Point-of-Sale Facilitated Enrollment of Dual Beneficiaries

Process Outline

This process applies only to full-benefit dual eligible individuals

- This does not include either:
  - The deemed population (QMB-only, SLMB-only, QI-1) or
  - Medicare-only beneficiaries

The 14-step process entails:

1. Full-benefit dual eligible individual presents at the pharmacy with either a Medicaid card, or previous history of Medicaid billing.

2. The pharmacist bills Medicaid and the claim is denied.

3. The pharmacist requests photo identification and checks for Part D enrollment **or** eligibility for Medicare Parts A & B by submitting an E1 query to the TrOOP facilitator.
   - Other (offline) ways to check for A/B Medicare eligibility:
     - Request to see a Medicare card; or
     - Call 1-800-MEDICARE (available 24/7) or the dedicated Medicare pharmacy line (1-866-835-7595) available Mon.-Fri. 8 AM-8PM EST; or
     - Request to see a Medicare Summary Notice (MSN).

4. If the E1 query returns Part D plan enrollment information, the pharmacist bills the appropriate plan. If the pharmacist can not identify the appropriate plan to bill, but is able to verify both Medicaid eligibility (step 1) and Medicare eligibility (step 3), the process continues.

5. The pharmacist enters the claim into the automated pharmacy system, including:
   - Available beneficiary data, such as name, ID number (Medicare ID number, Medicaid ID number, or SSN), date of birth, address, and phone number.

6. The pharmacist submits the claim to the unique BIN/PCN account indicated on the POS Contractor's payer sheet.
   - Claim submitted to Anthem Prescription, LLC
   - BIN- 610575
   - PCN- CMSDUAL01

   In compliance with the paid claim response, the pharmacist provides the prescription drug to the beneficiary and collects copay of either $1 generic or preferred multisource brand or $3 for any other brand.

7. The POS Contractor processes the claim as paid (network pharmacies) or as a captured response (out-of-network pharmacy).

8. If the pharmacy is out-of-network, special instructions are sent to the pharmacy to establish the mechanism for payment.

9. The POS Contractor sends a daily file to the Enrollment Contractor with submitted beneficiary data.

10. The Enrollment Contractor uses this information to validate dual eligibility and returns a validation of eligibility or ineligibility to the POS Contractor.

11. If the individual is dually eligible, and not enrolled in a Part D plan, the POS Contractor enrolls him/her in a POS Contractor plan.
    - All facilitated enrollees have the option to choose another plan.

12. If the beneficiary is a full-benefit dual eligible individual, but already enrolled in a Part D plan, the POS Contractor will contact the pharmacy to reverse the claim, and the pharmacy will bill the appropriate Part D plan.

13. If the beneficiary is Medicaid-eligible only, the POS Contractor will contact the pharmacy to reverse the claim, and the pharmacy will bill the appropriate state agency.

14. If the person is Medicare-eligible only, the Enrollment Contractor notifies the beneficiary that s/he is ineligible for facilitated enrollment, but may enroll in a Part D plan under normal enrollment rules. The POS Contractor will contact the pharmacy to reverse the claim, and the pharmacy will pursue collection.