MEDICARE PRESCRIPTION DRUG RESOURCES AND TIPS

FOR MENTAL HEALTH OLMSTEAD COORDINATORS

Help Dual Eligibles Transition From Medicaid to Medicare Drug Coverage By January 2006

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IF YOU RECEIVE MEDICAID AND MEDICARE, YOUR PRESCRIPTION DRUG BENEFIT WILL CHANGE ON JANUARY 1, 2006

Beginning January 1, 2006, individuals who receive both Medicaid and Medicare (also called dual eligibles) and who currently get prescription drug coverage through Medicaid will change to a new prescription drug program under Medicare called Medicare Part D. This change, required by a new federal law called the Medicare Modernization Act, means that any prescription drug coverage under Medicaid for dual eligibles will end on January 1, 2006.

Everyone who is eligible for both Medicaid and Medicare will be automatically enrolled in a Medicare Part D drug plan. In November or December of 2005, a Medicare prescription drug card will be sent to you in the mail. On January 1, 2006 you will begin to use this Medicare card to pay for your prescriptions. Medicaid will continue to pay for all other medical services, except prescription drugs.

How Will Medicare Drug Coverage Be Different from Drug Coverage under Medicaid?

Most state Medicaid programs had just one drug plan that was administered directly by the state. Under Medicare Part D, however, you probably will have several drug plans to choose from. Each of these plans will be run by a private insurance company or other business that has contracted with Medicare to provide this coverage. With a few exceptions, these private companies can choose which drugs they will pay for and which they won't. Plans can also choose which pharmacies you can use to buy your drugs.

It is important to know that you do not have to stay in the Medicare drug plan that the state automatically enrolls you in. You have the opportunity to learn about different plans in your area. If you find a drug plan you like better than the plan the state enrolls you in, you are allowed to switch plans.

How Do I Know What Medicare Drug Plan I am In?

In November 2005, you should receive a letter from the state Medicaid office telling you what Medicare drug plan you have been automatically enrolled in, the name of the company that runs the plan, and a phone number to call for more information.

Also in November, the company that runs your plan will send you a letter telling you what drugs are covered under your plan, what drug stores will fill your prescriptions, and how much you will pay for each prescription (between $1 and $5). At that point, you can choose whether to stay in the plan the state put you in or to switch to another plan that is offered in your area.

Will it cost me anything to get prescription coverage under Medicare?

Dual eligibles will automatically get “extra help” paying for prescriptions. You should have received a letter from the Social Security Administration last June telling you that you are automatically enrolled in this program.

“Extra help” (also called the low income assistance program) will pay most of your drug costs, as long as you enroll in one of several low cost plans in your area. The plan the state automatically enrolls you in is just one of several different low cost plans in your state.

If you enroll in one of the low-cost plans available in your area, the “extra help” program will pay any premiums and deductibles that your Medicare drug plans may charge. Some more expensive plans will require you to pay an extra premium, so it is important for you to ask about this if you want to change plans.

“Extra help” does NOT pay co-payments charged with any of the plans, and you will be required to pay from $1 to $5, depending on your income, each time you fill a prescription. If you cannot afford the co-payment, ask your pharmacist if he or she can waive the amount. The government has said pharmacists can decide whether to fill your prescriptions without the co-payment.

Should I Stay In The Plan The State Put Me In or Switch To Another Plan?

When the state automatically enrolls you in a plan, it will **not** check to see if the plan covers the prescription drugs you need. Rather, the state will simply assign you to one of several basic low cost plans in your state on a random basis.

There may be a different drug plan in your state that you would like better. Things to consider include whether the plan does the following: (1) pays for more of the prescriptions you need; (2) allows you to use the pharmacy you like; and (3) permits you to get the drugs you want without requiring step-down therapy or prior authorization from your doctor. If you decide to switch drug plans ask if all of the premiums and deductibles will be covered by “extra help”. The plan may charge more in premiums and deductibles than what “extra help” pays for. You are responsible to pay for whatever “extra help” does not. .

How Do I Find Out About My Drug Plan Choices?

There are three ways to find out about your plan choices:

1. Call 800- Medicare (800-633-4227). The TTY number is (877) 486-2048. You will be connected to a computer that will ask you what you want. You should say “drug coverage”. You can then talk to a person who will ask for your Medicare number and your address. The expert can answer your questions about all of the drug plans in your state. Once you have narrowed down your choices, the

Medicare expert will mail information to you about the plans you like. You must then call the plan or fill out the paperwork to enroll.

2. Go to www.medicare.gov and click on the "drug plan finder tool". You will need to provide the number on your Medicare card and your address. The computer will give you a list of plans in your state. The computer can narrow down the list to only those plans that pay for your specific prescriptions, and that allow you to fill prescriptions at the pharmacies you like to use.

3. Read the *2006 Medicare and You* Handbook for a list of plans offered in your state. You can then call each plan listed in the Handbook for detailed information. If you like the plan, you can sign up on the phone. **IMPORTANT**: The Handbook you received may not list all the plans available in your state. Also, all of the handbooks have an ERROR. The handbook shows a chart of all the plans in your state. The chart says that "extra help" will pay the full cost of your premiums no matter what plan you join. **<u>This is incorrect.</u>** The correct information is that some plans will charge higher premiums than you will get in "extra help".

Are There any Prescription Drugs that Plans Must Pay for?

Each plan must cover at least two drugs in each drug category. In 2006, plans must also cover most anti-psychotics, anti-depressants, anti-convulsants, and HIV prescriptions. In 2007, drug plans may not be required to cover these prescriptions.

Plans are also allowed to do "fail-first" or "step therapy." This means the plan can require your doctor to prescribe the lowest price drug that will work for you, and the plan can refuse to pay for the higher cost drug unless your doctor says you tried the cheaper one and that it did not work as well. However, you should know that the Federal government has directed plans NOT to use step therapy if you are already stabilized on specific drugs, unless there are "extraordinary circumstances".

What If The Plan I Am Enrolled In Does Not Cover My Prescriptions?

The Government requires all Medicare drug plans to pay for a <u>one-time</u> 30 day prescription, even if the plan does not normally cover the prescription, or allow you to go to that pharmacist. You will need to give the pharmacist your Medicare card number or your social security number, and you may be charged a co-payment of between $1 and $5. You should not be charged the full price of the prescriptions.

Before your prescription runs out, you can do one or more of the following: (1) call your doctor and ask if there is another drug that is covered under your plan that would work just as well for you; (2) call 1-800-Medicare or go online to www.medicare.gov and enroll in a plan that does cover your prescriptions; or (3) call the drug plan and ask for them to make "an exception to the formulary" (a formulary is a list of the drugs the plan will cover). The plan will send a form for your doctor to fill out explaining why you need

that prescription and why no other drug will work as well. Once you send in the form, the plan has three days to tell you if it will cover the prescription. If the plan grants the exception, it will last only one year from the date of the decision. If the plan says no, you can call the plan and get them to send you a form to file an appeal.

Can Plans Change the Prescriptions They Cover?

Plans are allowed to change the drugs they cover. However, plans must give you 60 days notice of the change or give you a 60-day supply of the drug so you have time to change plans or get an exception.

Where Can I Go For More Information?

You can ask questions by calling 800-medicare (633-2273) or go to www.medicare.gov.

Dual Eligibles With Mental Illness: Issues and Action Steps for Olmstead Coordinators

On January 1, 2006, Medicare will begin providing payment for outpatient prescription drugs through approved prescription drug plans administered by private companies. This change comes as a result of the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

The new Medicare Prescription Drug benefit (known as Medicare Part D) will have significant implications for people who are eligible for both Medicaid and Medicare (known as dual eligibles). Specifically, the law terminates federal funding of Medicaid prescription drug coverage for all dual eligibles and requires them to move from Medicaid drug coverage into federally regulated, private Medicare prescription drug plans on January 1, 2006.

For some dual eligibles, the transition could result in a disruption of drug coverage, greater cost-sharing, and a more limited array of drugs than these individuals currently receive under Medicaid. This article highlights some of the potential challenges facing dual eligibles with mental illness or cognitive disabilities and provides some action steps Olmstead Coordinator's could take to minimize problems both during and after the transition.

The Issue: Individual is dually eligible, but has "fallen through the cracks" and NOT been automatically enrolled in a Part D Plan

Action Step: Inform the individual that CMS has assured "Point of Sale Protection" this means if a person presents at a pharmacy with evidence of both Medicaid and Medicare eligibility, but without current enrollment in a Part D plan, the beneficiary will be able to leave the pharmacy with a 30 day one-time prescriptions. All pharmacists are supposed to have received a uniform set of instructions for how to notify CMS and get the person enrolled in a drug plan.

The Issue: Individual does not know he or she is dually eligible or that he or she has been enrolled in a Part D Plan. The Pharmacist tells individual that Medicaid will no longer cover his or her drugs and asks for a Medicare drug plan ID.

Action Step: Inform the individual that Pharmacists have the ability to log into a CMS data base and do automatic Part D plan checks to identify a Medicare beneficiary's Part D plan billing information and immediately coordinate benefits with any other coverage the beneficiary may have through other payers, even if the beneficiary does not present the plan ID card or is even aware that he/she has been auto-enrolled into a Part D plan. This data base will be open and accessible by all pharmacies regardless of the network or pharmacy management system they use.

The Issue: Limited Drug Coverage and Restrictive Formularies

Medicare Part D will provide coverage of medications through prescription drug plans administered by private companies under contract with Medicare. Although there are some minimum federal requirements regarding what kinds of drugs must be offered, plans have considerable flexibility to choose which drugs to include in their formularies. For example, plans are allowed to limit the number of drugs available in various "therapeutic classes" to only **two** drugs per class; and plans are allowed to define what constitutes a therapeutic class for purposes of developing their formularies.

Action Steps:

* Get the word out that plans MUST cover "all, or substantially all" drugs in the antidepressant and antipsychotic categories during 2006. Program guidance issued by CMS on June 13, 2005 requires Part D plans to cover "all, or substantially all" drugs in the antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant and HIV/AIDS categories in 2006. However, plans are not required to cover all dosages of these drugs, multi-source brands with the identical molecular structure, and extended release products. The guidance also states that CMS will reevaluate the formulary guidance for 2007.

* Make sure that consumer and doctors are aware that CMS' June 13 program guidance directs plans NOT to use prior authorization or step therapy for patients already stabilized on specific drugs unless there are "extraordinary circumstances".

* Encourage your state to develop a Medicaid wraparound program to cover certain drugs that Medicare drug plans are prohibited from covering. Medicare Part D specifically excludes from coverage: drugs for weight loss/gain, cough and colds, and vitamins; and certain drugs, including benzodiazepines and barbiturates, which are sometimes used to treat generalized anxiety, insomnia, and seizure disorders (Valium, Ativan, Xanax, Rivotri, ProSom, Halcion, Librium, Tranxene, Paxipam, Serax, Centrax, Doral, and Klonopin). As a result, these drugs will not be included in Part D formularies. However, states have the option of providing Medicaid coverage for the excluded drugs and will receive full federal financial participation (FFP), or federal payment, if the drugs are covered. In a June 13, 2005 letter to State Medicaid Directors, CMS "ask[ed] state Medicaid programs that cover these excluded drugs to consider continuing this coverage for all Medicaid recipients, including full benefit dual eligibles, after the transition of dual eligibles to the Medicare drug benefit. CMS has included state-by-state information about different state wrap programs with specific information about what drugs the states will cover. The chart can be downloaded at: http://www.cms.hhs.gov/medicarereform/states/optdrugcov.asp. The one thing to be aware of is that the MMA and its implementing regulations prevent a state Medicaid program from paying for any drug that could be covered under Part D.
* Give consumers a copy of the CMS transition plan for duals which explains that, to avoid a coverage gap for dual eligibles, all pharmacist can fill a one time 30 day refill of

medically necessary non-formulary drugs during a transition period. A "transition period" must provide at least a one-time 30 day prescription refill which can be filled at an out-of-network pharmacy. The transition period must be long enough for an individual to check with their doctor about drug alternatives, file for an exception to the formulary, or enroll in a different drug plan.

* Find out if your state has looked into making "informed" auto-enrollment decisions, to increase the likelihood that individuals are auto-enrolled in a plan with a formulary that covers current prescriptions. The author only knows of one such system, which she knows nothing specific about and does not endorse in any way. I provide information as simply an example of a system some states are reportedly considering, not as an endorsement. It is called the "Informed Decision" Part D Enrollment Tool for Dual Eligibles. It is a free service to state Medicaid agency's (funded with unrestricted grant monies from Eli Lilly, Astra Zinica and a drug membership association) to help states make auto-enrollment decisions after matching an individual's specific prescriptions with the low-cost Part D plan that covers most or all of those prescriptions. They have a website at: www.id-health.com/BCE_healthcare_profs.htm.

The Issue: Increased Cost Sharing – and Enrollment in The Low Income Subsidy

All dual eligibles will automatically be enrolled in the Medicare low-income subsidy program to receive "extra help" in meeting the financial requirements of their plans.. In addition to dual eligibles, people in Medicare Savings Programs (MSPs), people with Supplemental Security Income (SSI), and people with incomes up to 135% of the federal poverty level (FPL) and assets not more than $6,000/individual or $9,000/couple will automatically be enrolled in the low-income subsidy program.

It is important to note that dual eligibles and these other populations will still be required to provide co-payments, which will vary based on income. In 2006, co-payments for these groups will be $1 or $2 for generic/preferred drugs and $3 or $5 for other drugs. The one exception is for dual eligibles who live in nursing facilities or other institutions – they will NOT have co-payments.

People with incomes up to 150% and with assets not more than $10,000/individual or $20,000/couple will receive a partial low-income subsidy. They will pay a sliding scale premium, a $50 deductible, 15% of the cost of each prescription up to the catastrophic threshold, then $2 for generic/preferred drugs and $5 for brand drugs.

It is important to understand that the "low-income subsidy" is intended to cover the premium and deductibles only in basic-low-cost prescription drug plans. Some plans are called "enhanced plans" and they cover more prescriptions than most "basic" plans. Enhanced plans may charge higher premiums and deductibles than what the low income subsidy will cover. CMS has confirmed that it will only automatically enroll dual eligibles into basic plans that have low-cost premiums and deductibles. To determine which plans are "low-cost" plans, CMS has established "benchmarks" for what

constitutes a lost-cost plan in particular areas. These "benchmarks" are available on-line at www.cms.hhs.gov/medicaidreform.

There is no prohibition on dual eligibles switching to either a "basic" plan with premiums above the benchmark or to an "enhanced" plan. However, if a dual eligible does switch to a plan with premiums and deductibles above the "benchmark," the beneficiary will be responsible for paying the amount not covered by the low income subsidy. In fact, the low income subsidy will only pay up to the amount of the lowest cost plan available, even if that plan is lower than the 'benchmark" set for the area.

Action Steps:

* Help your Medicare and Medicaid offices identify individuals eligible for the low-income subsidy and extra help. Advocates have heard reports that the notice of eligibility for the low income subsidy has not reached all dual eligibles. Olmstead Coordinator's could review the lists used to identify dual eligibles and help to identify population gaps.

* Assist your state in enrolling low-income persons in the "extra help" program. The new Medicare prescription drug law *requires* state Medicaid offices to screen and enroll people in the low income subsidy. Individuals can register by mail or with their local Medicaid office. State mental health authorities and their provider networks can help to make low-income subsidy enrollment forms available and inform consumers, mental health provider,s and family members about the subsidy. A sample copy of the application and an on-line qualifier tool to help determine whether someone is eligible for the subsidy are available at www.ssa.gov/organizations/medicareoutreach2/.

* Inform dual eligibles that some plans charge higher premiums and deductibles than the extra help they receive will cover. Dual eligibles should know that they can join a higher cost plan if they wish, but will be responsible for the extra cost.

* Notify clients that there is an error in the printed area-specific versions of the 2006 version of the *Medicare & You* handbooks that are already being mailed to Medicare beneficiaries. The error occurs in the comparison charts listing the Medicare prescription drug plans. In the last column of the comparison chart provides information about premium amounts. The heading of the column is "I qualify for extra help, will my full premium be covered?" This column should indicate "yes" only next to plans that have premiums at or below the regional benchmark. Instead, the column reads "yes" next to every plan, even those plans with high premiums that will not be fully covered by the low income subsidy. The error has been corrected on the version of the Handbook posted on www.medicare.gov.

* Notify consumers that pharmacies are permitted to waive or reduce co-payments for consumers that qualify for the low-income subsidy on a routine basis and for other people with Medicare on a non-routine basis. Pharmacies are restricted from advertising that they may waive costs, so providers should prompt consumers to ask for extra assistance.
* Encourage charitable organizations, state pharmacy assistance plans, or pharmaceutical

company assistance programs to cover out of pocket expenses.. It is important to note that 340B pharmacies that are in community mental health centers, federally qualified heath centers, or other publicly funded settings that waive costs will not count these fees toward the consumer's out-of-pocket expenses. CMS has told states that "model" state pharmaceutical assistance programs (SPAPs) would "utilize CMS' and SSA's "middleware" solution to apply for the LIS on behalf of its members. Middleware is a software program that will allow CMS and SSA to share the data necessary to identify beneficiaries eligible for LIS. The SPAP could send a letter to its members to collect any additional information it needs to submit a complete application and could follow up the letter with direct calls as necessary."

The Issue: Potential Dis-enrollment of Beneficiaries for "Disruptive Behavior"

Section 423.44(D)(2) of the MMA regulations allow prescription drug plans to dis-enroll beneficiaries if their behavior is "disruptive, unruly, abusive, uncooperative or threatening." Some mental health advocates are concerned that individuals will be dis-enrolled for "disruptive" behavior that is a manifestation of their disability.

Action Steps:

* Inform plans and providers that "disruptive behavior" might sometimes be a manifestation of a persons disability and that MMA regulations also require prescription drug plans to provide a "reasonable accommodation [to people with disabilities] as determined by CMS".

* Advise consumers that involuntary disenrollment from one plan does not apply to other plans; and that an individual must be permitted to enroll in a "fall back plan". The regulations are clear that if there are no "fall back plans" available CMS reserves the right to deny a plan's request to disenroll an individual for disruptive behavior.

The Issue: Lack of Help For Individuals With Cognitive or Mental Disabilities Without Legally Authorized Substitute Decision Makers

CMS regulations require that only beneficiaries themselves, the doctor prescribing the drugs, or their "authorized representatives" can actually enroll or dis-enroll in plans or file for coverage determinations and appeals. An "authorized representative" is defined narrowly in the CMS *Guidance on Eligibility, Enrollment and Dis-enrollment* as a legal guardian, a person with a health care power of attorney, a prescribing physician acting on behalf of the Medicare beneficiary, or a person who is an "authorized representative" under applicable state laws. A significant exception is that Social Security representative payees are NOT "authorized representatives," since Social Security representative payees are authorized to make only financial decisions, not health care decisions.

The enrollment guidelines make clear that individual prescription drug plans and the 1-800-Medicare staffers are not allowed to assist a person enroll or dis-enroll from a plan. They can provide information about different plan formularies and steer individuals to

plans that have low cost-sharing requirements, but they cannot do the actual enrollment. Even states that allow for proxies or surrogate decision makers may not be able to consider these persons “authorized representatives” if, in these states, health care proxy laws have been interpreted to preclude the proxy from enrolling someone in an insurance plan.

Action Steps:

* If this is a problem in your state, contact your state mental health agency attorney or protection and advocacy agency for help clarifying state law regarding who is authorized to make enrollment and dis-enrollment decisions for individuals with mental illness who do not have legal guardians.

The Issue: Special Rules for Residents of Long-Term Care Facilities

Long term care facilities will contract directly with Medicare prescription drug plans and will not bill Medicaid for drugs provided to dual eligibles who are long term residents of state hospitals and nursing facilities and who receive their drugs through the long term care pharmacy. Plans must accommodate the needs of long-term care residents by providing coverage for all medically necessary medications at all levels of care. Plans may use formularies and utilization management tools, but they must provide mechanisms to make exceptions and override restrictions. Dual eligibles who are temporarily residing in a psychiatric facility will follow the same procedures for enrollment as all other dual eligibles living outside institutions.

Action Steps:

- Inform hospital and nursing facility discharge planners that drug plans must cover a temporary or emergency supply of non-formulary Part D drugs for residents as part of their transition out of the institution.

The Issue: Individual who are auto-enrolled in a drug plan and also has retiree drug coverage may lose all of their retiree health benefits and not just their drug coverage if they stay enrolled in a Part D plan.

Action Steps: People who have retiree drug coverage that is creditable, i.e., considered as good as Medicare, may lose all of their retiree health benefits and not just their drug coverage if they enroll in a PDP. They need to check with their employer to understand the relationship between Part D and their retiree health coverage.

Bibliography of Online Medicare Prescription Drug Coverage Resources

2006 Medicare & You Handbook Online: available online: http://www.medicare.gov/publications/pubs/pdf/10050.pdf. This document contains a segment on the Medicare Prescription Drug benefit with specifics on plan options by region. The book was mailed to all Medicare beneficiaries in October 2005.

Medicare Prescription Drug Plan Finder Tool: available on the web at: www.medicare.gov/medicarereform/MPDP. It allows you to do online comparisons of costs, formularies, and drugstore locations that participate in each plan available in your state and actually enroll in a plan of your choice.

Medicare Prescription Drug Plan Cost Estimator: available on the web at www.medicare.gov/medicarereform/MPDP_Cost_Estimator.asp. This tool will provide people considering Medicare prescription drug coverage with quick reference information. By entering their monthly drug costs and the state they live in, users will get an estimate of annual savings if they join a Medicare prescription drug plan. The calculations are based on the defined standard benefit and the lowest premium amount offered by a plan for a particular region of the country.

State-by-State Information on the Low-Income Subsidy Amount: The low-income benchmark premium is equal to the weighted average of premiums of all prescription drug plans offered by the same plan or a weighted average of premiums of all prescription drug plans offered by multiple plan sponsors in a region. For state-by-state information on low-income subsidy amounts, go to: www.cms.hhs.gov/healthplans/rates.

Medicare Prescription Drug Low-Income Subsidy Application and Information: available on the web at: www.ssa.gov/prescriptionhelp It offers a tool to help individuals determine if they qualify for “extra help” paying the costs of premiums and deductibles. It also offers the online application to apply for the low-income subsidy.

Mental Health and Part D Website: available on the web at: www.mentalhealthpartd.org/. This site contains easy-to-understand, top-line information on Part D tailored specifically to psychiatrists and other physicians, providers at community health centers, and consumers and their families.

RxHelp a national hotline dedicated for professionals serving the Medicare population, operated from 10 a.m. to 6 p.m. EST by the Medicare Rights Center with support from the Brookdale Foundation. Dial **877-RXHELP-0** (877-794-3570).

Spanish language Part D hotline The National Alliance for Hispanic Health has opened a bi-lingual hotline to help people with the Medicare Part D decision and enrollment process. The hotline is 1-866-783-2645, In addition, the Alliance has bi-lingual materials about Medicare.

CMS Part D Question and Answer Website: continuously updated CMS web site has a very extensive list of Part D Q&As available at: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php

Understanding Changes in Prescription Drug Coverage for People with Disabilities on Medicare: A Guide for People with Disabilities, Benefits Counselors, Disability Organizations and Others On Transitioning to the Medicare Part D Prescription Drug Benefit. The report was a collaborative effort between Advancing Independence and the Health Policy Institute at Georgetown University. The guide can be downloaded at http://hpi.georgetown.edu/rxchanges.html.

C. *Ensuring Continuity of Care for Dual Eligibles with Developmental Disabilities: A Web-Based Guide to Transition From Medicaid to Medicare.* This guide was developed by the Disability Policy Collaboration, a partnership of The Arc and United Cerebral Palsy and the TheArcLink Incorporated. It can be accessed at http://www.theDesk.info/PartD.

CMS Part D Outreach Toolkit: available at www.cms.hhs.gov/partnerships/tools/materials/medicaretraining/MPDCoutreachkit.asp www.cms.hhs.gov/partnerships/tools/materials/medicarekit. This kit contains camera-ready fact sheets for distribution to Medicare beneficiaries.