ATTENTION:

MEDICAID MANAGED CARE AND FAMILY HEALTH PLUS MEMBERS EFFECTIVE OCTOBER 1, 2011, PHARMACY BENEFITS WILL BE PROVIDED BY YOUR HEALTH PLAN

Frequently Asked Questions (FAQ)

Q1. What has changed about the Medicaid Pharmacy benefit?
ANSWER: Beginning October 1, 2011, members enrolled with Medicaid and Family Health Plus managed care plans will have their pharmacy benefit paid for by their health plans instead of the Medicaid program directly. This means that members will need to work with their physicians and health plans to make certain the drugs they use are covered.

Q2. How do I know if the medications I am currently taking will be covered by my health plan?
ANSWER: You should have received a letter from your plan with information about which drugs are included on its formulary (list of covered drugs). If you did not receive this letter or have questions, please contact your health plan. You may also contact the NYS Medicaid helpline at (800) 541-2831 for assistance.

Q3. How can I obtain a list of the medications my plan covers?
ANSWER: You should contact your health plan directly to obtain its formulary or list of covered drugs. You may also contact the NYS Medicaid helpline at (800) 541-2831 for assistance.

Q4. Which card do I need to use at the pharmacy?
ANSWER: Effective October 1, 2011, Medicaid managed care and Family Health Plus beneficiaries must use their health plan card (not their Medicaid/CBIC card) at the pharmacy.

Q5. What if I do not have a health plan card?
ANSWER: You must contact your managed care plan and ask them to issue a new health plan card. All plans have help lines. Please visit your plan's Website or contact the NYS Medicaid helpline at (800) 541-2831 to obtain your plan's number.

Q6. What if I do not know what health plan I have chosen?
ANSWER: To find out what plan you currently have, please contact the New York State Medicaid helpline at (800) 541-2831.

Q7. Will my co-payment change?
ANSWER: Co-payments for drugs will remain the same in both Medicaid and Family Health Plus with one exception; there will be no co-payments for supplies if you are in a Medicaid Managed Care Plan.

Q8. I do not see my drug on my plan's formulary or list of covered drugs and I've been on this drug for a while; can I stay on it?
ANSWER: If you've been on the drug for a while, you may be able to stay on that drug. For example, many plans will continue to cover antipsychotics, immunosuppressants, antiretroviral therapy, anticonvulsant and antidepressant drugs for their members that are already on these drugs. You should contact your plan to find out if the drug you are on is one that your plan will continue to cover for you, even though it may not be on their list of covered drugs.

Q9. My drug is not covered by my plan; can I get a temporary supply?
ANSWER: Between October 1, 2011 and December 31, 2011, you can get a ***one-time*** temporary fill of up to 30 days for each drug you are currently taking that is not available through your plan.

Q10. I received a one-time fill and I need my medication again. What should I do? ANSWER: You need to contact your doctor. The doctor may decide to change to a drug covered by your health plan or your doctor can ask the plan to make an exception to their formulary rules.

ATTENTION:

MEDICAID MANAGED CARE AND FAMILY HEALTH PLUS MEMBERS
EFFECTIVE OCTOBER 1, 2011,
PHARMACY BENEFITS WILL BE PROVIDED BY YOUR HEALTH PLAN

Frequently Asked Questions (FAQ)

Q11. What if my drug is not covered and no other medication will work for me?
ANSWER: Your doctor needs to contact your plan and ask them to make an exception to their formulary rules and let you continue taking the drug.

Q12. What if the plan still won't pay for my medication after my doctor asks for an exception?
ANSWER: You can appeal your plan's denial to internal and external reviewers. Contact your plan for information about their appeal process. You can also call the Community Health Advocates Hotline at (888) 614-5400 for assistance, or the NYS Medicaid helpline at (800) 541-2831 for help with contacting your plan.

Q13. Can I also ask for a fair hearing?
ANSWER: Yes, you can ask for a fair hearing with aid continuing so that you can continue to receive the drug while you wait for the hearing. For help in requesting a fair hearing, you can call the Fair Hearings Hotline at (800) 342-3334 or call the Community Health Advocates Hotline at (888) 614-5400.

Q14. Will I be able to use the same pharmacy and doctor?
ANSWER: You can continue with the same pharmacy and doctor, as long as they participate with your managed care plan. Ask your pharmacy and doctor to check to make sure they are participating.

Q15. I cannot find a pharmacy in my neighborhood that accepts my health plan. What do I do?
ANSWER: You should contact your health plan for assistance in locating a neighborhood pharmacy that accepts your health plan.

Q16. I have Hemophilia (Bleeding disorder), how will I get my blood products (clotting factor)?
ANSWER: Clotting factor products will continue to be covered by Medicaid fee-for-service benefit for a limited period of time. When billing for these items the pharmacy can use your Client Identification Number (CIN) on the health plan card to bill Medicaid.

Q17. My managed care or Family Health Plus plan is Fidelis Care New York. How will I get my family planning prescriptions after the October 1 change?
ANSWER: You will continue to get your family planning items from Medicaid.Your pharmacy should bill Medicaid for these services using the alpha numeric Client Identification Number (CIN) on your Fidelis card.

Q18. When I used my Medicaid to get medications, I had no problems. Why can't I just continue to use my Medicaid card?
ANSWER: A new state law requires that these changes be made to your Medicaid benefit. The law and/or regulation(s) that allow us to do this are Social Services Law (SSL) Sections 365-i and 369-dd, as repealed by L. 2011, ch. 59, Pt. H, Section 5 (Medicaid managed care pharmacy benefit change); SSL Section 369-ee(1)(e)(v) and 369-ee(2-b) (FHP pharmacy benefit change).

Q19. Can I switch managed care plans if I do not like the pharmacy benefits?
ANSWER: If you are within the first 90 days of joining the health plan, then you may leave and join another plan. However, once the first 90 days are over, you are "locked in" to that plan for the rest of the year (the next nine months). After the 9 month "lock-in" you may switch plans at any time. However, the lock-in applies after the first 90 days of enrollment every time you switch plans. For help making a decision about which plan to join, you can call the State's Enrollment hotline at (800) 505-5678.