

## **Important Information for Providers Concerning Changes to the TennCare Program**

### **ELIGIBILITY CHANGES:**

#### **Closed Enrollment**

On April 29, 2005 new enrollment was closed into the TennCare Standard program (the waiver/expansion population). The only exception is that children under age 19 can still “roll over” from Medicaid to TennCare Standard if they meet the eligibility requirements for TennCare Standard.

Also on April 29, 2005, the non-pregnant adult Medically Needy (also called “Spend Down”) category was closed. The Medically Needy program remains open for children up to age 21 and pregnant women who meet the eligibility requirements.

All other TennCare Medicaid categories remain open to new enrollment.

#### **Loss of TennCare Coverage**

TennCare Standard Adults (defined for this purpose as 19 or older) will be losing their TennCare coverage. This includes:

1. Uninsureds
2. Uninsurables (also called “Medically Eligibles”)
3. Waiver duals (meaning people who are eligible for TennCare and Medicare but not Medicaid)

Enrollees in the three groups listed above, received a notice in early June explaining that they had 30 days to provide information to the Department of Human Services (DHS) to help determine if they might qualify for one of the Medicaid categories that continues to be open to new enrollment. If they did not respond in that time frame or if DHS determined they did not to qualify for Medicaid, this group has received or will receive a second notice informing them that they will lose coverage in 20 days. Special outreach is occurring to the Seriously and/or Persistently Mentally Ill (SPMI) population and “good cause” extensions to the 30 days to provide information to DHS may be granted to these enrollees or others in special circumstances. If you have patients with questions about the disenrollment process, please refer them to their local DHS office or to the DHS Family Assistance Center at 1-866-311-4287. A safety net hotline has also been set up to assist people who have been disenrolled or who have lost their pharmacy benefit pending disenrollment. That number is 1-888-486-9355.

## **BENEFIT CHANGES CURRENTLY IN EFFECT:**

### **Non-Covered Services**

- **Who** - TennCare adults (defined as 21 and older in both Medicaid and Standard)
- **Description** – The following services will no longer be covered for adults:
  - Dental Services
  - Methadone Clinic Services
  - Over the Counter (OTC) Drugs – except that prenatal vitamins for pregnant women and any OTC drug designated as “preferred” on the Preferred Drug List (PDL) will still be covered
  - Convalescent Care Services
  - Sitter Services

### **Elimination of Pharmacy Benefit**

- **Who** -TennCare Standard Adults (defined for this purpose as 21 or older). This includes:
  - Uninsureds
  - Uninsurables
  - Waiver duals
- **Description** - Enrollees age 21 and over who will be losing their TennCare coverage as a part of reform will no longer have coverage for prescription drugs.

### **Prescription Limit**

- **Who** –
  - TennCare Medicaid adults (defined as 21 or older) who are not in an institution or Home and Community Based Services (HCBS) waiver will be subject to a monthly prescription limit.
- **Description** -
  - Every calendar month the affected enrollees will be limited to 5 prescriptions and/or refills, of which no more than 2 can be brand names
  - TennCare has developed a list of medications, commonly referred to as the “Short List”, that do not count towards the prescription limit and that will continue to be available to the enrollee after the limit has been hit. Please see attached “Short List”.
  - The “Short List” is applicable *only* to persons who have pharmacy coverage with a monthly limit. Persons who have no pharmacy coverage pending disenrollment may not obtain drugs on the short list.
  - The pharmacy Point-of-Sale system (POS) will recognize Short List drugs and assure that they are not counted toward the limit.
  - The POS system will also enable the pharmacist to determine when a claim is denied because of the prescription limit.
  - Pharmacies may bill enrollees for prescriptions over the prescription limit; however, the pharmacy should always attempt to process the prescription and receive the “over the limit” denial before billing the patient.
  - In rare circumstances, the TennCare PDL may list only brand name drugs as preferred agents in a drug class in which generic drugs are available. In

such cases, the preferred brands will be treated like generics in that they will not count toward the 2 brand per month limit and they will not carry the brand co-pay (see below).

- Preferred insulins will be treated like generics (i.e. they will count toward the 5 prescription limit, but won't count toward the 2 brand limit and they will not carry the brand co-pay).

### **Pharmacy Co-pay**

- **Who –**
  - TennCare Medicaid adults (defined as 21 or older) who have a pharmacy benefit and who are not in an institution or HCBS waiver. Exceptions:
    - Pregnant women
    - People receiving hospice care
  - TennCare Standard Children at or above 100% of the federal poverty level

Note: Pregnant women and people receiving hospice care will need to self-declare at the pharmacy in order to be exempt from the co-pay.

- **Description -**
  - Brand name medications will have a \$3.00 copay per prescription
  - Generic medications will have no co-pay
  - Family planning drugs will not be subject to the co-pay
  - The pharmacy POS system will determine the co-pay based on the above rules
  - Enrollees cannot be denied services for failure to make a co-pay

### **WHAT YOU CAN DO TO ASSIST PATIENTS SUBJECT TO PRESCRIPTION LIMITS:**

1. Coordinate with other providers serving the patient to identify all medications the patient is on and to determine if all continue to be needed.
2. Whenever possible, prescribe generic drugs.
3. Prescribe 31 days at a time of medications for chronic conditions so that the patient is never in the position of needing to fill the prescription twice in the same month.
4. Keep a copy of the Short List in your office (and check the First Health website at <https://tennessee.fhsc.com> regularly for updates so that you are aware and can advise your patients of drugs that don't count toward the 5 prescription limit.
5. Remind your pregnant patients to let the pharmacist know they are pregnant so they won't be subject to co-pays.
6. Remind your hospice patients to let the pharmacist know they are receiving hospice care so they won't be subject to co-pays.
7. If your patient requires more than 5 drugs or 2 brands per month, advise them to consult with their pharmacist to obtain assistance identifying the most expensive drugs to submit to TennCare for payment.

8. Familiarize yourself with the list of over 55 generic medications available through “Rx Outreach” and the correct way to write a prescription for this program. This program is available to anyone (including TennCare patients who are subject to the prescription limit) if their income is below 250% of the federal poverty level. The program provides a 90-day supply of one of the listed medications at a cost to the patient of \$18 or a 180-day supply at a cost of \$30. More information and patient enrollment materials can be obtained at 1-800-769-3880 or at [www.rxoutreach.com](http://www.rxoutreach.com). A similar program is available through [www.xubex.com](http://www.xubex.com).

Please contact the First Health provider line at 866-434-5520 with any questions concerning these changes in the TennCare pharmacy program.

**Thank you for your participation in the TennCare program and your commitment to assist your patients as we implement the reforms necessary to bring program costs in line with available funding.**