

★ STATE ACTION ALERT ★

Obligations of Medicare Drug Plans That Serve Beneficiaries Dually Eligible for Both Medicare and Medicaid

The new Part D Medicare drug plans that dual eligibles have been enrolled in are required to meet the following standards:

- They must offer drug coverage to dual eligibles with no monthly premium, no annual deductible, and no coverage gap;
- They can *not* impose cost sharing on a dual eligible that exceeds \$1 for a generic drug, or \$3 for a brand-name drug. Cost-sharing is waived once overall annual costs exceed \$5,100 and for all dual eligibles in nursing homes, Institutes of Mental Disease (IMDs), public psychiatric hospitals, etc.;
- They must cover all drugs prescribed before January 1, 2006. If a dual eligible was stable on a regimen of medications before January 1, all of the drugs must be covered immediately. This transition coverage continues through at least March 31, 2006;
- They must cover "all or substantially all" of the medications prescribed to treat mental illness, including "all or substantially all" anti-psychotics, anti-depressants, and anti-convulsants;
- They can *not* cover medications known as benzodiazepines (e.g., klonopin, ativan, xanax); however, nearly every state Medicaid program is covering these medications for dual eligibles;
- They must allow a dual eligible to switch to a different drug plan at any time, so long as the plan is at, or below, the average "benchmark" plan in the region. If a participant decides to switch plans, they are encouraged to do so in the first two weeks of a month to ensure seamless coverage.
- They must respond promptly, usually within 72 hours, for a request from a beneficiary and their doctor for an exception to any restriction in coverage - e.g., to cover a medication that is not on the plan's preferred drug list or to waive a prior authorization requirement

"There is no reason whatsoever for a dual eligible to leave the pharmacy counter without getting all of their prescriptions filled at no more than \$1 for a generic and \$3 for a brand name drug." Centers for the Medicare and Medicaid Services (CMS) Administrator Mark McClellan, January 6, 2006.



NAMI, National Alliance on Mental Illness, the largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families.
Email: info@nami.org

www.nami.org

February 2006

Frequently Asked Questions on Transition for Dual Eligible Beneficiaries

What happens to dual eligibles who were not auto-enrolled (or were not notified of auto-enrollment) before January 1, 2006?

Some dual eligibles have not been auto-enrolled (due to the discrepancies between state and federal lists) or have not received enrollment notices (due to inaccurate mailing addresses, clerical errors, etc.). To deal with such cases, the Centers for Medicare and Medicaid Services (CMS – the federal agency that administers Medicare) has set up a "Point of Sale" system to allow any dual eligible to immediately get his or her prescriptions filled and initiate immediate auto-enrollment into a national Medicare Part D plan. All the dual eligible beneficiary has to produce is proof of eligibility in both programs and the pharmacy is required to do the rest, i.e. fill the prescription and charge only \$1 for a generic drug and \$3 for a brand name drug and enroll the beneficiary in the new plan.

Can a dual eligible ever be charged more than \$1/\$3 in cost sharing for a prescription?

Possibly. There are a very small number of dual eligibles who are above 100% of the federal poverty level (about \$12,000 annual income) who can be charged no more than \$2 for a generic and \$5 for a brand name prescription. However, in most states, Medicaid eligibility is below this 100% threshold.

Are pharmacies required to collect the \$1 / \$3 cost-sharing from dual eligible beneficiaries?

Sort of. The law appears to require that dual eligibles meet their cost sharing obligations (\$1 for a generic drug, \$3 for a brand name drug). However, the regulations specifically mention that a retail pharmacist can, at their discretion, waive cost sharing for a dual eligible. However, a retail pharmacist cannot establish a blanket policy to waive cost sharing for all dual eligibles, nor can they advertise their willingness to forgo cost sharing for dual eligibles. As a result, some pharmacies may be reluctant to waive cost sharing. At the same time, nothing prevents a pharmacist from allowing a third party, including a family member or friend, from making co-payments on the dual eligible's behalf.

Once the total annual costs for a dual eligible's medications exceed \$5,100, all cost sharing is waived – this is total costs, not just the beneficiary's share. All drug plans are required to track these costs for their dual eligible enrollees.

Are all pharmacies participating in the new Medicare drug benefit?

Yes. However, not every pharmacy – whether a chain drug store or an independent retailer – is part of every drug plan's pharmacy network. The law requires every Medicare drug plan to have an adequate pharmacy network – based on geographic proximity to plan enrollees (including dual eligibles).

Will Medicare beneficiaries who reside in IMDs, group homes, supportive housing programs, or other congregate settings that offer on-site pharmacies (or have agreements with a pharmacy) be able to continue to get their medications as before?

In some cases, yes. As noted above, every drug plan will have its own pharmacy network. Unfortunately, this does not mean that all Medicare drug plans have established contracts with in-house pharmacies in IMDs, group homes, board and care homes, supportive housing, etc. It is critically important for CMHCs, public mental health agencies, and non-profits to know which plans their dual eligible clients and tenants have been enrolled in and to reach out to these plans and insist that their pharmacies be included in each drug plan's network. CMS has provided guidance to every Medicare drug plan encouraging them to do this.

What happens if a medication is not on a drug plan's preferred drug list or is subject to an access restriction such as "prior authorization" "fail first" or "step therapy"?

In virtually every instance (except excluded benzodiazepines) where a Medicare drug plan refuses to make a medication available, a beneficiary can seek an exception, i.e. petition the plan to waive their policy. Exceptions are available to access drugs that are:

- not on the plan's covered list of drugs (referred to as the "formulary"),
- subject to a bureaucratic hurdle (prior authorization or step therapy),
- subject to a dosage or quantity limit, or
- placed on a higher cost sharing tier.

Exception requests need to be coordinated with the prescribing physician. Medicare drug plans must generally respond to exception requests within 72 hours (24 hours in emergencies). Denial of an exception request can be appealed to an Independent Review Entity outside of the Medicare drug plan.

Are there other Web-based resources with information on Medicare Part D enrollment?

www.medicare.gov

www.mentalhealthpartd.org

www.maprx.info

<http://www.cms.hhs.gov/partnerships/downloads/whatif1.pdf>

