Medicare 906
Michigan Pharmaceutical Association Conference
October 3, 2015

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Objectives - Part One

• Describe the differences in Medicare programs
• Differentiate prescription drug coverage under Medicare Part A, Part B and Part D
• Describe requirements of formulary coverage under Medicare Part D (protected classes, coverage exclusions, etc.)
• Understand B vs D drug coverage and recognize why drugs that may be covered under either benefit
Objectives - Part Two

- Describe the different programs that the Upper Peninsula Health Plan (UPHP) administers
- Discuss some current topics and good to know information

Part One
Medicare Programs

Medicare Programs
- Demonstration Plans
  - Differ by state
  - Michigan Program called MI Health Link
- Special Needs Plan (SNP, Duals)
- Advantage Plan
Michigan’s Demonstration Program - MI Health Link

- What is MI Health Link?
  - A new program that joins Medicare and Medicaid benefits, rules and payments into a **coordinated delivery system**
  - Integrated Care Organizations (ICOs) and current Michigan Pre-paid Inpatient Health Plans (PIHPs) provide covered services
  - Three year demonstration operating in 4 separate regions
    - Region 1 = All 15 counties in the Upper Peninsula
    - Region 1 ICO = Upper Peninsula Health Plan
- Eligibility Criteria:
  - Live in one of the four regions
  - Age 21 or older
  - Eligible for full Medicare and Medicaid benefits
  - Are not enrolled in hospice

Medicare/Medicaid Demonstration Plans

- Michigan Programs called MI Health Link
- Why was it developed?
  - Fast Issues (cards, who to bill, rejections)
  - Integration of Physical and Medical Care Bridge
  - Integration benefit
  - Coordinated health care
  - Case Managers

Michigan’s Demonstration Program - MI Health Link

- What makes Michigan Unique?
  - Two separate contracts to deliver services in a given region
    - One contract for physical health services, long term care and personal care services
    - Integrated Care Organizations (ICOs)
    - One contract for all behavioral and developmental disability supports and services
    - Prepaid Inpatient Health Plans (PIHPs)
  - Person-centered delivery system and supports coordination model
MI Health Link

Integrated Care Organization (ICO) responsible for:
• Physical Health Services
• Pharmacy Part D
• Longer Term Care Services & Supports (community based and nursing facility)
• Personal Care Services
• Management of person-centered medical home
• Care and supports coordination team at bridge.

Prepaid Inpatient Health Plan (PIHP) responsible for:
• Mild-Moderate Behavioral Health Services
• Serious Mental Illness
• Intellectual/developmental disabilities
• Substance Use Disorders
• Care and Supports Coordination team at the bridge.

MI Health Link Program

• One plan to cover all Medicare and Medicaid benefits
• No copays or deductibles for services including medications
  • Nursing home patient pay amounts still apply
• One ID card to access all MI Health Link Services
• Every member will have a Care Coordinator:
  • Work with the enrollee to create a personal care plan based on the enrollee’s goals
  • Answer questions and make sure that health care issues get the attention they deserve
  • Connect the enrollee to supports and services needed to be healthy and live where the enrollee wants
• Members can change or select their Care Coordinator or select an existing supports coordinator to serve as their primary point of contact
• Enrollees will have access to an Integrated Care Team

How Medicare Pays for Drugs

Part A
- Covers drug administered in a hospital health plan
- Drugs during a hospital stay
- Drugs administered during a covered stay in a SNP

Part B
- Administered by a health care professional in a physician’s office
- Select drugs related to specific disease states or part of a sustained treatment
- Drugs provided by dialysis facilities
- Drugs that cannot be patient self-administered
- Diabetic test strips, lancets, and glucometers
- Vaccines (Flu, Pneumonia, and Hepatitis B)

Part D
- Designed to provide coverage for outpatient prescription drugs
- Formulary based
- Covers insulin, insulin-related supplies, vaccines, and drugs for hepatitis C
- Fulfills any enrollment waits and prescription drug limits

Part D Benefits
- Many plans also offer additional drug coverage
- Includes a 70% coverage limit
Medicare Excluded Coverage

- ED agents, but may cover for PAH diagnosis
- Weight loss/weight gain agents
- Cosmetic purposes
- Symptomatic relief of cough and colds
- Prescription vitamins and mineral (except PN and Fl preparations)

Protected Classes

- Formularies must include all or substantially all drugs in the Protected Classes:
  - Immunosuppressant (for prophylaxis of organ transplant rejection)
  - Antidepressants
  - Antipsychotics
  - Anticonvulsants
  - Antiretroviral
  - Antineoplastic

- CMS Objectives:
  - Ensure that Medicare beneficiaries reliant upon these drugs would not be substantially discouraged from enrolling in certain Part D plans
  - Mitigate the risks and complications associated with an interruption of therapy for these vulnerable populations

- Requirements:
  - Formularies must include substantially all drugs in these six categories that are FDA approved by the last CMS specified HPMS formulary upload date for the upcoming contract year
  - New drugs or newly approved uses for drugs within the six classes that come onto the market after the HPMS formulary upload date must be added to CMS recognized formularies within 120 days of market entry
  - P&T committees must make a decision within 90 days, rather than the normal 180-day requirement
  - At the end of the 90 day period, these drugs must be added to Part D plan formularies

Part D Coverage Stages

<table>
<thead>
<tr>
<th>Initial Coverage</th>
<th>Coverage Gap</th>
<th>Catastrophic Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Threshold CY 2015 $2,960</td>
<td>In this stage until patient drug spending reaches a total of $4,700.</td>
<td>Patient drug spending more than $4,700.</td>
</tr>
<tr>
<td>Patient pays deductible (if applicable) plus cost share amount</td>
<td>Pay 45% of premium branded drugs, 65% of price for generic drugs. Majority of cost for formulary drugs is discounted</td>
<td>Reduced cost share until the end of the year</td>
</tr>
</tbody>
</table>
B vs D Coverage

- Difficult at best
  - Based on diagnosis and other medical criteria
  - Who administers the drug
  - Prior authorization process
    - Based on medical criteria
    - Determination of indicators on eligibility file
- Concern – Delay in treatment
- Encourage providers to put diagnosis on the prescription

Examples

- Anti-emetics
  - When given within 48 hours of chemotherapy – Part B
  - As replacement for IV anti-emetic therapy – Part B
  - Other situations – Part D
- Anti-cancer drugs
  - Oral anti-cancer drugs in which there is an infusible form of the drug are covered for the treatment of cancer – Part B
  - Methotrexate
    - Must determine if it is for rheumatoid arthritis before it can be under Part D
- Immunosuppressant drugs
  - Transplant covered by Medicare at an approved facility and Medicare A as the time of the transplant – Part B
  - Control of an autoimmune disorder – Part D
### Examples

- **Vaccines**
  - **Part B**
    - Influenza vaccine
    - Pneumococcal vaccines
    - Vaccines administered directly related to the treatment of an injury or direct exposure to a disease are always covered under Part B
  - **Hepatitis B Vaccine**
    - Intermediate to High-risk patients – Part B
    - Low-risk patients – Part D
  - **All Other Vaccines**
    - Part D
    - Example, Herpes Zoster is preventative – Part D

### Billing Nebulized Medications

- Part D billing MUST include a valid Patient Residence Code
- Nebulizer Medications
  - Patient resides in their home
    - Billed through their medical benefit (DME) Part B
  - Patient resides in a Nursing Facility
    - Patient Residence Code 3
    - Coverage through Medicare Part D

If a patient residence is unknown, pharmacies may default to Patient Residence Code 1 (Home)

### Medicare Part B vs. Part D Coverage

- For a more extensive discussion, please refer to “Medicare Part B vs. Part D Coverage Issues” at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCoverContra/Downloads/PartsBDCoverageSummaryTable_041806.pdf
- This table provides a quick reference guide for the most frequent Medicare Part B drug and Part D drug coverage determination scenarios facing Part D plans and Part D pharmacy providers.
- It does not address all possible situations.
Point of Sale Edits and Messaging

- B vs D
- Common Point of Sale Rejections
  - M/I member place of residence
  - M/I provider type
  - Non-covered NDC
- Transition Notice
  - Generic vs. Brand
- MHL Demonstration Plans (Integrated Benefit)
  - Additional Drug Demonstration (ADD) File
- Medicare Notice of Patient Rights
- Quality
  - Star Ratings
  - Adherence
  - High Risk Medications
- Coverage Determinations
  - "Cover My Meds"

Prescriber Requirement

- Physicians or eligible professionals must either be enrolled in Medicare in an active status or have a valid opt-out affidavit on file with the applicable MAC in order for their prescriptions to be covered under the Part D benefit
- Regulatory citation 42CFR423.120(c)(6)

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" on May 22, 2014. This rule requires physicians and, when applicable, other eligible professionals who write prescriptions for covered Part D drugs to be enrolled in Medicare or have a valid opt-out affidavit on file with the applicable MAC in order for their prescriptions to be covered under Part D. The final regulation stated that the effective date for this requirement would be June 1, 2015. However, CMS is announcing that it will delay enforcement of the requirement in 42 CFR 423.120(c)(6) until December 1, 2015. Nevertheless, prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare Administrative Contractors (MACs) by June 1, 2015, or earlier, to ensure that MACs have sufficient time to process the applications and avoid their patients' prescription drug claims from being denied by their Part D plans, beginning December 1, 2015. Note that enrollment functions for physicians and other prescribers are handled by Part B MACs.

Prescriber Requirement

- Part D Prescriber Enrollment - Home
- Any physician or other eligible professional who prescribes Part D drugs must either enroll in the Medicare program or opt out in order to prescribe drugs to their patients with Part D prescription drug benefit plans. Medicare Part D may no longer cover drugs that are prescribed by physicians or other eligible professionals who are neither validly enrolled, nor opted out of Medicare. All prescribers should enroll before January 1, 2016 to allow for the processing of applications and to ensure enrollees get their prescriptions.
Medicare Notice of Patient Rights

- Must distribute the Medicare Notice of Patient Rights (Prescription Drug Coverage and Your Rights – Form CMS 1047) during each claim rejection that cannot be resolved at the point of sale
- Educate Staff
- Must be able to demonstrate the process by which beneficiary received this notice
- Coverage determination process does not remove this requirement

CMS Resources

- Medicare Learning Network

- Part B vs D Coverage
  - https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/PartsBDCoverageSummaryTable_041806.pdf

- Vaccines Coverage

- Medicare Prescription Drug Benefits Manual – Chapter 6
Adherence

Barriers
- Patient related factors
  - Cost
  - Transportation
  - Literacy/understanding
  - Complex schedule
  - Multiple medications
- Physician related factors
  - Discussion
  - Benefits/Adverse effects
  - What to expect
  - Communication
- Health System issues
  - Data
  - Time
  - Understanding of patient issues
  - Engagement

Strategies
- Teach back
- Empowering patients
- Medication lists
- Teaching Resources
- Apps
- Refill reminders
Other Opportunities

- **Quality**
  - High Risk Medications
  - Annual Flu Shots
  - Care of Older Adults

- **Customer Satisfaction**
  - Trustworthy
  - GET STATISTIC

- **Collaboration**
  - P4P
Managed Care Pharmacy

- Drug Utilization Management
  - Formulary Management
  - Utilization Management
  - Prior authorization
  - Drug Utilization Review
- Quality
  - Federal, State, NCQA (Nations Committee for Quality Assurance)
- Provider and Member Outreach
- Interdisciplinary Care Team Member
- Medicare Part D
- Pharmacy Benefit Manager Partner
  - Contract Network
  - Claims adjudication
About the Upper Peninsula Health Plan (UPHP)

• UPHP became a health plan for Upper Peninsula of Michigan residents on August 1, 1998.
• Began by serving Medicaid and MIChild (CHIP) beneficiaries
• CMS approved “rural health waiver for Medicaid managed care” for the Upper Peninsula region in 2002.
  ▫ Resulted in UPHP being awarded sole Medicaid managed care contract in the UP.
  ▫ Similar waiver was approved in 2013 for MIChild program (CHIP) resulting in UPHP being awarded sole MIChild contract in the UP.
• Began operating a Medicare Advantage Special Needs Plan in 2011, added traditional Medicare Advantage in 2014
• UPHP has more than 900 providers and 134 employees
• Currently cover approximately 44,000 UP residents (14% of population)

Our Service Area

• 15 rural counties of the Upper Peninsula of Michigan
  ▫ All counties below 200% Federal Poverty Level
• 16,419 square miles
• 315 miles East to West
• 311,629 residents
• 29% of Michigan’s land mass but only 3% of the population
• Population significantly older (≥65 years of age)
  ▫ UP – 26%
  ▫ MI – 12.3%
  ▫ US – 12.4%
• 90% Caucasian
• 15 hospitals (11 Critical Access)

About UPHP’s Program

• Current Programs (August 2015)
  ▫ Medicaid – 26,398 members
  ▫ Healthy Michigan Plan – 13,782 members
  ▫ Children with Special Healthcare Services (CSHCS) – 457 members
  ▫ MIChild – 1,543 members
  ▫ Medicare Advantage Programs – 4,419 members
    ▪ UPHP Plus (HMO SNP) – 112 members
    ▪ Members from this program were passively enrolled in the demonstration program
    ▪ UPHP Advantage (HMO) – 90 members
    ▪ MI Health Link Program (Demonstration Plan) – 4,217 members
Medicaid

- August Enrollment = 26,398 members
  - Includes pregnant women, disabled adults, foster care children, Medicare-Medicaid members, etc.
- Member Services
  - Transportation Services
  - Disease and Case Management
  - Health Education
  - Assistance with PCP selection, pharmacy issues, benefit questions
- Provider Services
  - In-hospital claims processing & payment
  - Case Management for patients/members
  - Clinical Practice Guidelines
  - Physician Incentive Opportunities
- Changes
  - Consensus Formulary
  - Co-Pay Changes (October 1, 2015)

Healthy Michigan Plan (HMP)

- August Enrollment = 13,782 members
- Follows Medicaid benefit plan with a few caveats and additional benefits
  - NO COPAYS at the point-of-service (copays collected through MIHealth Account)
  - Habilitative services (in addition to rehabilitative services)
  - Additional preventive services
  - Adult vision, hearing and dental benefits
  - UPHP has partnered with Delta Dental of Michigan to administer dental benefits for HMP
- Same Member and Provider services are available for Medicaid and Healthy Michigan Plan members
- All HMP members have some level of cost sharing
  - Funds are held in MIHealth Account
  - HMP members are required to complete an annual Health Risk Assessment (HRA)
  - Members are eligible for an incentive if they complete the HRA and agree to maintain or engage in Healthy Behavior

Children with Special Health Care Services (CSHCS)

- August Enrollment = 457 members
- CSHCS members previously excluded from health plan enrollment
  - October 2012 Medicaid-CSHCS members transitioned to health plan
  - October 2013 MIChild-CSHCS members transitioned to health plan
- Transition occurred due to added benefits of being in a health plan
  - Assigned a PCP
  - Coordination of care
  - Access to outpatient behavioral health services (Medicaid only)
  - Increased access to non-emergent medical transportation (Medicaid only)
- Covers all the same benefits as Medicaid/MIChild with some carve-out services
  - Orthodontia
  - Respite Care
  - DeVos Feeding Clinic
- CSHCS members have no copays (even adults)
- Other services/benefits available to CSHCS members and families
  - Access to Family Center for Children and Youth with Special Needs
  - Access to Children with Special Needs Fund
  - Partnership with Local Health Departments
- UPHP/Health Departments Annual CSHCS Family Forum
MiChild

- August Enrollment = 1,543 members
- Covers children age 19 and younger
- Families pay a nominal monthly premium
- Similar to Medicaid; slightly different benefits
  - Behavioral health services are carved-out
  - Non-emergent medical transportation not a benefit
  - Covers Acupuncture (not a Medicaid benefit)
  - Covers more Chiropractic visits
- As of October 1, 2013 UPHP is the sole MiChild Health plan in the Upper Peninsula

Pharmacy Provider Contact Information

<table>
<thead>
<tr>
<th>Plan</th>
<th>BIN</th>
<th>PCN</th>
<th>Pharmacy Help Desk</th>
</tr>
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<tbody>
<tr>
<td>Medicaid</td>
<td>017480</td>
<td>01990000</td>
<td>888-274-2031 248-540-6686</td>
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<tr>
<td>CSHCS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MiChild</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>UPHP Plus</td>
<td>017480</td>
<td>0718781</td>
<td>888-274-2031 248-540-6686</td>
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<tr>
<td>Dual Medicaid</td>
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<td>Advantage</td>
<td>012353</td>
<td>0718782</td>
<td>866-508-0237</td>
</tr>
<tr>
<td>UPHP MMP</td>
<td>012353</td>
<td>0696676</td>
<td>855-822-0273</td>
</tr>
</tbody>
</table>

UPHP Formulary Information

- Formulary Information
  - Website at www.uphp.com
  - Searchable formularies
  - Website has many other resources
    - Sections for each program (Medicaid, MiChild, HMP, CSHCS, Medicare programs)
    - Health Education
    - Links and Resources
  - ePocrates
  - Encourage Providers to prescribe electronically
UPHP Contact Information

- Members can contact UPHP with any questions!
- Call Customer Service at **1-800-835-2556**
  - Benefits and billing questions
  - Provider Network
  - Request a new UPHP ID Card
  - Medication Issues

Current Topics

Items for Networking Discussions

- Beneficiary Monitoring Program (BMP)
- Medicaid Co-Pays
- MDHHS Consensus Formulary
  - [http://www.michigan.gov/mdch/0,4612,7-132-64157_3149-360121--.00.html](http://www.michigan.gov/mdch/0,4612,7-132-64157_3149-360121--.00.html)
- MAC pricing
  - PBM managed program
  - Timely updates/Responsiveness
- Compounds
- MTM (Medication Therapy Management)

Good To Know Information

- UPHP membership is determined by MIEnrolls not by the health plan.
  - UPHP cannot enroll people in Medicaid (or any program) and/or UPHP.
  - UPHP Customer Service cannot answer questions as to why/why not someone is on the health plan.
- All demographic information needs to be updated through the DHS office not through UPHP.
  - i.e. name changes, address changes, etc.
- UPHP does not pay for "carve-out" medications and cannot answer questions on prescription denials and/or prior authorization requirements related to "carve-out" medications.
- UPHP cannot advise or encourage potential MI Health Link enrollees to enroll into the UPHP MI Health Link plan.
  - UPHP Customer Service (1-877-349-9324) can provide information on the program and answer questions.
  - If a potential enrollee needs assistance deciding what plan is best for them we refer to the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174.
We're out of antihistamine. Take a quarter-pound of ground beef every twelve hours.