

## Center for Medicaid and State Operations

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March 17, 2006

SMD 06-004

Dear State Medicaid Director:

As you are aware, with the transfer of responsibility for outpatient drugs for dual eligible Medicare and Medicaid beneficiaries from States to Medicare Part D, Medicaid programs no longer must pay for high-cost home infusion drugs. With the new drug benefit in effect, Part D now covers those drugs. It is critical, however, that States and the Medicare Part D program work together to assure that home infusion services are efficiently and effectively provided.

Questions have been raised about the coverage of drugs, medical supplies, and other services for dual eligible Medicare and Medicaid beneficiaries that are commonly provided as a service package. In particular, we are aware of some confusion concerning the payment for home infusion services that may affect beneficiaries' access to proper and timely services. This letter clarifies the roles of the Medicare Part D drug program and the State Medicaid programs in providing these services. Because of the separate coverage responsibilities for components of this service, providers may be required to bill both the Medicare drug plan and the State Medicaid agency in order to receive payment. The Centers for Medicare & Medicaid Services (CMS) sent a similar letter to Medicare Part D drug plans so as to clarify their responsibilities for home infusion drugs. (See the letter at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/HPMSGH/list.asp#TopOfPage> on the CMS Web site.)

Medicare Part D requires coverage of home infusion drugs that are not currently covered under Parts A and B of Medicare. Although the Medicare Part D benefit does not cover equipment, supplies, and professional services associated with home infusion therapy, it does cover the ingredient costs and dispensing fees associated with infused covered Part D drugs.

In addition, the Part D plan's contracted pharmacy is expected to deliver home infused drugs in a form that can be administered in a clinically appropriate fashion. Home infusion networks must have contracted pharmacies capable of providing infusible Part D drugs for both short-term acute care (e.g., IV antibiotics) and long-term chronic care (e.g., alpha<sup>1</sup> protease inhibitor). While the same network pharmacy does not necessarily need to be capable of providing the full range of home infusion Part D drugs, the home infusion network, in aggregate, must have a sufficient number of pharmacies capable of providing the full range of home infusion Part D drugs to ensure that enrollees have adequate access to medically necessary home infusion therapies.

Generally, facility discharge planners, in collaboration with a patient's physician, are responsible for ensuring that the components needed to safely administer a drug at home are present upon a patient's discharge. However, the Part D plan's in-network contracted pharmacy vendor—particularly a vendor that does not supply the necessary ancillary services (which are not Medicare Part D benefits)—must seek assurances that another entity, such as a home health agency, can arrange for the provision of these services. In other words, Part D plans must require their contracted network pharmacies that deliver home infusion drugs to ensure that the professional services and ancillary supplies are in place before dispensing home infusion drugs. This action of obtaining assurances is a minimum quality assurance requirement on Part D plans under the Federal regulations at 42 CFR 423.153(c).

Except as provided below (in connection with bundled services), Medicaid Federal financial participation (FFP) is not available when the home infusion drugs are covered under Part D. Medicaid FFP, likewise, is not available for the dispensing fee associated with the provision of these drugs, as the Part D payment includes this fee. Medicaid FFP is available for medical supplies and services associated with administering the infused drugs. Section 1902(a)(10)(B) of the Act requires that the coverage afforded to each categorically needy individual eligible under the State plan be equal in amount, duration, and scope to the coverage afforded to all other categorically needy individuals. In addition, coverage afforded to categorically needy eligibles must be no less in amount, duration, and scope than that provided to medically needy individuals covered under the State plan. Therefore, to the extent to which Medicaid covers these supplies and services for its non-dual eligible Medicaid population, the State must also cover these for full benefit dual eligibles.

States also have the option to bundle Medicaid payment for home infusion and pay a single fee to cover the drug, supplies, and services associated with this treatment. In this case, the entire payment is eligible for FFP. This does not violate the requirement that Medicare be the primary payer for Part D covered drugs (at 42 CFR 423.906(b)), because the payment is for the bundled service and not specifically for the drug.

Please inform your Medicaid provider community of these split billing and coverage requirements so that Medicaid can work with Part D to assure access to home infusion drugs and services. Also, please make sure that your Medicaid Management Information System can process this type of split billing.

If you have any questions regarding these Medicare provisions, please contact Ms. Alissa Deboy at (410) 786-6041 or for the Medicaid provisions, please contact Ms. Deirdre Duzor of my staff at (410) 786-4626.

Sincerely,

/s/

Dennis G. Smith  
Director

cc:

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