

8. DRUG BENEFITS

Overview of the Original Program Prior to Pharmacy Carve-out (August 1, 1998)

Prior to August 1, 1998, the State permitted MCOs to establish prescription formularies, including therapeutic category formularies, as long as the formulary included all categories of drugs as listed on the New York State Medicaid formulary.

In establishing a formulary, MCOs also had to put in place a brand name and therapeutic category exception process for providers to use when deemed medically necessary.

Drugs Excluded from Capitated Benefits Package

The following drugs were excluded from the MCO capitated benefit package and continued to be reimbursed fee-for-service when prescribed by a licensed physician:

- Clotting products for hemophiliacs
- Dornase Alpha (Recombinant Human Deoxy Ribonuclease) for cystic fibrosis patients
- Protease inhibitors for treatment of HIV

State Monitoring of MCO Activities

MCOs were required to submit their formularies to the Office of the Medical Director within the State Department of Health's Office of Managed Care for review prior to implementation or revision. The Office of Managed Care monitored MCO compliance with formulary lists and brand name exception processes through normal oversight activities, including tracking of member and provider complaints.

The Medical Director, in consultation with the Drug Utilization Review Committee, might require changes to an MCO's formulary to ensure contract compliance. If changes were required, a Statement of Deficiency was issued and the MCO was given twenty days to respond with a Plan of Correction (POC). The timeframes allowed for implementation of POCs varied depending on the nature of the deficiency.

State Legislation Excluding Pharmacy from Medicaid Managed Care Capitated Benefits Package

As of August 1, 1998, prescription drugs covered on the NYS List of Medicaid Reimbursable Drugs are not a covered Medicaid managed care plan benefit and are reimbursed on a fee-for-service basis pursuant to Chapter 19 of the Laws of 1998. Over-the-counter pharmaceuticals, medical supplies and enteral formula covered under the Medicaid program are also reimbursed on a fee-for-service basis. With a few exceptions, the carve-out does not include injectable and infusion drugs administered in the office setting by a provider (these drugs are sometimes

referred to as “J-code” drugs). Drugs administered in this setting remain a MCO covered benefit.

As of 4/1/05, Medicaid managed care enrollees are responsible for pharmacy co-payments, except for certain enrollees who are exempt from co-payments. For a list of populations that are exempt from co-payments, see the July 2008 Medicaid Update.

The State’s Drug Utilization Review Committee continues to monitor drug utilization to ensure the necessity and appropriateness of prescription drugs and identify instances of over-medication and potential drug interactions.

Medicaid managed care enrollees who lose eligibility for Medicaid continue to be eligible for pharmacy services on a fee-for-service basis during the guarantee period. The scope of benefits was adjusted to reflect this change in policy and the pend/pay/deny logic was also adjusted to allow payment of pharmacy claims. Specifications for billing pharmacy services can be found at www.emedny.org.

8. DRUG BENEFITS IN FHPlus

Prior to October 1, 2008, Family Health Plus MCOs were capitated for all prescription drugs, including clotting products, Dornase Alpha, protease inhibitors, and enteral formula. Medical supplies and over-the-counter pharmaceuticals were not covered, with the exception of diabetic supplies and equipment, smoking cessation agents, and antihistamine and proton pump inhibitors.

The State allowed MCOs to establish prescription formularies and to employ the services of a Pharmacy Benefit Manager or Utilization Review agent provided that they covered all therapeutic classes on the Medicaid formulary and maintained an internal and external review process for medical exceptions.

MCOs could make use of mail order prescription deliveries, where clinically appropriate and desired by the enrollee. For certain conditions, such as hemophilia, PKU and cystic fibrosis, MCOs were further encouraged to make pharmacy arrangements with specialty centers treating these conditions, where such centers were able to demonstrate quality and cost effectiveness.

The State Department of Health's Office of Managed Care monitored compliance through its regular oversight activities consisting of on-site surveys, monitoring of complaints and grievances, fair hearings and external appeals.

State Legislation Excluding Pharmacy from the Family Health Plus Capitated Benefits Package

Effective October 1, 2008 and pursuant to Chapter 58 of the Laws of 2008, the pharmacy benefit for Family Health Plus enrollees is carved out of the managed care plan benefit package. Therefore, prescription drugs covered on the NYS List of Medicaid Reimbursable Drugs are reimbursed on a Medicaid fee-for-service basis. With a few exceptions, this carve-out does not include injectable and infusion drugs administered in the office setting by a prescriber (these drugs are sometimes referred to as "J-code" drugs). Covered drugs administered in this setting remain a Family Health Plus MCO benefit, and should continue to be billed to the enrollee's Plan.

The following drugs and items are also part of the Family Health Plus pharmacy benefit:

- Insulin and diabetic supplies currently covered as a pharmacy benefit by Medicaid (e.g., insulin syringes, blood glucose test strips, lancets, alcohol swabs)
- Smoking cessation agents, including OTC products
- Select over-the-counter medications covered on the Medicaid Preferred Drug List (e.g., Prilosec OTC, Lorantadine, Zyrtec)
- Hearing aid batteries
- Enteral formula with prior authorization by Medicaid
- Vitamins covered by Medicaid that are necessary to treat an illness or condition

- Prescription and OTC Plan B, Plan B One-Step and Next Choice DTZ (OTC covered only for enrollees 17 years of age and older)

For purposes of the pharmacy benefit carve-out, Family Health Plus enrollees are issued a Medicaid Benefit Identification card and must utilize Medicaid enrolled providers to access their pharmacy benefit. Family Health Plus co-payments and co-payment exemptions continue to apply. Resources for co-payment information include: Managed Care Model Member Handbooks (http://www.nyhealth.gov/health_care/managed_care) and the July 2008 Medicaid Update.

Since the pharmacy benefit for Family Health Plus enrollees is now administered by Medicaid, it is subject to all Medicaid fee-for-service program requirements, such as prior authorization for coverage of some drugs, required timeframes for filling and refilling prescriptions and the Preferred Drug Program, Clinical Drug Review Program, and Mandatory Generic Drug Program. Resources for Medicaid fee-for-service program information include:

- Medicaid Pharmacy Program (www.nyhealth.gov/health_care/medicaid/program/pharmacy.htm),
- NYS Medicaid Prior Authorization Programs (<https://newyork.fhsc.com>),
- eMedNY Provider Manuals (<http://www.emedny.org/providermanuals/index.html>),
- Medicaid Updates (http://www.nyhealth.gov/health_care/medicaid/program/update/main.htm).

Individuals who lose eligibility for Family Health Plus continue to be eligible for their Family Health Plus pharmacy benefit on a Medicaid fee-for-service basis during the guarantee period. The scope of benefits was adjusted to reflect this change in policy and the pend/pay/deny logic was also adjusted to allow payment of pharmacy claims. Specifications for billing pharmacy services can be found at www.emedny.org.