NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

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DAVE HEINEMAN, GOVERNOR

PROVIDER BULLETIN

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TO: All Pharmacies Participating in Nebraska Medicaid

FROM: Mary Steiner, Administrator
Medicaid Division

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RE: Implementation of Medicare Part D

Medicare Part D was created by the Medicare Modernization Act of 2003 (P.L. 108-173).

Medicare Part D is a voluntary program for Medicare beneficiaries; however, for those persons eligible for Nebraska Medicaid and eligible for Medicare Part A or enrolled in Medicare Part B (dual eligibles) their drug coverage must be through a Medicare Part D plan for most drugs. Medicaid coverage of most drugs for dual eligibles will end on December 31, 2005.

Q. Will dual eligibles be notified of these changes in coverage?

A. Nebraska HHS is required to send a notice at least ten days prior to the effective date of the change to Part D coverage of drugs for duals. In addition, CMS has sent a letter to each dual eligible informing them of this change in coverage, as well as informing the person of the Part D plan that they have been auto-enrolled into.

Q. What changes does Medicare Part D make for coverage of diabetic supplies and equipment?

A. Medicare Part D generally does not change Medicare coverage of drugs or supplies that are currently covered under Medicare Part B. For example, glucose monitors and testing strips continue to be coverable as Medicare Part B services.

Insulin syringes, needles, alcohol swabs and gauze associated with insulin administration, as well as insulin, are coverable as Medicare Part D services. Nebraska Medicaid will no longer cover insulin for dual eligible clients, beginning January 1, 2006. Also, Nebraska Medicaid will no longer cover the syringes, needles swabs and gauze when associated with insulin administration for dual eligibles, effective January 1, 2006.

Q. What drugs will Nebraska Medicaid continue to cover?

A. Nebraska Medicaid will continue to cover the following classes that are generally excluded from Medicare Part D coverage, for all Medicaid recipients including the dual eligibles:

1. Benzodiazepines: Coverage is generally limited to the generic only, unless no generic exists (for example Alprazolam, Diastat®).
2. Barbiturates
3. Over-the-counter drugs: These must be prescribed and rebatable with the same limits and exclusions in current regulation. Coverage is generally limited to the generic only (for example Docusate, Acetaminophen).
4. Vitamins: Except prenatal. These must be prescribed and rebatable.
5. Cough and cold preparations (for example guaiafenesin w/dextromethorphan) with the same limits and exclusions in current regulation. Note: This does not include Rx only antihistamines such as Zyrtec or Allegra which are Part D drugs.

All other drugs and classes of drugs are defined as Part D drugs and are the responsibility of each dual eligible's Part D plan, whether these drugs are on that plan's formulary and regardless of tiering or prior authorization of each plan.

Medicaid drug coverage will be determined through the point of sale system. A list of covered drugs may be found on the Department's website at www.hhs.state.ne.us/med/pharm/. This list is updated quarterly.

Q. Will Nebraska Medicaid continue to cover those Part D drugs that have been prior authorized for dual eligible clients?

A. Nebraska Medicaid will not cover Part D drugs that have been prior authorized for dual eligible clients, beyond December 31, 2005. All prior authorizations granted for Part D drugs for dual eligible clients have been terminated in the ACS Point of Sale system, effective that date. For example, Nebraska Medicaid will not cover Viagra for a dual eligible client after December 31, even if that coverage was previously authorized. All Part D drugs become the responsibility of the Part D Plans, beginning January 1, 2006.

Q. How will I know if my patients have Medicare Part D?

A.

- Through the E1 transaction established by CMS (more detail to follow from CMS)
- The Medicaid monthly eligibility card will provide basic information about Medicare coverage, including Medicare Part D.
- The NMES line will also provide basic Medicare coverage including Part D. (That phone number is 800-642-6092.)
- Part D plans are expected to issue an eligibility card to each enrollee.
- By calling 1-800-Medicare; CMS representatives have access to all beneficiaries' enrollment data.

Q. What resources are available if a Medicaid client provides proof of Medicaid eligibility and also Medicare Part A or B enrollment, has not been (auto) enrolled into a Plan, but should have been (i.e., for some reason they were missed in the auto enrollment process).

A. CMS has addressed this issue by the creation of a fallback Plan. This Plan will allow the pharmacist to contact the fallback Plan to verify the client's eligibility for Part D enrollment. The fallback Plan will provide real-time information to the pharmacist to allow them to bill the fallback Plan, so that the client will receive the drug at that time and the pharmacist will be paid. A follow up with the client will be made by a contracted enrollment broker to get them enrolled into a Part D Plan for the next month. CMS will be providing more information about this in the near future.

Q. Will the provider manual be updated?

A. Yes. The public hearing on regulation changes was held on November 28. They will be mailed in the near future to all pharmacies.

Q. How many plans are available to dual eligibles that may be selected without paying a premium or other penalty?

A. There are fourteen plans. They are:

Contract	Organization Marketing Name	Plan	Plan Name	Phone
S5597	Prescription Pathway	090	Prescription Pathway Bronze Plan Reg 25	800-765-8900
S5601	Silver Script	050	Silver Script	866-552-6106
S5644	Rx America	059	Advantage Freedom Plan	877-279-0370
S5644	Rx America	080	Advantage Star Plan	877-279-0370
S5660	Medco	025	Medco Prescription Savings Plan	800-758-3605
S5743	Medicare Blue Rx	001	MedicareBlue Rx Option 1	866-456-3725
S5803	Community Care Rx	094	CCRX BASIC	866-684-5353
S5820	United Health Care Insurance Company	024	AARP Medicare Rx Plan	888-867-5564
S5820	United Health Care Insurance Company	128	United Medicare MedAdvance	888-566-6657
S5820	United Health Care Insurance Company	139	United Health Rx	888-556-7052
S5884	Humana, Inc.	083	HumanAPDP Standard S5884-083	800-281-6918
S5921	PacifiCare Life and Health Insurance Company	248	Pacific Care Saver Plan	800-943-0399
S5960	Unicare	025	Medicare RX Rewards	866-892-5335
S5967	Well Care	059	Well Care Signature	888-423-5252

Q. How often may a dual eligible person change plans?

A. A new plan may be selected each month. If multiple changes are made during the month the last plan selected will become effective the first day of the next month.

Q. Will nursing facility (NF) patients be required to pay co-payments under Medicare Part D?

A. Nursing facility patients who are in a nursing facility for a full month or more will not be subject to co-payments.

Q. How much are the Medicare co-payments for dual eligibles?

A. For persons with income below 100% of federal poverty level the co-payment will be $1 for preferred and $3 for non-preferred drugs. For persons with income greater than or equal to 100% of federal poverty level the co-payment will be $2 for preferred and $5 for non-preferred drugs. Each Part D plan will determine drugs' preferred and non-preferred status. The co-pay for drugs not covered by Part D and still paid by NE Medicaid will remain at $2.

Q. 1) May a pharmacy waive the co-pay?
2) May a pharmacy refuse to dispense if the co-payment is not paid?

A. 1) The pharmacy may waive the co-payments.
2) The pharmacy may refuse to dispense the prescription if the co-payment cannot be paid. This refusal to dispense applies only to drugs coverable under Medicare Part D, not Medicaid. Nebraska rules for inability to pay co-payments on services covered by NE Medicaid are still in effect and can be reviewed at 471 NAC 3-008 in the Provider Manual.

Q. Will HHS pay the Medicare co-payment for all dual eligibles that are required to pay Medicare Part D co-payments?

A. No. HHS will only pay the Medicare co-payment (limited to $3 per prescription for those with income less than 100% of (FPL) Federal Poverty Level and $5 per prescription for those with income greater than or equal to 100% of FPL) for recipients currently excluded from Medicaid co-pay. These payments will be made through the point of sale system. The claim for co-payment must be submitted with an "8" in the other payor code field which is other coverage code field 308-C8 on the NCPDP 5.1 layout. The date the claim was paid by the Part D plan must be submitted in field 443-E8, Other Payor Date. An updated Payer Sheet will be posted on the ACS website at acspbmhipaa.com.

These co-payments will be covered for only the following:

1. Residents of assisted living facilities, centers for developmentally disabled and other alternate care arrangements.
2. Persons receiving services through Home and Community-Based waivers.

Q. What does the Department recommend for billing purposes for clients with Medicare Part D, Medicaid coverage and/or other insurance covering drugs?

A. The Department requires that other insurance must be billed as primary coverage and Medicaid as secondary.

For dual eligibles with Part D and Medicaid coverage only, the Department recommends that Medicare Part D plans be billed as primary coverage and Medicaid as secondary for all drugs. This is recommended to maximize the benefit to the client of the Part D coverage and to minimize the cost to Medicaid (and the State of Nebraska). Providers may elect to bill certain Part D excluded drugs such as over-the-counters and benzodiazepines to Medicaid as primary coverage (when no Part D coverage applies).

Q. What will happen to billings for nursing facilities and other facilities served with modified unit dose systems when most drugs must be billed to the Part D plan and only a few drugs are billed and covered by Medicaid?

A. The Department understands that transition to Part D for providers serving dual eligibles will result in changes. While the Department prefers to maintain billing for drugs for which Medicaid is primary payor at the end of the month, it will not enforce the requirement until further notice. Medicaid will continue to pay one dispensing fee per Medicaid-covered drug per month.

Q. May a pharmacy steer its patients into the Part D plan preferred by the pharmacy?

A. If a pharmacy presents information about any Part D plan to a patient it must present information about all the plans and must not steer patients. Straightforward, unbiased information must be provided to the patient. This may include the plans that the pharmacy currently participates in. The patient must be allowed to select a plan.

Q. What procedure should be followed if a patient's drug is not on the Part D plan's formulary?

A. CMS requires that each Part D plan have an appeal process. The patient or prescriber may appeal to the plan to obtain drug coverage. The CMS response standard for the first three levels of appeals is 24 hours, 72 hours and 72 hours. An alternative solution may be for the prescriber to change the prescription to a product that is on the formulary for that plan. A third alternative may be to change to a Part D plan that has the drug on formulary.

Q. What is the policy on coverage of additional supplies of drugs for dual eligibles prior to December 31, 2005?

A. CMS announced, during an all-states conference call on December 5, 2005, that at the beginning of the transition period, all Part D Plans must cover a "transition supply" of current drugs, regardless of that drug's status on the formulary, tiering etc. In addition, the initial supply of drugs for NF patients must be covered during the transition period and when first prescribed following the initial transition period. This coverage is to allow time to work through the issues of coverage, while assuring that the patient gets the drug that was prescribed. CMS did not define the days supply of drug that the Plans will be required to cover during either the initial transition period or for NF patients in the future.

Nebraska HHS policy for oral, maintenance medications is coverage of up to a 90-day supply. This policy is intended to allow recipients to have a reasonable quantity of maintenance drugs under normal circumstances as well as during times of transition, such as at the end of Medicaid eligibility. It also creates an upper limit of financial responsibility for the Department. Dispensing a supply of drug that provides the client with no more than this 90-day supply, in total, may be appropriate for transition to Part D, especially in cases where the Part D Plan has placed the drug into a non-formulary category or other similar restriction which cannot be resolved prior to January 1, 2006 between the Plan and the patient. Pharmacies who override early refill rejects in order to provide a transition supply will be responsible for determining that clients have no more than a 90-day supply on 12/31/05. Failure to do so may result in claim reversals and recovery of the entire amount of the claim.

The policy for injectable medications is coverage of up to a 30-day supply.

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