Guidance to States
Transitional State-Part D Plan Coordination of Benefits
01.14.2005

States will minimize payments, promote a timely transition for the beneficiary to Part D coverage, and help assure straightforward repayment while achieving the goal of ensuring that all beneficiaries get their prescriptions if they use a process at their pharmacies that includes opportunities for using a beneficiary's Part D coverage while the State remains a payer of last resort. This includes encouraging the following steps at the pharmacy before billing the State:

1 Checking for enrollment in a Part D plan, by asking for a plan ID card or other documentation from a Part D plan, or by submitting an E1 query. Pharmacists can also get information on a beneficiary's enrollment, and on how to contact the plan, by calling Medicare's dedicated pharmacy assistance line (1-866-835-7595), which is available 24/7.

2 If the individual is enrolled in a plan but is not being charged the correct dual-eligible copayment amounts, contacting the drug plan (which has expedited access for pharmacy requests to adjust copayments), or if the situation is urgent and other steps have not worked, contacting Medicare's pharmacy assistance line for urgent caseworker assistance for the beneficiary.

3 If there is no evidence of a Part D plan enrollment but there is clear evidence of both Medicare and Medicaid eligibility (for example, a Medicare card and a Medicaid card or prior history of Medicaid prescription coverage at the pharmacy), billing the POS Contractor (WellPoint) for the claim. The pharmacist can also call the dedicated pharmacy assistance line to confirm that beneficiary is in Medicare. Pharmacists should understand that there is no need to call WellPoint to confirm enrollment, since there is no enrollment to confirm – they should just go ahead and bill the POS payer. If pharmacists have any questions about using this POS system, they can call Medicare's pharmacy assistance line for step-by-step assistance in submitting a POS bill.

Only when the pharmacy is unable to complete these processes should the State Medicaid system be billed for a short-term, temporary period.

If needed at all, we recommend that the State set up its systems to pay as either the secondary or the primary payer in order to take advantage of Part D plan primary payments when these occur. This will limit State financial exposure for cases in which the Part D plan can be identified and billed, but the plan is charging excessive cost sharing due to an error in subsidy assignment. The State should charge the appropriate $1/$3 or $2/$5 copays, since the State cannot be reimbursed for that portion of incurred costs. We also strongly recommend that the State exchange "finder file" information with CMS about the duals using State payment, so that CMS can connect the beneficiary with

their Part D plan and provide information to the State about how the beneficiary can receive their Part D coverage in the future.

Immediate State Exchange of Files with CMS on Dual Prescription Fills

States should quickly and regularly extract and send to CMS beneficiary finder files for dual eligible residents whose prescriptions are being paid in whole or in part by the State Medicaid systems. CMS will identify and notify Part D plans responsible for any matched beneficiaries, and will retroactively assign plans for any matched dual eligibles that were not previously auto-enrolled into a plan. CMS will also notify the States of these responsible Part D plans, so States can redirect pharmacies to these payers instead of billing State systems in the future.

State/Part D Plan Reconciliation Process

In order to avoid imposing the burden of claim reversal and rebilling on pharmacies, CMS proposes the following process for State/Part D plan reconciliation.

1. CMS and States will agree on a short-term temporary period and a cut-off for the concurrent payment systems, and an appropriate reconciliation timeframe.

2. CMS will enforce its Coordination of Benefits Guidelines for Part D plans that require plans to coordinate payment for drug benefits based on the correct order of payment. Since the Part D plan should have been the primary payer, the plan must reimburse any other payer the amount that the plan would have paid, had the plan adjudicated the claim first.

3. State sends a final aggregate eligibility file on all members for whom it paid claims during the affected period to CMS for eligibility file match and Part D plan identification.

4. CMS identifies all Part D plans responsible for matched beneficiaries.

5. State sends claims records using the NCPDP 1.1 batch standard to each Part D plan on applicable members. Claims records do not include Part B covered or excluded drugs.

6. State submits to CMS an aggregate itemized report of claims sent to all Part D plans.

7. Part D plans receive the NCPDP 1.1 batch files from the States and process claims records to determine primary liability. Plans reimburse states for any amount of the primary liability incurred by the state. Primary liability extends to non-formulary drugs for transition period. However, no reimbursements are due for Part B covered or excluded drugs.

8. Part D plans send to CMS an aggregate itemized report of claims received from and reimbursed to States.

9. CMS compares itemized reports for reasonable correspondence between State payments and plan reimbursements (difference generally equal to dual level copays), and enforces resolution.