

## **Specific Question Regarding Managed Care Prescription Benefit Roll-Out**

### **PATIENT VERIFICATION:**

*Question:* Is there any way that pharmacies can get some sort of a lookup system to verify eligibility if patient has no information? If they walk up to the pharmacy and tell us they have Medicaid, what's our process to verify if they do not have a card with them?

*Answer:* HHSC will be delivering a Your Texas Benefits card to all Medicaid patients (it will have their Medicaid number). That is the card that will be used to transmit prescription claims in the Fee for Service (FFS) environment. When the patient migrates from FFS to Medicaid managed care, the MCO should send a new card to the patient. The patient will continue to be tracked by their Medicaid number. If the patient has not received a card from their MCO, you'll be able to enter their Medicaid number from the Your Texas Benefit Card to hit the VDP site. They're working on a system that will tell the pharmacy which MCO (not PBM) the patient is enrolled under. HHSC does not contract directly with PBMs, so their official contact is through their contracted entity (the MCO).

*Question:* For those that do present an insurance card, will there be any identifying feature so we know that it is a Medicaid policy along with specific call in number/billing address, etc. for the individual PBM?

*Answer:* Yes, the MCOs/PBMS will deliver a card to their enrollees to use with all appropriate identifying information on the card.

*Question:* It is our understanding that the State will continue to collect manufacturer rebates. This means pharmacies need to know *not* to process the claim with 340B drug to avoid prohibited "double dipping" to the manufacturer. If they present a regular looking Caremark or Catalyst card, how will we know? Group #? TX Medicaid somewhere on the card?

*Answer:* Yes, Texas will continue to collect the manufacturer rebates. Still waiting for a response to the second half of the question.

*Question:* Can we get more information of the eligibility process (will be helpful to pharmacists as patients come to them with questions related to timing). We understand that the patient is in FFS for a short period of time while paperwork is processed/patient is enrolled into a managed care plan. Process: (a) social worker

deems as Medicaid eligible; (b) What happens next? Will they be issued a temporary card stating effective date and with what plan?

*Answer:* The processing time for a patient to go from FFS to managed care will range from 15 to 45 days, depending on which day of the month they become Medicaid eligible. Most will be in the 30 day range. For more info, see response above.

*Question:* Will patients be able to use their new benefit throughout the state (someone travels from Dallas to Austin)? Will they be able to cross state lines if on a national plan such as Caremark?

*Answer:* Patients that travel into another service area where the MCO does not have a contract will be able to have their prescriptions filled at a local pharmacy (treated a little like out of network care, similar to the way they handle out of state prescriptions). The fulfilling pharmacy will be given a temporary number by the MCO/PBM. If it's a national plan like CVS, it should not be a problem. This will primarily be an issue for MCOs that contract with PBMs that don't operate in a wide range of Medicaid managed care contracts.

*Question:* What procedure does a patient need to use if they opt to change their plan? (Caseworker? 800#? in writing?).

*Answer:* Waiting for detailed response.

*Question:* Can a patient become Medicaid eligible at any particular time or any time during the month to be eligible next month?

*Answer:* Patients can become Medicaid eligible at any time.

*Question:* If a patient does not receive a registration packet, who should they call?

*Answer:* Still waiting on response to this.

*Question:* If a patient is allowed to switch MCOs every 30 days, how will pharmacies be able to tell if the patient has changed managed care plans.

*Answer:* They'll still have their Your Texas Benefits card, and still be tracked by their Medicaid ID number (regardless of the plan).

*Question:* Can each Medicaid eligible family member be on a different plan. We are concerned that this will put the pharmacist in very difficult situations, serving as the middle man, with no way to verify eligibility on a specific plan.

*Answer:* Yes, each family member could have a different plan. Individuals are tracked by their own Medicaid number. You can always ping the VDP system to find out which plan they are in.

*Question:* We understand that CHIP is included in Medicaid managed care. Is the Children with Special Healthcare Needs (CSHCN, formerly NHIC and CDIC) program also?

*Answer:* CHIP is included. CSHCN is not.

*Question:* It is our understanding that patients will be in FFS payment processing for the first 30 days of their eligibility. How will this impact patients who become Medicaid eligible after the auto-selection process is implemented in mid-February?

*Answer:* Patients that are auto-enrolled in plans will have a state Medicaid card (Your Texas Benefits), and should also receive a card from their MCO/PBM.

### **IMMUNIZATIONS AND ADVANCED IMMUNIZATIONS:**

*Question:* Will immunizations services continue to be covered as a Medical or thru Pharmacy benefits?

*Answer:* Medical benefit. So MCOs may allow a pharmacy to bill on the pharmacy system, but it's billed to Medicaid as a medical benefit. Each immunizing pharmacist must be enrolled as a Medicaid immunizer in order to be on an MCO network and be paid for that service.

*Question:* Will all MCOs/PBMs or just certain plans provide the immunization benefits?

*Answer:* All MCOs will administer this benefit. They may have a system to bill through the PBM. Pharmacies should confirm that they're enrolled as a Medicaid immunizer with the MCO before proceeding. This is a medical benefit, not a pharmacy benefit. The pharmacy will need to contract with MCO. In fact, HHSC recommends that pharmacies contact the MCO to be sure that they are considered are enrolled as a pharmacy provider in their system (even if you have a PBM contract).

*Question:* Does a pharmacy need to have a special certification/registration through Medicaid in order to be an immunization provider or just be designated/approved by the MCOs/PBMs?

*Answer:* Yes. Pharmacists (individually) must be enrolled as authorized immunizers through HHSC.

### **AUDITS:**

*Question:* Will the Texas Medicaid Desktop audit process continue under the PBMs or will it go away? Will it continue for FFS patients? If it stays, will it be High Dollar and Brand Necessary?

*Answer:* The desktop audits will remain in place for all Fee For Service. PBMs will establish their own audit process. Texas Medicaid will not be re-auditing the PBM audits

unless it is determined that there has been fraud.

**PRIOR AUTHORIZATION:**

*Question:* It is our understanding that the MCOs/PBMs will use the state's current formulary and prior authorization process. How will the prior authorization process look to providers (call the state or call the PBM)? What will the procedures be to get a prior authorization?

*Answer:* provided a year worth of claims data on each patient (as available). Prior authorizations currently in place will be valid with the PBMs for 90 days (even if the prior authorization was for 12 months). After that, prior authorizations will be done by individual PBMs. The Prior Authorization standard at the PBM may not be more stringent than those of the Vendor Drug Program.

**REIMBRSEMENT FROM PBMs:**

*Question:* Any insight on from each PBM both national and regional.

*Answer:* Not yet. HHSC is looking at this issue as it relates to the availability of the MAC pricing for pharmacist review.

**FORMULARY/BILLING CODES:**

*Question:* Which Pay Codes will stores be able to use for billing the MCOs/PBMs? 1 through 6?

*Answer:* Medicaid working to get this answer for us.

*Question:* How will we be able to get a PBM to add a NDC number? Will that state have to approve the formulary change/addition?

*Answer:* Call Vendor Drug. The State's formulary will be in place.

*Question:* How will we know when a drug has been MACed?

*Answer:* Vendor Drug will list it.

*Question:* Will billing be the same for DME Supplies for CSHCH children as it has in the past through PERX?

*Answer:* DME will continue to be billed as a medical benefit. CSHCH is not part of Medicaid manger care.

**SPECIALTY DRUGS:**

*Question:* Which drugs are considered Specialty Drugs?

*Answer:* VDP is finalizing the list. Proposed rules and a proposed list have been published and will be adopted soon. There may be some slight modifications, but it will largely look like the published list.

*Question:* As a patient moves into Medicaid managed care, is the Provider Manual still applicable to their claims/coverage? For example:

- Exclusion of nursing for blood factor products (and Medicare certification requirement for nursing)
- Title XIX for supplies no longer required?
- 11 refills max per rx (state law allows prn or "99" within a year to help accommodate partial filling where stock is not adequate for the full amount or in home infusion where stability is only 7 days... Medicaid allowed for 2 delivery dates and for us to reverse the first claim and run both together for the first delivery which was not a problem then for 11 refills in a year, but typically commercial plans do not allow this reversal and combination claim, necessitating prn or 99 refills if authorized that way from the prescriber).
- No high dollar overrides needed (currently have to call Vendor Drug to make claims higher than \$9999.99 go through)

*Answer:* Medicaid researching for us.

*Question:* Is the Hemophilia Assistance Program (HAP) included in Medicaid managed care. If so, how is it affected? (This may be completely separate, but I know their rates are affected by Medicaid rates currently.)

*Answer:* No. Kidney Health also remains carved out. HHSC to get a complete list of carved out areas/categories.

*Question:* We heard a rumor that all bleeding disorder patients may be reclassified as SSI and therefore still be able to be processed through Vendor Drug. Is that correct? (All? Some? None?)

*Answer:* They didn't think this was accurate, but are checking.

### **TROUBLESHOOTING:**

*Question:* Who should the pharmacist contact when they have a problem, the Plan or Vendor Drug?

*Answer:* Pharmacists should try to resolve their problems with the PBM directly. If the issue is not resolved, There is a complaint/appeals process in place that will funnel prescription questions to retrained VDP staff to resolve. VDP goes directly to MCO to let them know of the problems with their subcontractors.