SENIOR HEALTH NEWS

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Prescription Coverage Limits for Adults on Medicaid Start January 3, 2012

Starting January 3, 2012, **adults on Medicaid who use the ACCESS card** to get their prescriptions will have their coverage limited to **six prescriptions per month**. The Corbett Administration is implementing this benefit reduction, among others, in an attempt to reduce Medicaid program spending and to make benefit recipients more responsible for their health care. This benefit change will not apply to MA recipients who are under age 21, pregnant, or residents of a nursing home or intermediate care facility.

The Department of Public Welfare (DPW) sent notices about this coverage limit in November and there has been much confusion and many questions about this change, both from consumers as well as from advocates and providers. This article addresses the most common questions and concerns that have been raised through our Helpline.

If I get my Medicaid through a managed care plan, will my prescription benefits be limited? The January 3rd date does not apply to you but only applies to those receiving their Medicaid benefits through the ACCESS card (these individuals are in the fee-for-service (FFS) system). However, your prescription coverage may be limited in the future. It is up to each Medicaid managed care plan to decide if and when they will limit prescription drug coverage to their members. Medicaid managed care plans must give their members written notice **30 days before** implementing the pharmacy benefit limit.

As of the date of this publication, only two Medicaid MCOs have committed to implementing the pharmacy benefit limits: **UnitedHealthcare Community Plan** and **UPMC for You**. United is hoping to follow the FFS benefit limit implementation sometime in January 2012, but the actual date has not been announced and 30-day notices have not been mailed to members. UPMC is targeting February 1st as their implementation date, but again 30-day notices have also not been sent.

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AmeriHealth Mercy Health Plan, **Keystone Mercy Health Plan** and **Gateway Health Plan** have not made a final decision on the implementation of the pharmacy limits (this is an update from information available last month and reported in our November *Health Law PA News*).

Aetna Better Health, **Coventry Cares**, and **Health Partners** will not be implementing the pharmacy benefit limits at this time.

The remainder of the questions will focus on adults getting their Medicaid through the ACCESS card and are answered addressing only these individuals and how they will be impacted by the limit.

If I have Medicare, will my prescription benefits be limited?
Only drugs covered by the ACCESS card (either as primary or secondary coverage) will be impacted by the limit. For people covered by both Medicare and Medicaid (called dual eligibles), most of their drugs are covered by **Medicare Part D**. If a drug is covered by Medicare Part D, the ACCESS card does not pay as secondary insurance. **This six prescription limit does not apply to drugs covered by Medicare Part D**.

Dual eligibles use their ACCESS card to cover drugs that are excluded from the Part D benefit (that is, benzodiazepines like Klonipin or Xanax, barbiturates like Valium or Phenobarbital, or certain over the counter medications).

Dual eligibles may also use their ACCESS card to help pay for drugs that are covered by **Medicare Part B** (including anti-rejection medications for people whose organ transplant was covered by Medicare, oral anti-cancer medications, and other drugs administered in a doctor's office or that are administered through a nebulizer). If a medication is covered by Part B, then ACCESS acts as secondary insurance to cover the 20% coinsurance left after Medicare Part B pays.

If a dual eligible is taking six or more medications covered by the ACCESS card (as described above), then they will be subject to the limit. However, please read on to learn about exceptions to the limit.

Will older adults and people with disabilities who are not yet on Medicare be impacted by the prescription limits?
Yes. These are some examples of older adults or people with disabilities who are not on Medicare and who rely on the ACCESS card for their medications:

- Individuals under age 65 who are on SSI and who live in the 42 counties in Pennsylvania with ACCESS Plus
- People between ages 60-65 who are on the Aging Waiver (Aging Waiver recipients get their Medicaid through the fee-for-service system/ACCESS card, regardless of where they live)
- People under age 65 who live in long-term care settings that are not nursing homes or intermediate care facilities (such as personal care homes, assisted living residences, long-term structured residences, or group homes) and who live in the ACCESS Plus counties

I take more than six prescriptions per month because of all my health conditions, can I file an appeal to be exempt from this limit?
If you are under 21, pregnant, or live in a nursing home or intermediate care facility and you received a notice about the prescription limits, you should **appeal by January 3rd** because the limit

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(Continued from Page 2) should not apply to you. If you appeal by this date, you should get "Aid Paid Pending" which means the limits will not go into effect for you during the appeal process.

If you do not fit into one of these categories, you cannot successfully appeal to be exempt from this limit (regardless of your health condition or number of medications you require in a month). If you need more than six prescriptions per month because of your health conditions, some of the medications may be automatically exempt from the limit; otherwise, your doctor can request a Benefit Limit Exception (see below).

Will certain drugs be exempt from this limit?
Yes. Once you reach the six prescription limit, you may be able to get additional drugs covered depending on what kind of drug it is. A list of drugs that will be automatically exempt was included in the notice DPW sent out. For example, medications to treat hemophilia, diabetes, cancer, and serious mental illness will be automatically exempt.

Some medications will be exempt only for consumers who have a certain diagnosis (based on claims data). Examples include drugs to treat bipolar disorder and/or depression and anti-infective medications (only exempted for consumers with HIV/AIDS, cancer, organ transplant, sickle cell anemia, or diabetes).

Will drugs that are exempt still count toward the 6 prescription limit?
Yes. Drugs that are automatically exempt from the six per month limit still count toward the limit. So, if an individual has already had six prescriptions covered by their ACCESS card in a month and they need their diabetes medication as number seven, the medication should go through because it's on the automatically exempt list.

However, if the diabetes medication is the second prescription someone has filled that month, it will still count toward the limit. If that person then needs coverage for medication number seven, and it's not a drug that is automatically exempt, then their provider will need to request a **Benefit Limit Exception** and have it approved in order for Medicaid to cover drug number seven.

What if I need a drug that is not automatically exempt and I've reached my monthly limit?
In this case, a consumer's doctor or health care provider must request an individual exception to the monthly cap. To request this Benefit Limit Exception, the prescriber will need to call DPW Pharmacy Services at 1-800-558-4477 (or fax a form that DPW is creating) and supply clinical information showing that granting the exception will be either cost-effective or necessary to avoid jeopardizing their patient's life or risking serious deterioration of their health.

DPW will respond to such requests within 24 to 72 hours. If DPW denies the request, it must issue a written notice explaining the denial and applicable appeal rights (including a right to aid paid pending appeal if current medication is denied and appealed within 10 days).

What if I am completely out of a medication and cannot go without meds for the 24-72 hours before my doctor gets a decision about a Benefit Limit Exception?
You can ask your pharmacy for an emergency supply. Pharmacies can provide a five-day emergency supply, but this is at the pharmacist's discretion. Consumers are encouraged to ask for an emergency supply since many pharmacies may not be aware of this policy.

What if I have further questions or need more help with the six prescription/month limit?
You can contact the Medical Assistance Recipient Service Center at 1-800-657-7925, your local legal aid office, or PHLP's Helpline.

Medicare Annual Disenrollment Period Starts January 1st

As a reminder to our readers, Medicare now has an Annual Disenrollment Period that runs for the first six weeks of every year-from January 1st through February 14th. This takes the place of the *Medicare Advantage Open Enrollment Period* that went from January until the end of March of every year but has now been eliminated.

Medicare beneficiaries who find themselves in a Medicare Advantage Plan in 2012 that they cannot afford, or that does not meet their needs in some other way, can use the Annual Disenrollment Period (ADP) to disenroll from that plan and return to original Medicare (using their red, white and blue Medicare card). These individuals will also get a Special Enrollment Period that allows them to enroll into a stand-alone Part D Plan (even if their Medicare Advantage plan did not include drug coverage).

Keep in mind:

- consumers can **only use the ADP to disenroll** from a Medicare Advantage Plan and go to original Medicare. They cannot join or switch to another Medicare Advantage Plan during this time.
- those who take advantage of the ADP, and who don't have any insurance other than Medicare, will then have to pay their Part A and B deductibles and co-insurance. These beneficiaries can contact APPRISE at 1-800-783-7067 to learn about whether they have a right to buy a Medigap policy to help with the costs of original Medicare.
- changes made during this ADP will be effective the first of the following month.

Common Special Enrollment Periods for Medicare Beneficiaries

Generally speaking, Medicare beneficiaries cannot make changes to their Part D coverage during the year outside of enrollment periods like the Annual Open Enrollment Period (Oct 15-Dec 7) and the Medicare Advantage Disenrollment Period. However, individuals may qualify for a Special Election Period (SEP) allowing them to change their Part D coverage during the year. Here's a quick review of common Part D SEPs:

- All dual eligibles have an ongoing SEP and can change Part D plans at any time
- All low-income subsidy recipients have an ongoing SEP and can change plans at any time. Individuals who are losing their subsidy at the end of this year can make one Part D plan change from January 1 through March 31st.
- Individuals enrolled in a State Pharmaceutical Assistance Program (like PACE/PACENET, CRDP and SPBP) can make one change to their Part D coverage throughout the year.
- Individuals who move into, live in, or leave a Nursing Home or certain other long-term care facilities (i.e., psychiatric hospital, rehab hospital) have a SEP to join or leave a Part D plan. The SEP starts the month they are admitted and ends two months after discharge.

No Part D Co-Pays for Waiver Recipients Starting January 1st

As we reported in our October Newsletter, Medicare beneficiaries who receive long term care services at home through one of PA's home and community-based waiver programs will no longer have co-pays for their Part D covered drugs beginning January 1, 2012. This change applies to all Medicare beneficiaries enrolled in one of these waiver programs:

- Aging (PDA)
- LIFE Program
- Attendant Care
- OBRA
- Independence
- COMMCARE
- Person/Family Directed Support (PFDS)
- Consolidated
- AIDS
- Adult Autism

In order for the new policy to work, DPW must send data to Medicare indicating which consumers on Medicare and Medicaid are enrolled in a waiver program. Medicare updates their system to show the individual should have no Part D co-pays and then tells the individual's Part D plan so that no co-pay is charged to the consumer when they pick up their Part D medications at the pharmacy. If the state delays sending data to Medicare, this policy may not actually be in effect on January 1st. However, once the information is sent and all systems are updated, the change will be retroactive to January 1st and consumers are entitled to automatic reimbursement from their Part D plan for any co-pays they paid in the interim.

Waiver recipients who are charged Part D co-pays after January 1st can give their Part D plan proof that they are enrolled in a waiver program (i.e., an eligibility notice or an active service plan dated July 2011 or later). The Plan is required to accept the proof and stop charging Part D co-pays to the beneficiary.

Waiver participants who are incorrectly charged Part D co-pays in 2012 can call PHLP's Helpline for assistance at 1-800-274-3258.

Reminder About Medicare's Transition Requirements for Part D

Within the first 90 days of coverage, Part D plans must offer a temporary supply of medications for new enrollees in need of a drug not covered on the Plan's formulary or that requires authorization from the plan before it can be covered. This transition requirement also extends to current enrollees who are affected by changes to a plan's formulary from one year to the next. The temporary supply is to be provided to allow time for the prescriber to either switch the person to another appropriate medication covered by the plan or to seek authorization or a formulary exception from the plan.

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Happy Holidays from PHLP!

As the year ends, we take a moment to wish all our readers happy and safe holidays and a healthy New Year!

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