



***Pharmacy Service
Requirements Under
Medicaid Reform***

***Duval County
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Florida Medicaid Reform Overview

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Key Elements of Reform

- ❖ *New Options / Choice:*
 - *Customized Plans.*
 - *Opt-Out.*
 - *Enhanced Benefits.*
- ❖ *Financing:*
 - *Premium Based.*
 - *Risk-Adjusted Premium.*
 - *Comprehensive and Catastrophic Component.*
- ❖ *Delivery System:*
 - *Coordinated Systems of Care (PSN and HMOs).*

Medicaid Reform Is

- ❖ *Increased access to appropriate care.*
- ❖ *Benefits that better meet recipients' needs.*
- ❖ *Access to services not traditionally covered by Medicaid.*
- ❖ *An opportunity to provide choice and control to recipients in regard to health care decisions.*
- ❖ *Ability to earn credit to pay for non-covered services.*
- ❖ *Bridge to private insurance.*

Medicaid Reform is Not

- ❖ *Reform will NOT change who receives Medicaid.*
- ❖ *Eligibility does NOT change.*
- ❖ *Reform will NOT “cut” the Medicaid budget. The budget will continue to grow each year.*
- ❖ *Reform is NOT connected with Medicare Part D.*
- ❖ *The state will NOT limit medically necessary services for pregnant women or children.*
- ❖ *The state has NOT asked to waive Early and Periodic Screening Diagnosis and Treatment (EPSDT) for children.*
- ❖ *The state will NOT increase cost sharing requirements.*

Customized Plans

- ❖ *Benefits for Medicaid Eligible Individuals:*
 - *Variety of plan choices.*
 - *Increased access to care.*
 - *Ability to select a plan that best meets their needs.*
 - *Must provide coverage of all mandatory services and all optional services required by plan enrollees.*
 - *May vary in scope, amount and duration of benefits.*
 - *May cover services not traditionally covered by Medicaid.*
- ❖ *All medically necessary services for children and pregnant women will be provided.*
- ❖ *All plans are required to cover prescription drugs and must meet standards that ensure they're sufficient to meet the needs of the population(s) they serve.*

Customized Benefit Packages Plan Design Guidelines

- ❖ *Levels of amount, scope and duration flexibility:*
 - *Certain services must be provided at or above current coverage levels.*
 - *Other services must be provided to meet sufficiency standards for the population.*
 - *Remaining services must be offered, but amount, scope and duration are flexible.*
- ❖ *Reform plans can enhance any service above current levels.*
- ❖ *Reform plans can add services not currently covered.*

Covered Services Plan Design Guidelines

❖ Required at least to current State Plan levels:

- EPSDT and other services to children.*
- Maternity care and other services to pregnant women.*
- Physician and physician extender services.*
- Hospital inpatient care.*
- Emergency care.*
- Transplant services.*
- Medical/drug therapies (chemo, dialysis).*
- Family planning.*
- Outpatient surgery.*
- Laboratory and radiology.*
- Transportation (emergent and non-emergent).*
- Outpatient mental health services.*

Covered Services

Plan Design Guidelines (continued)

- ❖ *Required and tested for sufficiency:*
 - *Hospital outpatient services.*
 - *Durable medical equipment.*
 - *Home health care.*
 - *Prescription drugs.*

Covered Services

Plan Design Guidelines (continued)

- ❖ *Required to be offered, but amount, scope and duration are flexible:*
 - *Chiropractic care.*
 - *Podiatry.*
 - *Outpatient therapy.*
 - *Adult dental services.*
 - *Adult vision services.*
 - *Adult hearing services (hearing aids and related services offered at State Plan level).*

Additional Services At Plan Option (Examples)

- ❖ *Over-the-counter medications.*
- ❖ *Adult preventive dental.*
- ❖ *Acupuncture.*
- ❖ *Respite Care.*
- ❖ *Nutrition Counseling.*

Opt-Out

- ❖ *Recipient can choose to enroll in employer-sponsored health insurance instead of Medicaid certified plan.*
- ❖ *Self-employed individuals may purchase private insurance.*
- ❖ *Medicaid will pay the employee share of the employer-sponsored premium on behalf of the recipient.*
- ❖ *Individuals with access to employer-sponsored insurance may opt out at any time.*

Enhanced Benefits

- ❖ *A pool of funds is set aside to encourage recipients to engage in “Healthy Behaviors.”*
- ❖ *Individual Medicaid recipients earn access to “credit” dollars from the pool by completing defined healthy practices and / or behaviors.*
- ❖ *Once credits are earned, they may be used to purchase health-related services and products, at participating pharmacies.*
- ❖ *Recipients use their Medicaid card to purchase items.*
- ❖ *Earned credits may be used during or within three years following cessation of Medicaid eligibility.*

Risk-Adjusted Premium

- ❖ *A process to predict health care expenses based on previous diagnoses.*
- ❖ *Distributes capitation payments across health plans based on the health risk of the members enrolled in each health plan.*
- ❖ *Captures adverse selection without using experience rating (health status, not health use).*
- ❖ *Rate allocation, not rate setting.*
- ❖ *Uses historical diagnosis codes and / or pharmaceutical utilization available on individual's claims records as basis for risk assessment.*

State Reinsurance Component (Catastrophic Component of Premium)

- ❖ *A single set of benefits:*
 - *Recipients see their chosen set of benefits.*
 - *Transition between Comprehensive and Catastrophic component is transparent to the recipient.*
 - *Continuous coverage of benefits.*
- ❖ *All Plans must provide both Comprehensive and Catastrophic Services.*
- ❖ *Comprehensive Care covers the cost of most services for most Medicaid recipients:*
 - *Plan is financially responsible up to a set threshold.*
 - *Represents approximately 90% of total premium in aggregate.*

Types of Reform Plans: FFS vs. Capitated

- ❖ *What are going to be the different types of managed care organizations participating in Reform?*
 - *Provider Service Network (PSN):*
 - *Fee-for-Service (FFS) PSN.*
 - *Capitated PSN.*
 - *Health Maintenance Organizations (HMO).*
 - *Other licensed insurers.*

Patient Enrollment

- ❖ *Process of transitioning recipients to Reform plans.*
 - *Based on recipient choice.*
 - *If the plan converts to a Reform plan.*
 - *Required to enroll at re-determination date or open enrollment period.*
- ❖ *May be required to enroll sooner if:*
 - *Recipient is currently enrolled with a Medicaid managed care organization that converts to an approved Reform plan.*
 - *If the recipient's MediPass doctor joins a PSN.*
- ❖ *May also join a Reform plan prior to the required re-determination date.*

Mandatory Population

(Current Managed Care Eligibles)

- ❖ *Beginning on July 1, 2006 in Duval and Broward Counties:*
 - *Temporary Assistance for Needy Families (TANF).*
 - *TANF-Related Group:*
 - *Low income single parent families.*
 - *Low income families with a disabled or unemployed parent.*
 - *Aged and Disabled (not receiving Medicare).*
 - *Specialty Populations:*
 - *Children with Chronic Conditions.*
 - *HIV / AIDS Patients (Capitated Plans).*

Voluntary Populations

- ❖ *The following individuals, eligible under the groups below, will be excluded from mandatory participation during the initial phase:*
 - *Foster care children / adoption subsidies.*
 - *Individuals diagnosed with developmental disabilities.*
 - *Pregnant women with incomes above the TANF poverty level.*
 - *Individuals with Medicare coverage (dually eligible).*

Excluded Populations

- ❖ *Medically Needy population.*
- ❖ *Aliens receiving emergency assistance.*
- ❖ *Enrollees diagnosed with breast and cervical cancer.*
- ❖ *Individuals enrolled in the following programs:*
 - *Family Planning Waiver,*
 - *Hospice and Institutional Care,*
 - *Residential commitment programs / facilities operated through the Department of Juvenile Justice (DJJ),*
 - *Residential group care operated by the Family Safety & Preservation Program of the DCF.*

Excluded Populations (continued)

- ❖ *Individuals enrolled in the following programs:*
 - *Children's residential treatment facilities purchased through the Substance Abuse and Mental Health District Offices of the DCF (also referred to as Purchased Residential Treatment Services - PRTS),*
 - *Substance Abuse and Mental Health residential treatment facilities licensed as Level I and Level II facilities,*
 - *Residential Level I and Level II substance abuse treatment programs, and*
 - *Florida Assertive Community Treatment Team (FACT).*



Medicaid Reform Pharmacy Services

Doug Harper

Agency for Health Care Administration

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Prescribed Drug Services

- ❖ *Under Medicaid Reform, prescribed drug services are required to be provided and will be tested for sufficiency.*
- ❖ *The PSN/HMO shall provide for the coverage of pharmacy products and services as required by state and federal Medicaid statutes and rules and in accordance with Chapter 465, F.S.*
- ❖ *Prescribed Drug Services generally include all prescription drugs listed in the Agency's Preferred Drug List ("PDL"), as described in Section 409.91195, F.S.*

Prescribed Drug Services

(continued)

- ❖ *Policy requirements include, but are not limited to, the following:*
 - *The PSN/HMO shall make available those drugs and dosage forms listed in the PDL and shall be no more restrictive than the Agency's PDL.*
 - *The PSN/HMO can implement pharmacy management controls such as Prior Authorization or step therapy mechanisms.*
 - *The PSN/HMO shall not arbitrarily deny or reduce the amount, duration or scope of prescriptions solely based on the Enrollee's diagnosis, type of illness or condition.*
 - *The PSN/HMO shall make available those drugs not on the PDL, when requested and approved, if the drugs on the PDL have been used in a step therapy sequence or when other documentation is provided.*

Prescribed Drug Services

(continued)

- ❖ *The PSN/HMO shall provide name brand drugs in compliance with State law. The PSN/HMO shall authorize claims from a pharmacy for the cost of a multi-source brand drug if the prescriber:*
 - *Writes in his or her own handwriting on the valid prescription that the “Brand Name is Medically Necessary,” and*
 - *Submits the Multisource Drug and Miscellaneous Prior Authorization form to the PSN/HMO, indicating that an Enrollee has had an adverse reaction to a generic drug or has had, in his or her medical opinion, better results when taking the brand-name drug.*

Expanded Services

(Applies to HMOs and Capitated PSNs only)

- ❖ *The PSN/HMO may offer an Agency-approved over-the-counter expanded drug benefit, not to exceed ten dollars (\$25.00) per household, per month.*
- ❖ *Such benefits shall be limited to nonprescription drugs containing a National Drug Code ("NDC") number and first aid supplies.*
- ❖ *Such benefits must be offered through the PSN/HMO's pharmacy or the PSN/HMO's agreement with a pharmacy.*
- ❖ *The PSN/HMO shall make payments for the over-the-counter drug benefit directly to the pharmacy.*

Provider Network

- ❖ *Pharmacy*
 - *If the PSN/HMO elects to use a more restrictive pharmacy network than the non-Medicaid Reform fee-for-service network, the PSN/HMO shall provide one (1) licensed pharmacy per 2,500 Enrollees.*
- ❖ *The PSN/HMO shall provide a directory which shall include the names and addresses of the participating pharmacies.*
- ❖ *If all pharmacies that are part of a chain and are within the PSN/HMO's Service Area are under contract with the PSN/HMO, the Provider Directory need only list the chain name.*
- ❖ *Plans are encouraged to contract with providers in neighborhoods in which beneficiaries live.*

Toll-Free Help Line

- ❖ *The PSN/HMO shall operate a toll-free telephone help line. Such help line shall respond to all areas of Enrollee inquiry.*
- ❖ *The PSN/HMO authorization requirements for prescribed drug services are subject to the Hernandez Settlement Agreement (HSA).*
- ❖ *The PSN/HMO may allow the telephone help line staff to act as Hernandez Ombudsman, pursuant to the terms of the HSA, so long as the PSN/HMO maintains a Hernandez Ombudsman Log (Section V.D.14, Prescribed Drug Services).*

Hernandez Settlement Agreement

- ❖ *The PSN/HMO shall comply with all aspects of the Settlement Agreement to Hernandez, et. al. v. Medows (case number 02-20964 Civ-Gold / Simonton), referred to as Hernandez Settlement Agreement (HSA).*
- ❖ *An HSA situation arises when an Enrollee attempts to fill a prescription at a participating pharmacy location and is unable to receive his/her prescription as a result of:*
 - *An unreasonable delay in filling the prescription;*
 - *A denial of the prescription; and/or*
 - *The reduction of a prescribed good or service.*

Hernandez Settlement Agreement

(continued)

- ❖ *The PSN/HMO shall maintain a log of all correspondences and communications from Enrollees relating to the HSA Ombudsman process.*
- ❖ *The PSN/HMO shall conduct HSA surveys on an annual basis, of no less than five percent (5%) of all participating pharmacy locations to ensure compliance with the HSA.*

Hernandez Settlement Agreement

(continued)

- ❖ *The PSN/HMO shall require all participating pharmacy locations that fail any aspect of the HSA survey to undergo mandatory training within six (6) months and then be re-evaluated within one (1) month of the PSN/HMO's HSA training to ensure that the participating pharmacy location is in compliance with the HSA.*
- ❖ *The PSN/HMO shall offer to train all new and existing participating pharmacy locations regarding the HSA requirements.*

Mail or fax completed Fair Hearing Request Form to:

Office of Public Assistance Appeal Hearings
1317 Winewood Boulevard, Building 5
Tallahassee, FL 32399-0700

FAX: 1-850-487-0662

Remember, you must contact your doctor (if prior authorization or pre-approval is required) AND the Ombudsman before requesting a hearing.

Incomplete Forms Will Be Returned And No Action Will Be Taken Until
A Completed Form Is Received.

When can I NOT receive a fair hearing?

- If your prescription requires prior authorization and you have not contacted your doctor; OR
- Your doctor has not tried to get prior authorization; OR
- You came in too soon for a refill; OR
- The prescription has a problem that only the doctor can fix, and the doctor refuses to fix it.

If the pharmacist tells me Medicaid will not cover my prescription, when will I get a three (3) day supply of my medicine?

- If your prescription was to fill the exact prescription that Medicaid paid for last month; OR
- The pharmacist believes you should receive the medication to prevent serious or permanent harm to your health; OR
- The pharmacist believes that, if you do not receive your prescription, you could be hospitalized or need emergency treatment, or you have a serious contagious disease.

Note: The three (3) day supply can be repeated one time.

When is the three (3) day supply of refills not provided?

- If you already have the drug, or should still have some of your last prescription left; OR
- Your prescription may be harmful to your health; OR
- You are not a Medicaid recipient.

Can I keep getting my drug covered by Medicaid after the three (3) day supply is gone and the problem has not been fixed?

Yes, if you have asked for a fair hearing and asked for ongoing coverage of your prescription within ten (10) days after you get this pamphlet.

This coverage will continue until the Hearing Officer makes a decision about your request for a hearing.

10/03/05

Rx
Rx
Rx
Rx
**Important
Information**

about
your
**Florida
Medicaid
Prescription
Drug
Benefits**



Date: _____
 Dear _____
 (Pharmacist - Insert recipient's name)

Your pharmacist received a message from Medicaid or your Medicaid HMO that it will not cover your prescription for:

The reason given for not covering this prescription is:

This pamphlet has important information about:

- What you or your doctor must do to help you get medicine you need with your Medicaid.
- How to get help if your doctor cannot fix the problem.
- When you can request a fair hearing.
- When you can receive a three (3) day supply of your prescription.
- Where to call if you have questions not answered in this pamphlet.

Frequently Asked Questions and Answers

What should I do if my prescription needs "prior authorization" because it is not on the "Preferred Drug List" (PDL)?

Generally, you must first try the drugs that are on the PDL (this is called "step therapy"), unless there are special circumstances that your doctor can justify for using the non-PDL drug.

For drugs not on the PDL or that require "prior authorization" for other reasons - such as off-label use - you must first contact your doctor. Only your doctor or the doctor's staff can get prior authorization.

What if I need to fill my current medication, but it is no longer on the PDL or is not covered for some other reason?

Generally, you should get at least a three (3) day supply of your current medication from the pharmacist, and you should contact your doctor right away. If your pharmacist is unable to assist you, contact your Ombudsman at the number below to see if you qualify for a three (3) day supply of your current medication.

What if I cannot get my medicine for another reason? What if the pharmacist cannot fix the problem?

You MUST contact the Ombudsman's Office at 1-866-490-1901 (TOLL FREE).

What is the Ombudsman's Office?

Medicaid (and each Medicaid HMO) has an office to help fix certain prescription coverage problems. The name of the office is the "Ombudsman".

What if the Ombudsman does not fix the problem and Medicaid or the HMO still does not cover my medicine?

You may be able to request a fair hearing if the Ombudsman cannot fix the problem.

What are examples of when I can have a fair hearing?

- If you have made reasonable efforts to fix the problem; AND
- You have contacted the Ombudsman and they do not fix the problem within three (3) business days; AND
- You think Medicaid's reason for not covering the drug is wrong; OR
- The reason for not covering the drug is "lack of prior authorization", and you can verify that your doctor tried to get prior authorization. This information is available either through your physician's office or the Ombudsman office.

(continued)

Fair Hearing Request Form

Do not request a hearing unless you have contacted your doctor and the Ombudsman as described in this pamphlet.

- (1) On _____ Medicaid refused to pay for my drug _____
 because _____ and I believe that reason is wrong.
(Date) (Name of Drug)
(Insert reason written on pamphlet or attach the pharmacy printout, if you were given one by your pharmacist.)
- (2) I want ongoing coverage of the prescription until my appeal is decided, since this is a request for coverage of a medication I am currently taking and I am appealing within 10 days of getting this pamphlet. Yes No

Circle the # of the paragraph(s) below that applies to you:

- (3) If the reason in (1) is "no prior authorization", I want a hearing, (a) because my doctor tried to get prior authorization and could not, or (b) because the drug I need does not require prior authorization. **I verified my physician's request for prior authorization with (check one) my physician or the Ombudsman's office.**
- (4) If the reason in (1) is "too early", I request a hearing because that is wrong. I last filled this prescription on _____.
- (5) I request a hearing, because I contacted the Ombudsman and gave them all the information they asked for to fix my rejection, and they could not do so, or would not help me, or would not answer my calls.

I assert, under penalty of perjury, this _____ day of _____, 200____, that the foregoing is true and correct.

 Recipient - Sign Name

 Requestor - (If Not Recipient) Sign Name

 Recipient's Medicaid ID Number

 Requestor - (Relationship to Recipient)

I understand that I can represent myself or use legal counsel, a relative, friend or spokesperson in the hearing.

How can we contact you about your request for a hearing?

Name: _____
Print your name

Mailing Address: _____
Street address

City Zip Code

Phone number where we can contact you: _____
Area Code and Number

If you have followed the steps outlined in this pamphlet, and you believe you are entitled to a hearing, you or your representative must fill out this form and mail or fax it to the address shown on the back. Be sure to include all the information requested and circle the paragraph(s) that explains the reason you are requesting a hearing.

Remember to enter your Medicaid ID# and print and sign your name.

See Reverse Side for Mailing Instructions

(Cut Along Dotted Line)

Pharmacy Benefits Administrator

- ❖ *Pharmacy Benefits Administrator — An entity contracted to or included in a health plan accepting pharmacy prescription claims for enrollees in the plan, assuring these claims conform to coverage policy and determining the allowed payment.*
- ❖ *The PSN/HMO may delegate any or all functions to one (1) or more Pharmacy Benefits Administrators (PBA).*

Information Systems

- ❖ *Data Exchange and Formats and Methods Applicable to PSN/HMOs:*
 - *HIPAA-Based Formatting Standards Apply:*
 - *PSN/HMO Systems shall conform to the following HIPAA-compliant standards for information exchange effective the first day of operations in the applicable service region:*
 - *HIPAA Compliant Batch transaction types.*
 - *HIPPA Compliant Online transaction types.*

Information Systems

Pharmacy Encounter Data

- ❖ *PSN/HMOs shall submit pharmacy encounter data on an ongoing quarterly payment schedule.*
 - *Example:*
 - *all claims paid during 04/01/06, and*
 - *06/30/06 are due to the Agency by 07/31/06.*
- ❖ *The following should be used when submitting the data:*
 - *Any claims paid during the payment period should be submitted within 30 days after the end of the quarter.*
 - *Only the final adjudication of claims should be submitted.*

Behavioral Health Services

- ❖ *The PSN/HMO shall participate in the Substance Abuse and Mental Health (SAMH) Substance Abuse and Mental Health Services planning process in each DCF district. (See Section 409.912, F.S.)*
- ❖ *The PSN/HMO shall design and implement a Drug Utilization Review ("DUR") program. Once the PSN/HMO's pharmacy utilization indicates that an Enrollee is receiving an antipsychotic medication from a PCP or prescribing non-psychiatrist physician, the PSN/HMO shall request a consultation with the PCP or prescribing non-psychiatrist physician.*



Choice Counseling

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What Will Change With Reform?

- ❖ *Comprehensive choice counseling.*
- ❖ *Education needs will change:*
 - *Recipients will need to understand differences between benefit packages.*
 - *Information on opting out of a Medicaid plan to employer's insurance.*
- ❖ *New eligibles will receive only emergency services until they enroll or are assigned to a plan.*

Choice Counseling Vendor Requirements

- ❖ *Ensure the choice counseling process and related material are designed to provide counseling through face-to-face interaction, by telephone, in writing and through other forms of relevant media.*
- ❖ *Provide flexibility in approach to effectively reach all Medicaid populations.*
- ❖ *Require the contractor to hire choice counselors who are representative of the state's diverse population and to train choice counselors in working with culturally diverse populations.*
- ❖ *Promote health literacy and provide information to reduce minority health disparities throughout outreach activities for Medicaid recipients.*

The ACS/AHCA Vision for Choice Counseling

- ❖ *Comprehensive choice counseling program to assist beneficiaries in making an important choice:*
 - *Strong face-to-face component.*
 - *Involvement of sister agencies and community organizations.*
- ❖ *Several modalities to effectively reach individuals:*
 - *Mail.*
 - *Outbound and inbound calls.*
 - *Group and individual face-to-face sessions.*
 - *Informational website.*

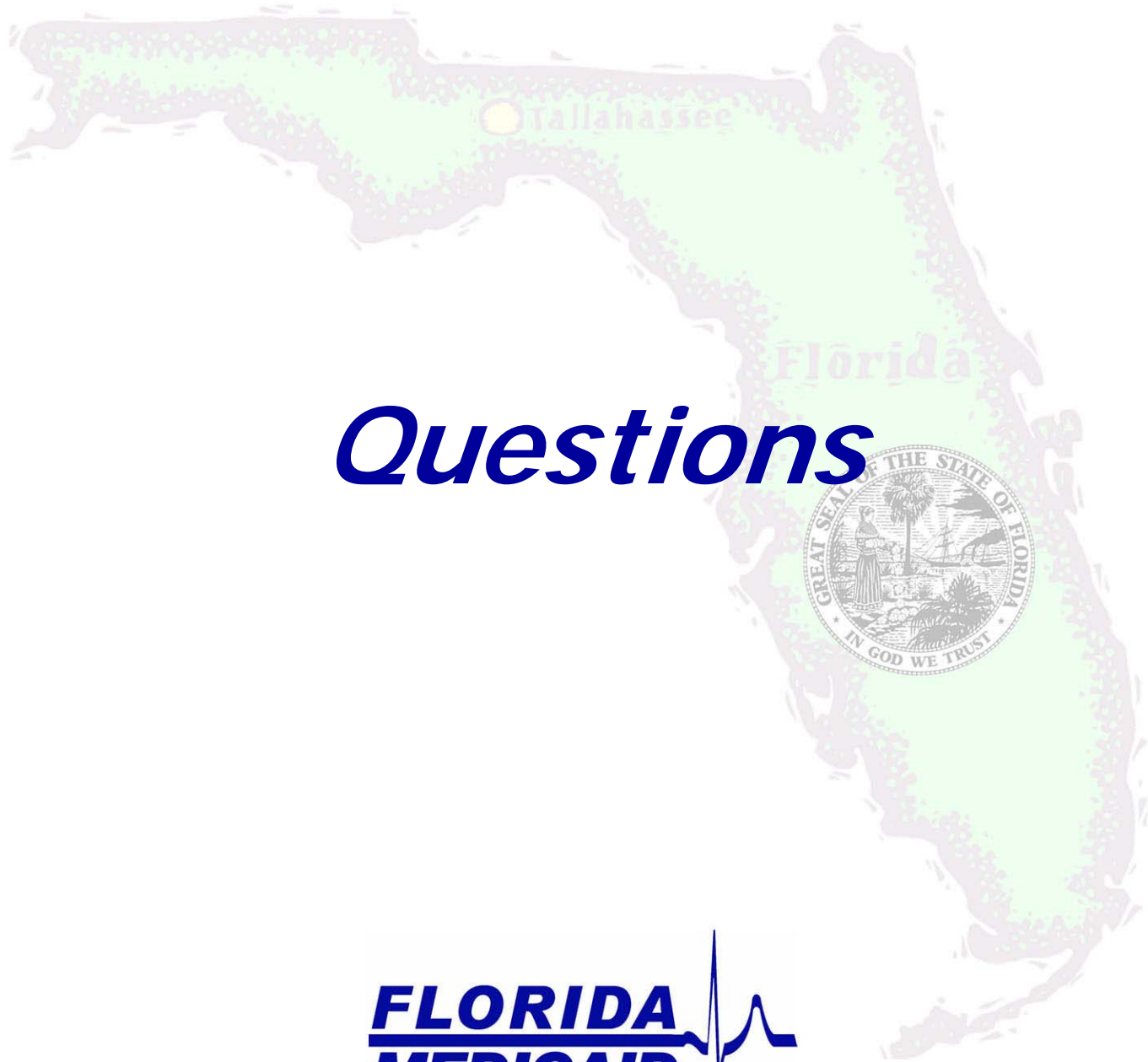
Enrollment Timeline for Current Medicaid Beneficiaries

- ❖ *Overall, a 7 month phase in beginning September 1, 2006.*
 - *Uncommitted MediPass Population - phased in over 7 months (1/2 in September 2006, then 1/6th in each of the next six months).*
 - *PSN Population - phased in evenly over 3 months, beginning October 2006.*
 - *HMO Population - phased in 1/12th of their enrolled population for 3 months, starting in October then 1/4th each month, beginning January 2007.*

Status Update

Florida State University Contract

- ❖ *Develop educational and outreach materials:*
 - *Materials to be mailed to recipients.*
 - *Outreach DVDs.*
 - *Other items as needed.*
- ❖ *Focus groups used in development of materials.*
- ❖ *Develop Choice Counselor Certification program.*



Questions

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