Hello and welcome to "Medicare Prescription Drug Benefit Pharmacy Training." CMS has developed this presentation to address five topics of special interest to pharmacies participating in the Medicare prescription drug program. The topics that will be covered include:

- New Electronic Transactions
- Point-of Sale Facilitated Enrollment of Dual Beneficiaries
- Katrina Out-of-Network Access
- Coverage of Drugs: Medicaid versus Medicare, and
- Medicare Part B versus Part D

This presentation is not intended to be a comprehensive discussion of the new Medicare Prescription Drug Benefit. Pharmacists wanting additional information about the benefit should visit the CMS website at www.cms.hhs.gov/medicarereform/pdbma.

The Medicare Modernization Act requires Medicare Part D Prescription Drug Plans to ensure effective coordination of benefits between the plan and entities providing other prescription drug coverage with respect to the processing of claims and the calculation of the out of pocket limit for catastrophic coverage.

As a result of this coordination of benefits requirement, Part D plans must adjust each beneficiary's out of pocket balance to account for payments made on behalf of the enrollee by certain secondary and tertiary payers. We refer to this adjusted out of pocket balance as true out of pocket costs (or TrOOP).

To support the Part D plans' coordination of benefits and the tracking of beneficiary true out of pocket expenditures, CMS contracted for the services of a TrOOP Facilitation Contractor.

As this diagram shows, the TrOOP Facilitator is a special switch that routes secondary and tertiary transaction data back to the Part D plans.

With the implementation of Medicare Part D, new electronic transaction capabilities will be available to pharmacies. These offer pharmacies the ability to submit eligibility inquiries without the need to fill a prescription and to bill payers supplemental to Medicare. The discussion of electronic transactions will cover both types of transactions.

A pharmacy uses the eligibility inquiry process, which is also known as an E1 transaction, to submit real-time transactions to the TrOOP Facilitator. Eligibility transactions are used to determine a Medicare beneficiary's Part D coverage information.

Pharmacies will use this service when the beneficiary does not have their Medicare Part D Plan Card information to retrieve information needed to bill a claim to a patient's insurance plan, or to determine billing order if the beneficiary has multiple insurance coverage.

To use this process, pharmacies use basic information about the beneficiary and submit the real-time eligibility query to the TrOOP Facilitator through the switch that handles the pharmacy's regular billing claims.

The TrOOP Facilitator uses the information furnished in the eligibility query to match the data contained in the Medicare eligibility file and returns a response back through the switch to the pharmacy.
The pharmacy system will either display the information to pharmacy personnel or will populate the system so that a billing claim can be submitted to the proper plan or payers.

A pharmacy may receive a rejected message to an Eligibility inquiry when: 1) the information provided was not accurate, 2) not enough information was provided for the TrOOP Facilitator to identify a match, or 3) the Medicare beneficiary is not included in the eligibility file.

When a rejected message is received, the pharmacy should first verify that the information submitted was accurate. Once that is verified, the pharmacy should make sure that all of the available information was provided.

The pharmacy should include the following data elements in an eligibility request:
Date of Birth, First Name, Last Name, ZIP Code, Cardholder ID, and Sex Code

Not all these data elements are necessary, but including all the information that is available increases the chance of a match being found. However, because each field is weighted, submitting incorrect information will have no more effect on the chance of finding a match than completely omitting that information. If enough fields can be matched to put the score over the threshold, then the patient is considered a match. If the system finds only one match, then that information is returned to the pharmacy. If multiple matches or no matches are found, the system returns a rejected message to the pharmacy. If the Cardholder ID is a Medicare Part A or Part B ID, then that will be considered a match and the other fields need not be used.

The following examples describe information provided in the response to an E1 eligibility inquiry transaction. Specifically how this electronic transaction process will look and operate in your pharmacy depends upon your software vendor. Please contact your vendor for specific details concerning this process.

This is an example of an eligibility response returned to the pharmacy. Again, depending on your software vendor, you may (or may not) be able to view this response.

Note that all primary and other insurance information is included in standard message format.
This information will be in Field 504-F4 in the Message field; any overflow information from this field will be in 526-FQ (Additional Message Information).
A Help Desk phone number is also always included in the response from the Facilitator.

These abbreviations are used in the examples of the fields providing primary and other insurance information. In these examples,
BN = BIN Number
PN = PCN Number
GP = Group Number
ID = Patient ID
PC = Person Code
PH = Help Desk Phone Number

Here we see the information provided when the patient has only primary insurance coverage.

Now let's look at an example of primary and secondary insurance information.

And, finally a sample response containing primary, secondary and tertiary insurance information. Note the secondary payer will be addins:1 and the tertiary payer will be addins:2.

It is expected that beneficiaries will bring their Medicare Part D Plan ID card to the pharmacy. In the event they arrive without it however, pharmacies will derive significant benefits from the E1 query capability, particularly from the solutions it offers to two problems.
First, before Part D, when a beneficiary presents with no idea of what insurance they have, the pharmacist either "pings" likely plans or calls a number of insurance companies. Now with Part D, he just enters some basic information and, he gets the information he needs without spending a half an hour on hold with an insurance company trying to track the information down.

Second, before Part D, the pharmacist has to figure out what insurer is primary and who is secondary and this gets more complicated when the pharmacist doesn't know there is a secondary payer or even to look for a primary payer when a secondary payer looks primary. With Part D, a few easy keystrokes solve the problem. The pharmacist knows who to bill and in what order.

Part D Plans, supplemental payers, switches, and the TrOOP Facilitator must interact to accurately track a patient's true out of pocket expenses. While this interaction involves primarily real-time communication of claims data, it will also support delivery of batch claims when needed.

Claims to supplemental payers, known as B transactions, are submitted by the pharmacy to their Switch.

The Switch will forward to the TrOOP Facilitator the B transactions that are not rejected by the supplemental payer and that contain a BIN/PCN combination for a plan that covers Medicare Part D beneficiaries. This BIN/PCN combination is the flag that switches use to route the data to the Facilitator.

The TrOOP Facilitator uses the B transaction to trigger the creation of a Reporting Transaction (N transaction) Request and delivers the Request to the Part D Plan in real-time. If the Part D plan requires a batch process, the Facilitator will support batch delivery.

All supplemental billing claims must be processed through a switch so that the switch can deliver the transactions to the TrOOP Facilitator in order for accurate TrOOP reporting at the Part D Plan.

In addition to verifying Part D enrollment, the E1 inquiry can also be used to verify Medicare Part A and B eligibility. To use the E1 for this purpose, the pharmacist submits an inquiry containing five data elements:
Date of Birth, First Name, Last Name, ZIP Code, and Cardholder ID.

Again, not all these data elements are necessary, but including all the information that is available increases the chance of a match being found. If a match is found, the response will provide a Medicare eligibility indicator and a dedicated pharmacy help desk telephone number.

For further information on the new electronic eligibility and supplemental claims transactions and TrOOP facilitation in general visit the NDC Health website at medifacd.ndchealth.com/home/Medifacd_Home, or contact your software vendor.

Beneficiaries with Medicare and full Medicaid coverage are being auto-enrolled by CMS into Medicare Part D plans. In spite of all best efforts to identify and auto-enroll dual eligible individuals prior to the effective date of their Medicare Part D eligibility, it is possible that some individuals may show up at pharmacies before they have been auto-enrolled. For this reason, CMS has developed a process for a point-of-sale solution to ensure full dual eligible individuals experience no coverage gap. We are establishing a process whereby beneficiaries who present at a pharmacy with evidence of both Medicaid and Medicare eligibility, but without current enrollment in a Part D plan, can have the claim for their medication submitted to a single account for payment. The beneficiary can leave the pharmacy with a prescription, and a CMS contractor will immediately follow up to validate eligibility and facilitate enrollment into a Part D plan.

This special facilitated enrollment would apply only to full-benefit dual eligible individuals. This does not include the deemed population. That is, individuals who are Qualified Medicare Beneficiaries, Specified Low-income Medicare Beneficiaries or Qualifying Individuals are not included, nor are Medicare-only beneficiaries.

Point-of-sale facilitated enrollment will be operational by January 1, 2006 to catch any potential full dual missed in auto-enrollment.

CMS is contracting with two vendors that will coordinate to expedite the facilitated enrollment process. The first vendor is a national PDP (Anthem Prescription, LLC a

subsidiary of Wellpoint, hereafter referred to as the "POS Contractor") that can provide point-of-sale access and offer plans below the low-income premium subsidy amount in every region. The second vendor is an enrollment contractor ("Enrollment Contractor") that can expedite validation of dual eligibility and return independently verified information on the individual's eligibility for enrollment in the national PDP.

This POS Contractor has set up a unique BIN/PCN account to handle the initial processing of the claims. If the patient turns out not to be a dual eligible individual, the POS Contractor will notify the pharmacy to reverse the claim. Therefore, it is important that the pharmacist take time to verify Medicaid and Medicare eligibility to the best of their ability.

The process will start at the pharmacy with the pharmacist billing a special account that will set off the series of steps that are described next.

The process will involve 14 steps.
Step 1. A full-benefit dual eligible beneficiary presents at the pharmacy with a Medicaid card, previous history of Medicaid billing in the pharmacy system patient profile, or a recent Medicaid award letter indicating current eligibility.
Step 2. The pharmacist bills Medicaid and the claim is denied.
Step 3. The pharmacist requests photo identification and first checks for Part D enrollment by submitting an E1 eligibility query to the TrOOP facilitator. If no Part D plan enrollment is returned, the pharmacist can alternatively verify eligibility for Medicare A and B by means of the E1. If for some reason the E1 inquiry capability is not available, the pharmacist may request to see a Medicare card; call 1-800-MEDICARE**;** or request to see a Medicare Summary Notice (MSN).

Like the E1 inquiry, 1-800-MEDICARE is available 24/7. In addition, we have created a dedicated number for pharmacist inquires on beneficiary eligibility that is available Monday through Friday during the hours of 8 AM to 8 PM Eastern time.

When calling the dedicated pharmacy line for Part D plan enrollment information or the effective dates of Medicare coverage, callers will be required to provide the pharmacy name and address, as well as patient identifying information. The Call Center Customer Service Representative will furnish Part D plan information or the effective dates of A/B coverage.

Step 4. If the E1 eligibility query returns Part D plan enrollment information, the pharmacist bills the appropriate plan. However, if the pharmacist can not identify the appropriate plan to bill, but is able to verify both Medicaid eligibility (which was done in step 1) and Medicare eligibility (accomplished in step 3), then the process of facilitated enrollment continues.

In step 5, the Pharmacist enters the claim into the automated pharmacy system, including entering available data on the beneficiary. This includes information such as the beneficiary's name, their ID number (such as the Medicare ID number, Medicaid ID

number, or SSN), as well as date of birth, address, and phone number. This is information that pharmacies routinely collect at point-of-sale anyway in accordance with state pharmacy laws.

Step 6. The pharmacist submits the claim to the single, pre-established service account indicated on the Point-of-Sale (POS) Contractor's payer sheet. Then, as directed in the paid claim response, provides the prescription drug to the beneficiary at the specified $1 or $3 cost-sharing level.

Step 7. The POS Contractor processes the claim as either: paid (if the pharmacy is in-network) or as a captured response (if the pharmacy is out-of-network).

Step 8 pertains to only these latter situations. In this step, the POS Contractor sends special instructions to the out-of-network pharmacy to establish a mechanism for their payment.

Step 9. The POS Contractor sends a daily file to the Enrollment Contractor containing the beneficiary data that were submitted with these paid claims.
In Step 10, the Enrollment Contractor uses this beneficiary information to validate the individual's dual eligibility via access to both CMS and state systems. The Enrollment Contractor then returns a validation of eligibility or ineligibility to the POS Contractor.

Step 11 relates to individual who are verified to have dual eligibility and who have not been enrolled in a Part D plan. In this step the POS Contractor immediately submits an enrollment transaction on behalf of the dual to enroll him or her in a POS Contractor plan.

As in all facilitated enrollment, the beneficiary always has the option to choose another plan.

If the beneficiary is a full dual and already enrolled in a Part D plan, Step 12 involves the POS Contractor reversing the claim. The pharmacy then bills the appropriate Part D plan.

Step 13 pertains to situations where the beneficiary is only Medicaid eligible. In these cases, the POS Contractor reverses the claim and the pharmacy then bills the appropriate State Medicaid agency.

Finally if the beneficiary is found to be eligible only for Medicare, the Enrollment Contractor notifies the beneficiary by letter that she or he is ineligible for the facilitated enrollment service, but may enroll in a Part D plan under normal enrollment rules. The POS Contractor then reverses the claim to the pharmacy for collection.

The dislocation experienced by many Medicare enrollees in the areas affected by Hurricane Katrina has the potential to disrupt these beneficiaries' access to prescription drugs once the Medicare prescription drug benefit is implemented on January 1, 2006. For this reason, CMS has developed a strategy that will allow all enrollees receiving extra help from Medicare to remain in the plans into which they have been enrolled – whether that enrollment was automatic or voluntary – and to obtain their drugs outside the plan's service area.

Many of the plans in the affected areas serving beneficiaries receiving extra help are national plans and, as result, will have national pharmacy networks that will provide convenient access to retail pharmacies no matter where they currently (or temporarily) live. However, because not all Katrina displaced individuals will enroll in national plans or necessarily go fill their prescriptions at plan network pharmacies after their Medicare prescription drug benefits begin, CMS has developed a strategy that leverages our electronic coordination of benefits process and our out-of-network access policies so as to protect beneficiaries receiving extra help. Because many individuals receiving extra help will be automatically enrolled into a Medicare prescription drug plan by CMS in order to ensure their prescription drug coverage does not lapse, they may not be enrolled in a plan that includes in its network a pharmacy that is convenient for the beneficiary based on his or her new location. Given mail disruptions and prolonged displacement situations, beneficiaries who have been automatically enrolled in a prescription drug plan may not even be aware that they can make enrollment changes before their coverage under the Medicare prescription drug benefit begins.
Any Katrina displaced individual who qualifies for extra help on his or her prescription drug plan costs from Medicare will be able to access his or her Medicare prescription drug benefits after January 1, 2006 regardless of his/her location.

A Katrina displaced individual qualifying for extra help with his or her prescription drug plan costs from Medicare will be able to access Medicare prescription drug benefits after January 1, 2006 in the following way:
The individual will go to a pharmacy to fill a prescription and will present to the pharmacist some form of identification (for example, a Medicaid or Medicare card) or, in the absence of any documentation, identifying information (for example, name, Medicare number, date of birth).
The pharmacist will submit an E1 eligibility query that will provide information about the Medicare prescription drug plan in which the beneficiary is enrolled.
Once the pharmacist has identified a beneficiary's plan, he or she will fill the beneficiary's prescription and submit the claim to the plan for reimbursement. If the pharmacy is part of that plan's network, the beneficiary will be charged the appropriate cost-sharing and the transaction will be finalized.

If the pharmacy is <u>not</u> part of that plan's network and attempts to file a claim with that plan, the pharmacy will receive a message from the plan identifying the beneficiary as a Katrina evacuee and requesting that the pharmacy contact the plan's help desk.

Communication between the out-of-network pharmacy and the plan results in:

An arrangement for online payment with the plan;
The charging of appropriate beneficiary cost-sharing; and
The collection of updated beneficiary contact information.

After going through the Katrina out-of-network process, the beneficiary's plan will have the option of identifying someone with whom to negotiate a contract so that the out-of-network pharmacy is included in its network and can be used as a network pharmacy by the displaced beneficiary from that point on.

In general, after January 1st, 2006, drug coverage for dual eligible beneficiaries will be primarily under Medicare. There are however a limited number of exceptions you should know about.

The Medicare Modernization Act excludes certain drugs from the Part D benefit, such as benzodiazepines, barbiturates and drugs when used for specific conditions.

When a dual eligible beneficiary presents a prescription, the pharmacist will likely bill Medicare first to ensure the drug is not covered by Medicare.

If the pharmacist receives a response indicating the drug is not covered and is one of the Part D excluded drug, he may then submit a new claim to Medicaid for the excluded drug.

If the Medicaid program in that state does not provide coverage of the excluded drug, the claim to Medicaid will be denied. In these instances, the beneficiary will need to pay out of pocket.

It is important for the pharmacist to understand that Medicaid will never cover a drug covered by Medicare. It is either one or the other.

Also, Medicaid does not provide supplemental benefits to Part D beneficiaries. That is, the pharmacy cannot bill Medicaid for any cost sharing obligations of the beneficiary. Cost sharing obligations include deductible, coinsurance or copayments that must be made by the beneficiary under the Medicare prescription drug program.

This discussion is specific to Medicaid and those costs for which Federal financial participation is available. State Pharmaceutical Assistance Programs (SPAPs) using state-only dollars may supplement and "wrap around" Part D benefits.

We turn now to drug coverage under Part B versus Part D and briefly highlight the implications of this issue for pharmacies.
A significant implementation challenge facing CMS, Part D plans and the pharmacy community is the coordination of Part B Prescription Drug Coverage with the new Part D Prescription Drug Coverage.
The reason for this challenge is that the same drug that is covered under Part B for one Medicare beneficiary could be covered under Part D for another Medicare beneficiary.

Part B does not cover a defined list of drugs for all Medicare beneficiaries in all settings, but rather covers drugs based upon specific patient-setting situations.
Part D plans cannot pay for drugs that are covered under Medicare Part B as so prescribed. Therefore Part D sponsors must implement measures to prevent payment for Part B drugs.
For the practicing pharmacist, it is important to understand that the new Part D benefit wraps around Part B. Therefore, drugs that are currently covered under Part B will remain covered by Part B. If you have been filling prescriptions for a Medicare beneficiary who has been getting coverage under Part B, you can be sure that Part B will continue to provide coverage for that drug for that beneficiary. On the other hand, if you are filling a prescription for a drug that could be covered under Part B or Part D, and you have no prior history of Part B coverage, the question of Part B versus Part D presents itself.

The drugs that involve Part B versus Part D coverage determinations most likely fall into one of the following 5 categories:
Immunosuppressants,
Oral Antineoplastics,
Oral Antiemetics,
Inhalant Solutions; and
Insulin.

Because Part D plans cannot pay for Part B drugs, Part D plans should develop policies and procedures to prevent payment for Part B drugs. While CMS has not yet provided specific guidance on acceptable policies and procedures, we have stated that Part D plans cannot universally require a Part B denial before paying on any Part D claim.

CMS suggests that pharmacists participating in Part D become familiar with the likely Part B versus Part D coverage issues. This will help to minimize unnecessary delays in prescription processing. In addition, pharmacies participating in Part D may want to consider becoming a Medicare Part B supplier so that they can fill all Medicare covered prescriptions. Part B drugs must be billed to the Part B regional carrier and this can only be done by pharmacies that have a Part B provider number.

CMS has posted guidance on its website that discusses Part B versus Part D coverage issues in great detail. CMS continues to explore the possibility of providing additional operational guidance to assist Part D plans and Pharmacists with making these coverage determinations in the most prudent and efficient manner so as to ensure that Medicare beneficiaries have timely access to their Prescription Drug Benefit.

That concludes our presentation. If our beneficiaries need additional information, please direct them to call their plan or 1-800-MEDICARE. If you need any additional information on Part D, please visit the CMS websites at
www.cms.hhs.gov/medicarereform/pharmacy and
www.cms.hhs.gov/medicarereform/pdbma.