

# Changes in Medicare and Medicaid: What Do BPAOs & PABSS Need To Know? Winter Update 2006

Recent changes in Medicare and Medicaid are dramatically impacting how people with disabilities -- and low income people in general, access health care coverage. Every day, new policies and procedures are being released by the Center for Medicare and Medicaid Services ("CMS"). Set out below are highlights of some of the more recent policies and changes under Medicare Part D and Medicaid.

## **THE TRANSITION TO MEDICARE PART D: PROTECTIONS FOR DUAL ELIGIBLES AND OTHERS**

In some cases, dual eligible beneficiaries (enrolled in Medicare and Medicaid at the relevant point in time) are not recognized by the Medicare system. Verifying eligibility for both Medicaid and Medicare is done through a data exchange between the states and the Centers for Medicare & Medicaid Services (CMS). First, the state Medicaid agency must place the individual on the dual eligible list that is submitted to CMS. Second, CMS must receive and input the information. CMS must also auto-enroll the individual into a prescription drug plan. Third, the information must be transferred to the plan in which the dual eligible individual is enrolled and, the plan must input the dual eligible status into its system. Finally, if the dual eligible switches plans, the new plan must be informed of the dual eligible status as well. **A failure at any of these communication points can cause the pharmacist to charge the wrong cost share or have no record of enrollment on their computer system.**

In order to assure access to medications, CMS has implemented several measures to quickly resolve coverage issues. These include:

### **1. Enrolling Dual Eligibles Not Assigned to a Plan into the WellPoint Prescription Drug Plan.**

If a dual eligible individual **has not been auto-assigned to plan**, the pharmacy can enroll them into a back-up plan called WellPoint. There are specific steps for utilizing this procedure, which can be found at [www.cms.hhs.gov/pharmacy](http://www.cms.hhs.gov/pharmacy). It is important to understand that only those who have not been auto-enrolled into any plan can utilize this system to access their medications.

### **2. Expedited Procedure for Applying Proper Co-Payments to Dual Eligibles and Others with "Extra Help".**

In some cases, **individuals with "extra help" have been charged the wrong cost sharing** amount at the pharmacy. The Prescription Drug Plan has not "flagged" the individual as one with "extra help" and the computer system is directing the pharmacy to

charge higher cost sharing. On January 13, 2006, CMS sent a letter to the Prescription Drug Plans informing them that they must create a system for approving drug coverage at the proper co-payments in these situations. Under this guidance, the plans must create a system for honoring the "extra help" co-payments if the pharmacy is shown proof of "extra help" eligibility. Therefore, if an individual arrives at the pharmacy with a Medicaid card, a letter of auto-assignment, a notice of award letter from the Social Security Administration, or there is evidence of prior Medicaid billing in the pharmacy system, their proper co-payment should be charged. **Each Plan must have a system available to assist the pharmacist in overriding the incorrect charge.**

### **3. Transition Plans----The 30 Day Requirement and the Extension**

Prior to implementation of Medicare Part D, each Prescription Drug Plan was required to offer a transition plan. Such transition plans had to offer a meaningful time period for individuals to make any changes in medications from non-formulary drugs to formulary drugs. Initially, these transition plans varied. Some provided a 15 day supply for current prescriptions and some provided a 30 day supply. Some plans, in practice, had no meaningful transition plan at all! **By January 18, CMS had received a commitment from each Prescription Drug Plan to provide at least a 30 day supply of formulary and non-formulary medications without benefits management tools. (co-payments or prior authorization).**

On February 2, CMS "called for" the Prescription Drug Plans to extend their transition period to March 31. This would mean that individuals could continue to get prescriptions filled for formulary and non-formulary drugs without benefits management tools while they transitioned to another medication or sought exceptions. What is still unclear at this time is what legal effect a "calling for" will have on the Prescription Drug Plans.

### **4. State Emergency Plans**

The transition for dual eligibles from Medicaid prescription drug coverage to Medicare Part D drug coverage has not been smooth. Once Medicare Part D began, advocates, service providers, and Medicaid agency staff began to notice that a significant number of dual eligibles individuals were not able to access their medications. One by one, states began to implement emergency measures to assure that dual eligibles who could not access Part D benefits received their medications. Eventually, **CMS agreed to reimburse the states that incur these costs through a demonstration program.** To date, 31 states and the District of Columbia have implemented emergency procedures. For a list of states that have implemented these emergency programs and more information on specific programs, go to <http://www.ncsl.org/programs/health/PartDPatch.htm>.

## CHANGES IN MEDICAID IN THE DEFICIT REDUCTION ACT

The Deficit Reduction Act of 2005 states those **applying for Medicaid after July 1, 2006** and those undergoing **re-determination of Medicaid eligibility after July 1, 2006**, will be required to **provide satisfactory documentary evidence of citizenship or nationality**. One of the following documents can be used to satisfy this requirement:

- a United States passport;
- Form N-550 or N-570 (Certificate of Naturalization); Form N-560 or N-561 (Certificate of United States Citizenship);
- a valid U.S. driver's license; or
- identity documents, but only if the state issuing the document required proof of citizenship, or if the state obtained a Social Security Number (SSN) from the applicant and verified before the certification that the SSN is valid and assigned to the applicant who is a citizen and "Such other document as the Secretary [of Health and Human Services] may specify, by regulation, that provides proof of United States citizenship or nationality, and that provides a reliable means of documentation of personal identity."

If an applicant does not have any of the above documents, then the applicant can provide one document from each of the following groups of documents:

**Group 1:** Certificate of birth in the United States; Form FS-545 or Form DS-1350 (Certificate of Birth Abroad); Form I-97 (United States Citizen Identification Card); Form FS-240 (Report of Birth Abroad of a Citizen of the United States); and *"Such other documents as the Secretary may specify that provides proof of United States citizenship or nationality."*

**Group 2:** Any identity documents described in section 274A(b)(1)(D) of the Immigration and Nationality Act; and *"Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification."*

It appears states have some flexibility in determining which documents they can accept but this will need to be verified by CMS guidance.

### ***Why is this important for our constituency?***

Since this rule is for new applicants and redeterminations for all those categorically eligible for Medicaid, it will impact those who are participating in the Medicaid Buy-in programs. Some states already require proof of citizenship or verify a SSN before issuing a drivers license. Of course, most low-income individuals probably do not have passports and many may not have birth certificates. There are no exceptions to this provision, not even for those with serious physical or mental disabilities.