

# New York State Medicaid Pharmacy Fee-For-Service Program

An Overview and Reference Guide for  
Medicaid Managed Care Plans

# New York State Medicaid Pharmacy Program

- ▶ Coverage/Plan Design, Rules and Limitations
- ▶ Pricing
- ▶ Pharmacy Network
- ▶ Utilization Management Programs

# New York State Medicaid Pharmacy Program Coverage Determination

- ▶ Covers all FDA approved drugs made by manufacturers that have signed rebate agreements with CMS.
- ▶ Nearly all prescription drugs and certain non prescription drugs are covered.
  - Prescription drugs require a prescription order.
  - Non-prescription drugs require a fiscal order.
  - Certain drugs/drug categories require prescribers to obtain prior authorization.
- ▶ Insulin, diabetic supplies, certain medical supplies, hearing aid batteries and enteral formulas are also covered.
  - Diagnosis code is required for Supplies
- ▶ References:
  - Medicaid List of Reimbursable Drugs (aka formulary)
    - Contains codes to identify applicable prior authorization program, by drug

# New York State Medicaid Pharmacy Program Coverage Determination (continued)

## Exclusions

- ▶ Amphetamine and amphetamine-like drugs which are used for the treatment of obesity
- ▶ Drugs whose sole clinical use is the reduction of weight;
- ▶ Drugs used for cosmetic purposes
- ▶ Any item marked “sample” or “not for sale”
- ▶ Any contrast agents, used for radiological testing (these are included in the radiologist’s fee)
- ▶ Any drug which does not have a National Drug Code
- ▶ Drugs packaged in unit doses for which bulk product exists
- ▶ Any drug regularly supplied to the general public free of charge must also be provided free of charge to Medicaid beneficiaries
- ▶ Any controlled substance stamped or preprinted on a prescription blank
- ▶ Drugs used for the treatment of erectile dysfunction
- ▶ Drugs used to promote fertility
- ▶ Drugs or supplies used for gender reassignment

# New York State Medicaid Pharmacy Program Coverage Determination (continued)

Medicaid Fee-for -Service	Family Health Plus
Prescription Drugs	Prescription Drugs
<u>Certain non-prescription drugs (OTCs)</u>	<u>Select OTCs included on the Preferred Drug List (e.g. antihistamines and emergency contraception)</u>
<u>Diabetic Supplies</u>	Same
<u>Medical Supplies</u>	N/A
<u>Hearing Aid Batteries</u>	Same
<u>Enteral Formula</u>	Same

# New York State Medicaid Pharmacy Program Plan Limitations/Coverage Rules

- ▶ Prescriptions/fiscal orders are valid for six (6) months from the date written.
- ▶ An original prescription/fiscal order cannot be filled more than sixty (60) days after the it was date written.
- ▶ Controlled substances are valid for 30 days from the date written.
- ▶ Up to a 30 day supply is allowed, unless otherwise specified .
- ▶ Smoking cessation therapy is limited to two courses of treatment per year.
- ▶ Emergency contraception is limited to 6 courses of therapy in any 12 month period (prescription and OTC).

# New York State Medicaid Pharmacy Program Pricing

Reimbursement			Copayments	
	Ingredient Cost	Dispensing Fee	Fee-for-Service*	Family Health Plus**
Brand Name Drugs	Lower of AWP-17% or U&C***	\$3.50	\$3.00 \$1.00 (Preferred)	\$6.00
Generic Drugs	Lower of SMAC, AWP - 25%, FUL or U&C	\$3.50***	\$1.00	\$3.00
OTCs	SMAC	N/A	.50	.50
Medical Supplies	Cost plus 25-50%, as determined by the Department	N/A	\$1.00	N/A
Hearing Aid Batteries	Cost plus 25-50%, as determined by the Department	N/A	\$1.00	\$1.00
Enteral Formula	Acquisition Cost plus 30%	N/A	\$1.00	\$1.00
Diabetic Supplies	WAC +10%	N/A	\$1.00	\$1.00

\*Annual Copayment Limit for FFS is \$200 [calculated on a SFY basis (April 1- March 31)]

\*\*Family Health Plus does not have a maximum copayment.

\*\*\* Will be systematically applied 8/25/2011, and retroactive to 4/1/2011. Previously, brand reimbursement was AWP-16.25% and generic dispensing fee was \$4.50

An Overview and Reference Guide

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# New York Medicaid Pharmacy Program Pricing (continued)

Copayment Exemptions	
Fee-for-Service	Family Health Plus
Birth control pills, Plan B and condoms	Prescription birth control and Plan B
FDA approved drugs to treat tuberculosis	Same
FDA approved drugs to treat mental illness (psychotropic drugs)	Same
Enrollees younger than 21 years old	Same
Enrollees during pregnancy and for two months after the month in which the pregnancy ends	Same
Residents of Adult Care Facilities licensed by the NY State Department of Health	Same
Residents of nursing homes	Permanent residents of nursing homes or community based residential facilities
Residents of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)	Same



# New York Medicaid Pharmacy Program Pricing (continued)

## Copayment Exemptions (continued)

Medicaid Fee-for-Service	Family Health Plus
Residents Adult Care Facilities licensed by DOH or Office of Mental Health (OMH) and Office for People With Developmental Disabilities (OPWDD) certified community residences	Residents of the Office of Mental Health (OMH); Residential Care Centers for Adults (RCAA); and Family Care Homes (FC), but not adult homes
Enrollees in Comprehensive Medicaid Care Management (CMCM) or Service Coordination Programs	Same
Enrollees in OMH or OPWDD Home and Community Based Services (HCBS) Waiver Programs	Same
Enrollees in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI)	Same

# New York State Medicaid Pharmacy Program Pharmacy Network

- ▶ Open Network
  - ~ 4,200 pharmacies
- ▶ Office of Medicaid Inspector General responsible for credentialing and audit

# New York Medicaid Pharmacy Program Utilization Management Programs

- ▶ **Preferred Drug Program (PDP)** – Promotes access to the most effective prescription drugs while reducing costs, through the use of a Preferred Drug List
  - Enables supplemental rebate collection
  - Non-Preferred Drugs require Prior Authorization
- ▶ **Clinical Drug Review Program (CDRP)** – Prior Authorization is required for certain drugs due to concerns related to safety, public health or the potential for significant fraud, abuse or misuse
- ▶ **Mandatory Generic Program** – Excludes coverage for brand name drugs when the FDA has approved an A-rated generic equivalent, unless a prior authorization is received
- ▶ **Brand Less than Generic Program** – Promotes the use of multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic.
- ▶ **Drug Utilization Review (DUR) Program**
  - Prospective – Alerts pharmacists of potential therapy problems point-of-sale
  - Retrospective – Letters sent to physicians and/or pharmacists to notify them of potential drug therapy problems
  - [DUR Annual Report to the Governor and Legislature](#)

# New York Medicaid Pharmacy Program Utilization Management Programs (continued)

## Preferred Diabetic Supply Program

- Covers blood glucose monitors and test strips provided by pharmacies and durable medical equipment providers through the use of a Preferred Supply List.
- Enables rebate collection

## ▶ Pharmacists as Immunizers

- Provides coverage for the administration of select vaccines by qualified pharmacists

## ▶ Medication Therapy Management (MTM)

- Pilot Program in the Bronx

## ▶ **Utilization Thresholds**

- Limits the number of certain medical and pharmacy services per benefit year unless additional services have been approved

# New York State Medicaid Pharmacy Program Utilization Management Programs (continued)

## Preferred Drug Program (PDP)

- ▶ Pharmacy and Therapeutics Committee (P&TC) makes preferred or non preferred recommendation based on clinical review first, and then cost.
- ▶ The Preferred Drug List contains 90+ therapeutic drug classes.
- ▶ Non Preferred Drugs require Prior Authorization (with limited exceptions).
- ▶ Prior Authorizations are valid for up to 6 months (Maximum 5 refills).
- ▶ The prescriber prevails provision applies.
- ▶ Four classes of drugs; atypical anti-psychotics, anti-depressants, anti-rejection drugs used for the treatment of organ and tissue transplants and anti-retroviral drugs used in the treatment of HIV/AIDS, were previously excluded from the prior authorization process. MRT 15H removed this exemption.
- ▶ References:
  - PDP Annual Report to the Governor and Legislature
  - Prior Authorization Forms and Worksheets
  - NYS Legislation

# New York State Medicaid Pharmacy Program Utilization Management Programs (continued)

## Clinical Drug Review Program (CDRP)

- ▶ Certain drugs require prior authorization because there may be specific safety issues, public health concerns, the potential for fraud and abuse or the potential for significant overuse and misuse.
- ▶ The prescriber prevails provision applies.
- ▶ Most prior authorizations are valid for up to 6 months
- ▶ Drugs currently included:
  - ▶ becaplermin gel (Regranex®) – No refill
  - ▶ fentanyl mucosal agents (Actiq® or Fentora®) – No refill
  - ▶ lidocaine patch (Lidoderm®)– Maximum 2 refills
  - ▶ linezolid (Zyvox®)– No refill
  - ▶ palivizumab (Synagis®)– Off season or > 2 years of age– No refill
  - ▶ sildenafil citrate (Revatio®)– Maximum 5 refills
  - ▶ sodium oxybate (Xyrem®)– No refill for initial request– then maximum 2 refills
  - ▶ somatropin (Serostim®)– No refill
  - ▶ tadalafil (Adcirca®) – Maximum 5 refills
- ▶ References
  - ▶ [CDRP Guidelines and Prior Authorization Worksheets](#)

# New York State Medicaid Pharmacy Program Utilization Management Programs (continued)

## Mandatory Generic Program

- ▶ Excludes coverage for brand name drugs when the FDA has approved an equivalent generic product, unless a prior authorization is received
- ▶ Prior Authorizations are valid for up to 6 months (Maximum 5 refills).
- ▶ The prescriber prevails provision applies.
- ▶ Exemptions:
  - Clozaril®
  - Coumadin®
  - Dilantin®
  - Gengraf®
  - Lanoxin®
  - Levothyroxine Sodium (Unithroid®, Synthroid®, Levoxyl®)
  - Neoral®
  - Sandimmune®
  - Tegretol®
  - Zarontin®

# New York State Medicaid Pharmacy Program Utilization Management Programs (continued)

## Brand Less Than Generic Program

- ▶ Promotes the use of multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic.
- ▶ Drugs Included:
  - ❑ Adderall XR
  - ❑ Aricept 5mg, 10mg ODT
  - ❑ Arixtra
  - ❑ Astelin
  - ❑ Carbatrol
  - ❑ Diastat
  - ❑ Duragesic
  - ❑ Effexor XR
  - ❑ Lovenox
  - ❑ Nasacort AQ
  - ❑ Uroxatral
  - ❑ Valtrex
- ▶ Prior authorization is required for the generic
- ▶ Prior Authorizations are valid for up to 6 months (5 refills).
- ▶ The prescriber prevails provision applies.



# New York State Medicaid Pharmacy Program References

- ▶ [DOH Web Site](#)
- ▶ [Medicaid Reference Guide](#)
- ▶ [Medicaid Pharmacy Program](#)
- ▶ [NYS Medicaid Pharmacy Prior Authorization Programs \(Magellan\)](#)
- ▶ [Medicaid Pharmacy Provider Manual](#)
- ▶ [Medicaid Redesign Team](#)
- ▶ [Medicaid Update](#)