Alabama Medicaid Pharmacist

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Medicare Modernization Act

Adopted in December 2003, the Medicare Modernization Act (MMA) added a new Prescription Drug Benefit known as Medicare Part D to the Medicare program to provide coverage for prescription drugs through private plans beginning in 2006. Each private plan will design prescription drug coverage, with approval of CMS, and will be expected to use tools (such as formularies and tiered co-payments) to control costs. The MMA also includes low-income subsidies that reduce the cost-sharing requirements under Part D so that low-income beneficiaries will be better able to take advantage of the new benefit.

States currently provide drug coverage through Medicaid for low income seniors and people with disabilities who have both full Medicaid and Medicare. These recipients are often referred to as full "dual eligibles." In Alabama there are approximately 88,000 full dual eligible recipients. As of December 31, 2005, the MMA ends Medicaid drug coverage for full dual eligibles and requires that they instead secure their medications through private Medicare drug plans. Alabama Medicaid will continue to cover specific drug classes that CMS allows the private drug plans to exclude (see Table 1). Medicaid will not cover drugs that the private drug plans choose not to include on their formularies.

States are also required to finance much of the cost of providing drug coverage to dual eligibles through private Medicare drug plans. States are expected to send payments (often referred to as clawback payments) to the federal government on behalf of dual eligibles enrolled in a Medicare prescription drug plan on a monthly basis. The formula for the clawback payment is based on 2003 expenditures and does not take into account any actions states have taken in recent years to slow the growth of Medicaid prescription spending. The Alabama Medicaid Agency has initiated several savings initiatives including the Preferred Drug List and the Four (4) Brand Limit that are not calculated into the clawback payment.

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Table 1

Part D Excluded Drug Class	**Example Drug* Alabama Medicaid Will Continue to Cover** (Medicaid coverage of these optional classes is subject to change.)
Drugs for anorexia, weight loss, weight gain	Currently Medicaid covers orlistat under PA (specific additional co-morbidity must be medically confirmed)
Fertility drugs	nafarelin (Medicaid *does not cover* drugs with a fertility-only FDA approved indication)
Cosmetic use or hair growth	Medicaid *does not cover* drugs with cosmetic-only FDA approved indications
Symptomatic use of cough and colds	dextromethorphan, pseudoephedrine, hydrocodone combination cough syrups
Prescription vitamin and mineral products (excluding prenatal vitamins and fluoride preparations)	multivitamins for TPN, cyanocobalamin
Over the Counter (OTC) products	acetaminophen, aspirin, hydrocortisone 1%, ibuprofen
Barbiturates	phenobarbital, amobarbital
Benzodiazepines	clonazepam, temazepam, diazepam

* Example drugs are listed for reference purposes only. As these are optional coverage classes for Medicaid, not all drugs in these classes may be covered.

Drug Benefit Plan

The Medicare Part D benefit will be administered by private drug plans:

- Medicare-Advantage (MA-PD plan or Medicare Health Plans) managed care plan that offers the Part D benefit
- Prescription Drug Plan (PDP) offered to fee for service Medicare beneficiaries by plan sponsor under contract with CMS

The plans will derive payments from a number of sources:

- Monthly premium subsidies from Medicare
- Monthly premiums and co-pays from beneficiaries
- Risk-sharing payments from Medicare

The plans are required to develop formularies; the formularies must include two drugs in each therapeutic category or class. CMS may require more than two drugs per class in cases where additional drugs present important therapeutic advantages in terms of efficacy and safety. The plans are permitted to use tiered cost sharing structures and other mechanisms, such as prior authorization, step therapy and therapeutic interchange. All formularies must be approved by CMS which will use best practices in existing drug benefits and will expect that types of formularies must be in widespread use to be approved. The plans are also required to have a grievance and appeal procedure that allows beneficiaries to request specific coverage for a drug that is not in a plan's formulary.

The MMA requires plans to implement ongoing quality improvement programs including a Medication Therapy Management Program (MTMP). This program will be targeted at beneficiaries who:

- Have chronic conditions such as asthma, diabetes, or hypertension
- Are taking multiple drugs
- Have medical expenses that will exceed $4,000 annually

MTMPs must be administered by a pharmacist or other qualified provider. The services include both ambulatory and institutional settings. MTMPs must be coordinated with other chronic care management and disease state management programs. The plans will have a great deal of flexibility in developing these programs.

Standard Drug Benefit Design

The MMA specifies certain minimum standards for Part D coverage- the "standard Part D benefit," which is structured as follows:

- $32.20 per month monthly premium
- $250 annual deductible for out of pocket expense, before Part D benefit begins
- Medicare will pay 75% between $250 and $2,250; beneficiary pays the other 25%
- The beneficiary will pay 100% of expense between $2,250 and $5,100
- Medicare will pay 80%, the drug plan will pay 15% and the beneficiary will pay 5% of any expenses beyond $5,100

Dual Eligibles' Enrollment in Medicare Part D

The MMA mandates a fundamental shift in prescription drug coverage for dual eligibles.

These individuals must transition from Medicaid drug coverage to the new Medicare prescription drug plans. The federal government will no longer provide matching funds to state Medicaid agencies for the cost of providing prescription benefits to the dual eligibles. The dual eligibles are to enroll in one of the new private Medicare drug plans to secure their medications.

To make it more affordable to access the prescription coverage from the private Part D drug plan, the MMA provides dual eligibles (and other low-income Medicare beneficiaries) with a low-income subsidy that covers almost all out of pocket costs. The exact level of the subsidy will depend on a dual eligible's income level and institutional status. There are approximately 173,000 Medicaid recipients who qualify for the subsidy. There are 88,000 full dual eligibles in Alabama who are automatically enrolled in a Part D plan and will avoid any gaps in coverage. There are 85,000 Medicaid recipients in Alabama currently enrolled in a Medicare Savings Program only who currently do not have a pharmacy benefit. They will also automatically qualify for the extra help. Medicaid pays their Medicare premiums, coinsurance and deductibles. They will also avoid gaps in coverage. All of these recipients (excluding LTC residents) must pay a $1-$3 co-pay, but will not be subject to any other out of pocket expenses.

Full duals will be automatically enrolled in a drug plan if they do not choose a plan by December 31, 2005. Those currently enrolled in a Medicare Savings Program will not be automatically enrolled in a drug plan until May 2006 if they have not already enrolled. Both groups can change plans at any time to be effective the beginning of the next month.

Part D Low Income Subsidies Design

	Premium Subsidy	Deductible	Co-payment	Co-pay after Catastrophic Limit
Basic benefit: No low income subsidy	0%	$250	•Cost share =25% of drug costs up to $2,250($750 out of pocket) •Doughnut hole = 100% out of pocket from $2,251 to $5,100 of drug costs ($2,850 out of pocket) •Total out of pocket = $3600	5% of drug costs
Full Medicare/ Medicaid dual eligible	100%	$0	$1-$2 generic $3-$5 brand	$0
<135% FPL and meets asset test	100%	$0	$2 generic $5 brand	$0
135%-150% FPL and meets asset test	Sliding scale 25%-75%	$50	15% cost of drug	$2 generic $5 brand

FPL: 100% of Federal Poverty Level is $9,310 (individual) or $12,490 (couples)
Asset test: Assets cannot exceed $10,000 (individuals) or $20,000 (couples)

Medicare Part D Glossary

Auto-Enrollment- A process by which certain individuals may be automatically enrolled in a PDP plan. This is specific to full benefit dual eligibles who do not actively choose a Part D plan.
Beneficiary- An elderly or disabled person who has health insurance through the Medicare program.
Clawback formula- A formula established in MMA that requires states to pay a portion of dual eligibles' drug costs to Medicare for their coverage under Part D.
Coverage Gap- The portion of the Part D benefit structure in which beneficiaries pay 100% of their Part D drug expenditures. In 2006 there will be a $2,850 coverage gap in the standard benefit between the initial coverage limit ($2,250) and the catastrophic threshold ($5,100). (Also referred to as the "doughnut hole.")
Dual Eligible (Full Dual) - An individual who is eligible for both Medicare and comprehensive Medicaid coverage.
Formulary- The entire list of Part D drugs covered by a PDP sponsor's or MA organization's drug plan. Includes both a therapeutic classification system and other elements, such as tiered cost-sharing and fail first programs.
Medicare Advantage (MA) Program- The program that replaces the M+C program under Part C in Medicare. MA offers Medicare beneficiaries the option of enrolling in a managed care plan to receive their Medicare benefits. Private participating plans must cover all Medicare benefits under Parts A and B.
Medicare Modernization Act (MMA) - Legislation that allows for the Part D prescription plan.
Part D- The part of Medicare that allows for an outpatient prescription drug benefit.
Wraparound Benefits- When a state or other organization helps defray the out-of-pocket costs incurred by a Medicare beneficiary under Part D.

References and Resources

References

Implications of the Medicare Modernization Act for States: The Kaiser Commission on Medicaid and the Uninsured. January 2005.

Medicare and the New Medicare Prescription Drug Benefit: Novartis April 2005.

The Medicare Prescription Drug Benefit presentation by Tara Shaver-Jarmon, State Health Insurance Assistance Program (SHIP).

Medicare Prescription Drug Program (Part D) presentation by Georgette Harvest, Alabama Medicaid.

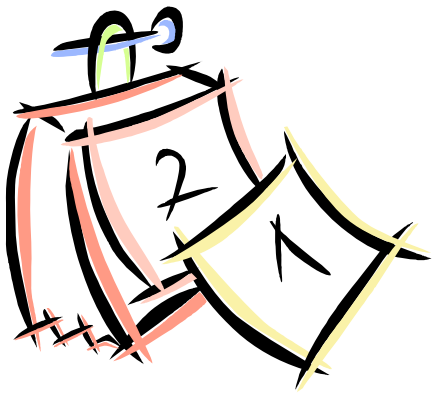
Resources

Medicare
1 (800) MEDICARE
www.medicare.gov

Social Security
1 (800) 772-1213
www.ssa.gov

SHIP
1 (800) AGE-LINE
www.ageline.net

AARP
www.aarp.org



Timetable for Prescription Drug Plan, 2005

February 18- Notice of intent to apply

March 23- Applications due to CMS

April 18- Formularies due to CMS for review

May/June- Decisions on contract eligibility

May 16- Preliminary approval of formularies

June 6- Bid submissions due

September 2- CMS completes review of bids

October 15- CMS information campaign starts

November 15- Open season for enrollment begins

January 1, 2006- Part D benefits begin

Physician Billing: Diagnosis Codes

Medicaid would like to clarify the importance of billing multiple diagnosis codes per each physician visit. Medicaid can accept up to eight diagnosis codes per physician visit; these diagnosis codes are used to determine a recipient's approval or denial in the event a prescription for that recipient requires Prior Authorization (PA). The Electronic PA process for prescriptions looks back one year in the recipient's medical claims history from the date of the request to ensure the patient has a diagnosis on file for the drug requested. If a physician has not billed that particular diagnosis code within the past year, the Electronic PA will be denied, and the physician and pharmacist must move forward with the manual PA process. All diagnoses must be supported by documentation in the patient record and may be subject to retrospective review. Ultimately, billing all appropriate diagnosis codes may result in less paperwork for all involved.

Schedule II Prescriptions

Schedule II drug prescriptions require the manual signature of the prescribing physician before dispensing. Stamped or typewritten signatures are not acceptable. In accordance with the Code of Federal Regulations, Section 1306.05, all prescriptions for schedule II substances shall be dated of, and manually signed by the prescribing physician the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use and the name and address and registration number of the practitioner.

Pharmacy Claims: Accurate Billing

Medicaid would like to clarify the importance of accuracy in specific elements of prescription billing. All aspects of billing, such as correct NDC, physician license number, directions for the patient, quantity, DAW, and days supply are part of accurate billing. Each specific component is an integral part of the formula that comprises legitimate pharmacy claims. Failure to bill accurately may result in retrospective pharmacy review.

To suggest topics for inclusion in the Alabama Medicaid Pharmacist, please call Health Information Designs, Inc., at 334-502-3262 or email us at info@hidinc.com.

HEALTH INFORMATION DESIGNS

1550 Pumphrey Ave.
Auburn, AL 36832
Tel: 800-748-0130
Fax: 800-748-0116