NATIONAL DISABILITY RIGHTS NETWORK
Protection & Advocacy for Individuals with Disabilities

Dual Eligibles With Mental Illness: Issues and Action Steps Revised May 2006

On January 1, 2006, Medicare 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) has 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 as of 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 advocates could take to minimize problems.

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 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.

* Make sure that consumer and doctors are aware that CMS' program guidance directs plans

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NOT to use prior authorization or step therapy for patients already stabilized on specific drugs unless there are “extraordinary circumstances”.

* 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. Advocates 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 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.

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.

February 15, 2006

SHORT-TERM CCD RECOMMENDATIONS FOR NEW MEDICARE PRESCRIPTION DRUG PROGRAM

The Consortium for Citizens with Disabilities, a coalition of 105 national disability organizations, calls on the Bush Administration to take immediate corrective measures to ameliorate the flawed implementation of the new Medicare prescription drug program, specifically as it relates to Americans with disabilities. The CCD recommends the following actions:

1. REIMBURSE IMPROPER CHARGES TO INDIVIDUALS IMMEDIATELY

Plans must reimburse dually-eligible individuals who were erroneously charged the full cost of their prescriptions or erroneously high co-payments in a timely manner and CMS must facilitate this reimbursement process. It is unfair to put the burden on beneficiaries to go through complicated administrative processes in order to receive reimbursement for these costs.

2. GUARANTEE REIMBURSEMENT TO PHARMACIES

To ensure that all dually-eligible individuals leave their pharmacies with all medically necessary prescriptions filled for an appropriate period of time without being required to pay either erroneously high co-payments or full price for their prescriptions, CMS must guarantee pharmacists that they will be fully reimbursed for medications dispensed to dual eligibles regardless of whether or not they have the correct billing code or can verify enrollment in a Part D plan or the Extra Help subsidy.

3. CODIFY CMS POLICY ON COVERED DRUGS

The CMS policy to require that Part D plans cover "all or substantially all" medications in six key drug classes including anti-depressants, anti-psychotics, anti-convulsants, anti-retrovirals, antineoplastics, and immunosuppressants must be strengthened in law or at least made a more formal requirement in regulation. In addition, the CMS policy that plans may not apply utilization management restrictions like prior authorization or step therapy to medications in these classes if the individual was already taking these medications before being enrolled in Part D must also be strengthened in law and regulation.

4. MAKE OUTREACH ACCESSIBLE AND PROVIDE TRAINED STAFF

CMS and plans must be required to consider the needs of people with a variety of disabilities in its outreach, education, appeals, and complaint processes. This requires establishing standardized forms and processes that all plans should use for exceptions and appeals and requires that these forms as well as any outreach materials be produced in accessible formats for people with sensory and cognitive disabilities. Access to www.Medicare.gov and 1-800-Medicare must also be accessible to people with sensory and cognitive disabilities and the State Health

Insurance Assistance Partnerships must include staff trained to address the needs of people with sensory or cognitive disabilities.

5. POLICE AND PUNISH NEGLIGENT DRUG PLANS

CMS must exercise its enforcement authority and impose appropriate sanctions against any Part D drug plan that:

* Fails to maintain sufficient staffing to respond in a timely manner to inquiries by beneficiaries.
* Fails to provide a transition supply of medicine
* Provides incorrect formulary information to CMS, pharmacies, beneficiaries, and others; or changes its formulary before March 1.
* Fails to provide information about the exceptions and appeals process
* Fails to maintain a system to respond immediately to requests for prior authorization, exceptions, or appeals.
* Fails to reimburse individuals in a timely manner.
* Fails to reimburse dually-eligible individuals who were erroneously charged the full cost of their prescriptions or erroneously high copayments in a timely manner.

These recommendations are explicitly endorsed by the following CCD organizations:
American Association of People with Disabilities
American Association on Mental Retardation
American Congress of Community Supports and Employment Services
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
Epilepsy Foundation
National Association of Councils on Developmental Disabilities
National Association of Social Workers
National Disability Rights Network
National Mental Health Association
Paralyzed Veterans of America
Title II Community AIDS National Network
The Arc of the United States
United Cerebral Palsy