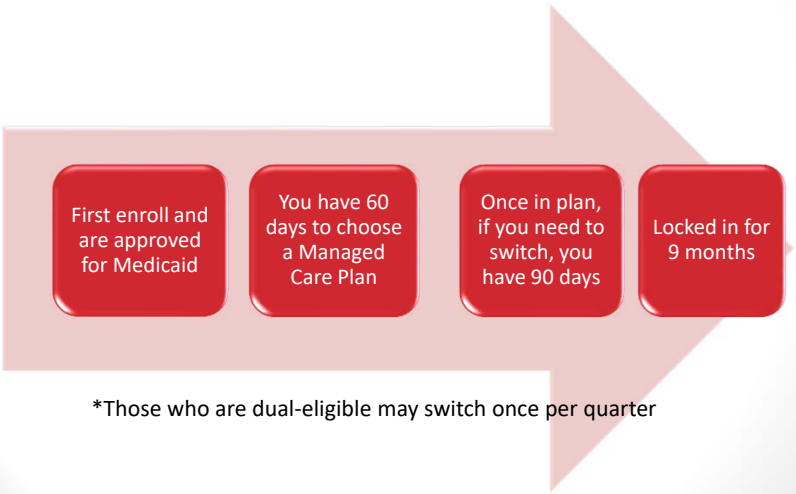
Recap: Medicaid Plan Enrollment

(not for dual eligibles)



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

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Prescriber Prevails (until April 2023)

- 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

Atypical antipsychotics	Anti-depressants	Anti-retrovirals
Anti-rejection	Seizure	Epilepsy
Endocrine	Hemotologic	Immunologic therapeutics

- 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

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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)

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Hepatitis C Treatments

- Effective October 2020, following a NYS Medicaid Drug Utilization Review Board recommended change, FFS Medicaid removed prior authorizations for first time direct acting antivirals (DAAs) treatment of hepatitis C infection and for re-treatment within one year for any reason. See Medicaid Update
- Prior authorizations are still required for patients needing retreatment after one year, when prescribing a non-preferred drug, or when no evidence of FDA-approved or compendia-supported diagnosis in history
- MMC plans can use different clinical criteria, although a number use criteria similar to fee for service Medicaid

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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

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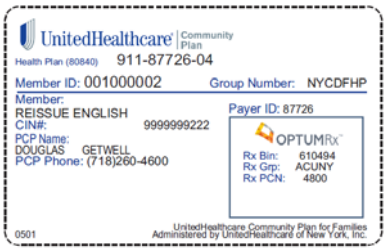
Case Example

- Client John shows you a prescription from their doctor for the anti-retroviral drug *Odefsey*.
- 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

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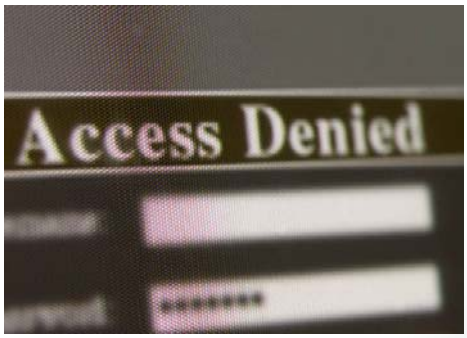
Addressing Denials



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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

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Three Appeal Pathways

Plan + External	Plan + Medicaid FH	Medicare Part D
plan websites & dfs.ny.gov	*health.ny.gov*	*medicare.gov*
Internal review to plan employed peer reviewers	Internal review to plan, aid continuing available in some circumstances	Coverage determination request (plan level)
External Review to State Division of Financial Services	In person review (fair hearing) with administrative law judge	Redetermination of coverage request (plan level)
Can be filed simultaneously with Fair Hearing	***Fair Hearing decision trumps External Review***	Reconsideration by independent contractor (IRE/Maximus)
		Hearing with Administrative Law Judge
		Medicare Appeals Council

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Plan Appeals… the details

- All MMC plans required to have internal & external review process
- If a plan denies approval or discontinues a drug that had been approved, enrollee receives an Initial Adverse Determination (IAD)
- *EXHAUSTION*: Enrollee must first request *internal* plan appeal, wait for plan's decision
  - Adverse decision = Final Adverse Determination (FAD)
  - 30 calendar days standard, 72 hours expedited
- After FAD, enrollee has right to request a Fair Hearing
  - *Unless DEEMED exhaustion*: if no FAD provided in required time, can request FH without FAD
- Aid continuing: if drug was reduced or terminated, request continued access to drug while awaiting plan appeal & FH (within 10 days of FAD, or before effective date of FAD)

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External Appeal

- Option after Internal Appeal
  - Plan notice denying your Internal Appeal will explain your right to request an **External Appeal** if the reason for the denial is because they determine the service is not medically necessary or is experimental or investigational
  - May request an External Appeal even if also requesting FH
  - Reviewed by a different State agency (DFS) than FHs
  - FH decision always trumps External Appeal decision
- If in first 90 days of enrollment, or past first 12 months of enrollment, also have option of switching plans to improve access to medications

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Changes ahead in 2023…

- "Carve-out"
- Beginning April 1, 2023, Medicaid pharmacy benefits will be transitioned from Managed Care to Fee for Service
- FFS Pharmacy carve-out applies to all Mainstream Managed Care plans, including HARP and HIV-SNP
- Does not apply to MLTC plans or the Essential Plan
- Will not change the scope of the existing Medicaid benefit
- DOH website for information and updates
  - https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_carve_out/

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During the COVID-19 PHE

- Federal PHE has been extended until April 16, 2022
- Everyone with Medicaid coverage on or after March 18, 2020 will keep coverage unless they voluntarily cancel or move out of NYS during the PHE
- Medicaid Coverage through Your Local Department of Social Services during the Coronavirus Emergency (Info about applying for and maintaining coverage)
- Those who turn 65, or become eligible for Medicare based on disability, would normally have their Medicaid transferred from NYSOH to the local district. Instead, they will have Medicaid automatically extended for 12 months.
  - These individuals will remain in MMC plan, even though they now have Medicare
- **Don't hesitate to ask for assistance on notices, applications, questions**

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Resources

- Medicare Rights Center
  - 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)
- https://www.medicare.gov/
- Medicaid Managed Care Pharmacy Benefit Info Center
- NY Medicaid Standard Prior Authorization Forms
- eMedNY – FFS formulary
- NY Health Access
- HIV SNP info

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Contact us for help…

- Empire Justice Center
  - www.empirejustice.org
  - Health Intake Line: 1-800-724-0490 x 5822
  - Email: health@empirejustice.org

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