

Medicaid

Medicaid Matters New York

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Managed Care Workgroup

MEDICAID MANAGED CARE FACT SHEET

The Managed Care Pharmacy Benefit

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Effective October 1, 2011, Medicaid's pharmacy benefit will be moved into the managed care benefit package. The pharmacy benefit includes prescription and some over-the-counter drugs, medical supplies, hearing aid batteries and enteral formula. All Medicaid recipients in managed care should have received notification from the New York State Department of Health (NYSDOH) in late August, 2011.

The Family Health Plus (FHP) pharmacy benefit will also be moved into the FHP managed care benefit package. The FHP pharmacy benefit is not as comprehensive as Medicaid's. It includes most prescription drugs and select non-prescription drugs, diabetic supplies, hearing aid batteries and enteral formula.

HOW WILL MANAGED CARE CHANGE THE PHARMACY BENEFIT?

The pharmacy benefit will vary by plan. Although managed care plans are required to have drug formularies that are "comparable" to the Medicaid fee-for-service formulary, each plan will have its own formulary, drug coverage policy, and network of participating pharmacies.

Plan formularies will be comparable to but not the same as the Medicaid formulary. Not all drugs covered by Medicaid will be on plan formularies, but there must be generic or therapeutic equivalents of all Medicaid covered drugs on each plan's formulary.

Utilization controls will vary by plan, and "prescriber prevails" will not apply. Drug coverage policies like prior authorization and step therapy can differ from plan to plan. Prescribers will need to satisfy plan requirements and plans are not required to abide by the prescriber's judgment in the event of a dispute over the medical necessity of the drug in question.

Pharmacy networks will vary by plan. Consumers must use in-network pharmacies. Letters from plans in August and September should provide more information on how to determine a pharmacy's participation status with a particular plan.

WHAT ARE THE TRANSITION POLICIES?

Temporary fills. Plans are required to provide a one-time temporary fill of up to 30 days for drugs prescribed for members, both current and new, during the transition period running from October 1, 2011 through December 31, 2011.

- This includes both non-formulary drugs and drugs that are on the formulary but subject to prior approval or step therapy or any other utilization restrictions.
- The one-time, temporary fill must be provided by a participating pharmacy.

Disruption analyses. Plans were required to conduct disruption analyses using prescription claim data supplied by NYSDOH to identify enrollees likely to experience disruptions in care due to the plans' formulary or network of providers and pharmacies and submit plans for ensuring continued access to medically-necessary drugs.

- Plans were also directed to develop plans to ensure continued access to specialty drugs and drugs of concern, including antipsychotics, immunosuppressants, antiretrovirals, anticonvulsants, and antidepressants.
- Several plans are providing ongoing access to the drugs of concern listed above; most have guaranteed 12 months of access.

Outreach to enrollees. Plans have been required to communicate the changes in the pharmacy benefit to all beneficiaries and providers in the months leading up to the change. Notification should include an explanation of plan specific changes in coverage, information about pharmacy networks, and a description of the plan's exceptions and appeals process.

Information on formularies. NYSDOH has requested that plans post their formularies and information about their drug coverage policies on their websites, but this is not required. NYSDOH has also requested that plans dedicate a helpline to help enrollees navigate the new pharmacy benefit. For phone numbers and websites for Medicaid managed care plans, visit the Department of Health's site:

http://nyhealth.gov/health_care/managed_care/reports/eqarr/2010/plan_profiles.htm

CAN CONSUMERS SWITCH PLANS IN ORDER TO GAIN ACCESS TO DRUGS?

Changing plans is often an effective strategy for consumers eligible for both Medicaid and Medicare (dual eligibles) who receive their pharmacy services through Medicare Part D, because dual eligibles are allowed to switch plans at any time. Medicaid consumers will have this option only in the limited circumstances during the first year of enrollment in managed care.

- Medicaid managed care enrollees can only leave and join another plan within the first 90 days of joining a health plan. After the 90 days has expired, enrollees are "locked in" to the plan for the rest of the year.
- Consumers can switch plans during the "lock-in" period only for good cause. The pharmacy benefit changes are not considered good cause.
- After the first 12 months of enrollment, Medicaid managed care enrollees can switch plans at any time.

WHAT ARE THE APPEAL RIGHTS WHEN PLANS DENY COVERAGE?

All plans are required to maintain an internal and external review process for exceptions and appeals. Enrollees have the right to use these procedures when prescriptions are denied. Internal and external review procedures are described in the plan's enrollee handbook and denial notices.

Medicaid managed care enrollees also have the right to request a fair hearing. If an enrollee requests a fair hearing because plan policies will result in reduction or termination of a course of ongoing treatment, he or she should qualify for aid continuing.

A fair hearing can be pursued simultaneously with the plan's review process. The decision in the fair hearing will take precedence over the plan appeal. So if a plan's denial is overturned during the managed care appeal process, the fair hearing should be withdrawn.

WHO YOU CAN CALL IF YOU HAVE A COMPLAINT OR NEED HELP?

- To file a complaint, call NYSDOH's Managed Care Help Line: (800) 206-8125 (Mon. - Fri., 8:30 am - 4:30 pm)
- Consumers needing help can call the Community Health Advocates Hotline: (888) 614-5400
- Advocates in need of technical assistance can call the Empire Justice Center: (800) 724-0490