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Evaluation of State Implementation of MMA Prescription Drug Benefits for Dual Eligibles with Serious Mental Illness

Final Report

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CONTENTS

CHAPTER PAGE

Chapter 1 Introduction 1

I. Purpose of the Study 1

II. Background 4

Medicaid Prescription Drug Coverage 4

Overview of Medicare Part D 5

Special Features of Part D for Dual Eligibles 7

Part D Coverage of Psychotropic Medications 8

III. Federal Implementation of Part D for Dual Eligibles 9

Outreach and Transition 9

Maintaining Access to Prescription Drugs 10

Additional Transition Challenges 12

Chapter 2 State Implementation of Part D Benefits for Dual Eligibles with Serious Mental Illness 14

I. Activities to Help Dual Eligibles with SMI Understand the Change from Medicaid to Part D 14

Planning 14

Information Dissemination 16

Training 16

II. Activities to Help Dual Eligibles with SMI Select and Enroll in a PDP 17

State-Level Support for Plan Selection 18

Local Provider Support for Plan Selection 19

III. Activities to Help Dual Eligibles with SMI Obtain Medications 20

State Wraparound Coverage of Medications 21

Local Provider Assistance 22

IV. Activities to Help Dual Eligibles with SMI Meet Copayment Requirements 23

State Wraparound Coverage of Copayments 23

Local Assistance with Copayments 24

Conclusion 24

Chapter 3 Remaining Challenges to Implementing the Part D Benefit for Dual Eligibles with Serious Mental Illness 26

I. Informing Dual Eligibles with SMI about Part D 26

II. Assisting with Plan Selection and Enrollment 27
Gathering Information about Current Medications 27
Restrictions on Third Parties Handling Plan Changes 28
Strains on Provider Resources 28
Delays in the Enrollment Process 28
III. Ensuring the Best PDP Coverage 29
Exceptions and Appeals 30
"All or Substantially All" Coverage Requirement 30
Transition and Grandfathered Coverage 30
Point-of-Sale Coverage 31
Injectable and Infusible Medications 31
Unit-Dose Dispensing 31
IV. Helping with Copayments 32
V. Monitoring the Effects of Part D 32
VI. Epilogue 33

TABLE OF EXHIBITS

NUMBER PAGE

1. Medicaid Eligibility Categories of Full-Benefit Dual Eligibles 2
2. Medicaid Prescription Drug Coverage in Study States 5
3. Key Features of the Medicare Part D Benefit 6
4. Part D Provisions for Dual Eligibles 8
5. Agency and Organizational Roles in Dual Eligible Enrollment in Part D 10
6. State-Identified Transition Challenges for Dual Eligibles with Serious Mental Illness 13

Chapter 1
Introduction

I. Purpose of the Study

The Department of Health and Human Services Assistant Secretary for Planning and Evaluation contracted with RTI International and its subcontractor, Human Services Research Institute (HSRI), to study states' experience implementing Medicare Part D for dual eligibles with serious mental illness (SMI).

Medicare Part D, created under Title I of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (P.L. 108-173), transitioned prescription drug coverage from Medicaid to Medicare for individuals who are dually eligible for both Medicare and Medicaid coverage. The shift from Medicaid to Part D changed many aspects of dual eligibles' prescription drug coverage, including drug formularies; cost-sharing requirements; the network of pharmacies available to fill prescriptions; and procedures for obtaining medications, such as utilization management. These changes affect how dual eligibles obtain prescription drugs and the types of medications they can receive.

Dual eligibles must satisfy the eligibility requirements for both Medicare and Medicaid. Medicaid beneficiaries *who qualify for Medicare as well as full Medicaid benefits* are called full-benefit dual eligibles. In addition to their Medicare benefit, these dual eligibles receive Medicaid services not covered by Medicare. Medicaid also pays their Medicare cost-sharing requirements (Part B premium, Part A premium if relevant, annual deductible, and coinsurance payments).[1] This study focuses on full-benefit dual eligibles with SMI. In this report, the term "dual eligibles" refers to full-benefit dual eligibles only.

Medicare covers two main groups: (1) people age 65 and over and (2) disabled people under age 65 who receive Social Security Disability Insurance (SSDI) benefits. Medicaid is a joint state-federal program that provides health care for certain low-income populations, including elderly persons and individuals with disabilities. Medicare beneficiaries can qualify for Medicaid under several eligibility categories, which are summarized in Exhibit 1. To qualify for Medicaid, Medicare beneficiaries' assets and income, including their monthly SSDI benefits, must be low enough to meet their states' Medicaid eligibility requirements.

In 2003, full-benefit dual eligibles represented approximately 16 percent of Medicare beneficiaries[2] and 12 percent of Medicaid enrollees.[3] About two-thirds of dual eligibles are age 65 and over, while one-third are disabled individuals under age 65.[4]

SMI is characterized by alterations in thinking, mood, or behavior that are sufficiently severe as to be outside the norm. They must be either sustained or recur over a period of time to be considered a serious mental illness. Almost 38 percent of dual eligibles report that they have a mental illness or mental disorder.[5] Dual eligibles under age 65 are substantially more likely to report having a mental illness or mental disorder (59 percent) than those age 65 and over (12 percent).[6] These estimates overstate the prevalence of mental illness, particularly among the under 65 population, because they include mental retardation. A recent study estimated that SMI is the primary disabling condition for 40 percent of dual eligibles aged 21-64 who receive both

Exhibit 1. Medicaid Eligibility Categories of Full-Benefit Dual Eligibles

Basis of Eligibility	Mandatory or Optional Coverage
Supplemental Security Income (SSI) recipients	Mandatory[a]
Medically needy individuals who spend down their income to state-specific Medicaid eligibility levels	Optional
Individuals in institutions or individuals receiving care through a home and community-based services (HCBS) waiver, with incomes up to 300% of the maximum SSI benefit	Optional
Individuals with incomes up to 100% of the federal poverty level (FPL) and assets up to SSI resource limit	Optional

[a] Some state Medicaid programs apply more restrictive income or asset limits than those required for SSI.

Supplemental Security Income (SSI) and SSDI benefits.[7] These estimates include people disabled due to major affective disorders, schizophrenia and psychoses, anxiety and neurotic disorders, and other mental health disorders, but not mental retardation.[8] They understate the prevalence of SMI among dual eligibles because an individual with another primary disabling condition may have a co-occurring mental disorder.

Many dual eligibles use psychotropic medications. In 2001, 47 percent of dual eligibles under age 65 had a prescription for an antidepressant and 31 percent were prescribed antipsychotics. Utilization was lower among dual eligibles age 65 and over; 38 percent were prescribed antidepressants and 20 percent used an antipsychotic.[9]

This report focuses on dual eligibles with SMI for several reasons. Prescription drugs are a critical component of treatment for people with SMI. This population faces potentially serious negative consequences if their medication regimens are disrupted. Such disruptions can have serious repercussions, because this population relies on prescription drugs not just to manage their conditions, but also to maintain functioning.

This population was considered to be at risk for disruptions in their medication regimens during the transition to Part D for two main reasons. First, establishing and maintaining a medication regimen can be very difficult for persons with SMI. Effective medication regimens are highly individualized and may take months of trials with different drugs and dosages to find one that works. Additionally, the fluctuating nature of psychiatric conditions requires ongoing monitoring and may require frequent changes in the type of drug or dosage, as well as the need for additional prescription drugs. Furthermore, without medications, persons with SMI often lack insight into

and awareness of their problems. Once medicated and stable, these persons may perceive their improved mental status as recovery and discontinue their medications. This cycle is compounded by the fact that psychotropic medications have serious side effects. These serious side effects alone often act as a deterrent to following a medication regimen. Also, an individual's medications may stop working altogether. Therefore, any difficulty obtaining medications may increase the likelihood of individuals discontinuing their medication regimens.

Second, even when people are taking their medications and are stable, they may still have cognitive deficits and lack the ability to focus and concentrate sufficiently to interpret information and make decisions. These deficits may be compounded by low literacy, making it more likely that persons with SMI will have difficulty learning about and understanding new policies and procedures to obtain their medications, specifically, making the necessary decisions to negotiate the Part D benefit and ensure that the plan in which they are enrolled meets—and continues to meet—their needs.

Thus, dual eligibles with SMI are at higher risk than other dual eligibles of experiencing disruptions in their medication regimens. Any disruption to their medication regimen can have devastating effects. If dual eligibles with SMI interrupt or prematurely stop their medication regimens, or if the medications lose their effectiveness, the crisis that results is psychologically costly to the person and financially costly to the health care system.

Historically, states have had a unique role in the provision of care for people with SMI. States are a likely resource for assistance to this population during its transition from Medicaid to Part D for coverage of prescribed medications. Disruptions in medication regimens for dual eligibles with SMI can increase their use of crisis intervention, emergency room, inpatient psychiatric, and other services funded not just by Medicare, but by Medicaid and state mental health agencies. Thus, although Part D eliminated states' responsibility for providing prescription drug coverage to all dual eligibles, state agencies and local providers have an interest in ensuring that dual eligibles, particularly those with SMI, obtain needed medications.

Part D implementation varies across states because of differences in Medicaid prescription drug coverage and in publicly funded mental health services. This report describes state agency and local provider efforts to assist dual eligibles with SMI in the transition to Part D in six states—Massachusetts, Missouri, New Jersey, North Carolina, Oregon, and Texas (hereafter called "the study states"). This report also discusses the challenges faced by these six states, their strategies to address the challenges, and the ongoing challenges they were not able to address.[10] Because none of the study states tabulate data on the number of dual eligibles with SMI (or other health conditions), the size of the populations in these states is unavailable.

Our study was limited to Part D implementation for community-dwelling dual eligibles with SMI because they face different challenges under Part D than do institutionalized individuals, who are exempt from all cost-sharing requirements under Part D and who receive medications through different distribution systems. Although the original study design included both dual eligibles with SMI and those with substance use disorders, the individuals that were interviewed considered Part D effects on people with substance use disorders less significant, in part because most state expenditures for substance use treatment are for non–dual eligible Medicaid beneficiaries. In addition, prescription drugs are not a primary component of addiction treatment

in many states. As a result, state substance abuse treatment agencies in the study states reported that they were largely unaffected by Part D and had not followed the program closely. Consequently, this study focused only on dual eligibles with SMI.

The study did not compare Medicaid and Medicare prescription drug benefits. Rather, the study focused on the first year of Part D implementation in 2006 and the early transition challenges for dual eligibles with SMI. This report identifies these challenges; state and federal strategies designed to address them; and ongoing challenges, some of which the Centers for Medicare & Medicaid Services (CMS) addressed after the study period. See Appendix A for an in-depth description of the methods used to conduct this study.

Note on Terminology

Throughout this report, the term "beneficiaries" will be used when referring to all individuals eligible for Medicare. The term "dual eligibles" will be used to refer to all individuals eligible for both Medicare and Medicaid benefits, i.e., full-benefit dual eligibles as defined above—including those with SMI. The term "dual eligibles with SMI" will be used when discussing this specific population.

II. Background

Medicaid Prescription Drug Coverage

States have the option of covering outpatient medications under Medicaid, and all states have elected to provide this benefit. Prior to implementation of Part D, dual eligibles in all states received prescription drug coverage through Medicaid. State Medicaid programs have flexibility to manage their prescription drug benefits, but they may not have closed formularies[11] and they must provide any drug when shown to be medically necessary for a particular individual.

State Medicaid programs, like other insurers, have experienced substantial growth in prescription drug expenditures. To control the rapid increase in drug costs among Medicaid beneficiaries, all states have adopted one or more cost-containment mechanisms. These include the use of a preferred drug list (PDL), prior authorization requirements, fail-first or step therapy, generic mandates, and limits on the number of prescriptions. However, states often exempt psychotropic medications, especially antipsychotics and antidepressants, from these requirements.[12,13]

Some Medicaid programs require beneficiary copayments for prescription drugs, although federal law requires pharmacists to dispense prescriptions to Medicaid beneficiaries even if they cannot make the copayment. Exhibit 2 shows selected features of Medicaid prescription drug coverage in the study states, including use of a PDL, beneficiary cost-sharing requirements, and limits on the number of prescriptions. Prescription drug coverage varies substantially in the study states. Three have a PDL, but only one state's PDL included psychotropic medications prior to 2006. Four of the six study states require copayments for prescriptions, although one of these states exempts people that receive institutional or community-based long-term care services. Two study states limit the number of prescriptions that can be filled each month.

Exhibit 2. Medicaid Prescription Drug Coverage in Study States

State	Preferred Drug List (PDL)	Beneficiary Cost-Sharing	Prescription Limits
Massachusetts	No PDL	$1 for generic and $3 for brand-name medications	None
Missouri	• PDL • Psychotropic medications excluded	$0.50-$2.00 depending on the price of the medication	None
New Jersey	No PDL	None	None
North Carolina	• No PDL • Has a list of preferred medications that is a voluntary guide to preferred prescribing practices	$3 for generic and brand-name medications	• Starting June 2006, adults limited to eight prescriptions per month • Override allowed for up to three additional prescriptions per month
Oregon	• PDL for individuals that receive fee-for-service prescription drug coverage • Psychotropic medications not included on PDL prior to 2007 • Depends on plan for individuals enrolled in fully capitated health plans	• $2 for generic and $3 for brand-name drugs for individuals with fee-for-service coverage • People receiving long-term care services (institutional and community based) are exempt • Depends on plan for individuals enrolled in fully capitated health plans	None
Texas	PDL	None	• Three prescriptions per month • People receiving long-term care services (intuitional and community based) are exempt

Overview of Medicare Part D

Medicare Part D is a voluntary prescription drug benefit available to all Medicare beneficiaries entitled to Medicare Part A or enrolled in Medicare Part B. Exhibit 3 summarizes key features of the Part D benefit.

Exhibit 3. Key Features of the Medicare Part D Benefit

Feature	Description
Delivery system	Part D benefit is provided through two types of private plans: • Stand-alone prescription drug plans, which only cover prescription drugs. • Medicare Advantage prescription drug plans, which are managed care plans that cover other Medicare services in addition to prescription drugs.
Plan enrollment	• Beneficiaries can enroll in any of the stand-alone or Medicare Advantage plans available in their region. • Beneficiaries can only switch plans during annual open enrollment.
Premium	Varies by plan
Standard benefit design	
Annual deductible	$250
Coverage gap	Beneficiaries are responsible for 100% of drug costs in coverage gap (between $2,251 and $5,100 in total drug costs in 2006).
Coinsurance	• 25% below coverage gap • 5% above coverage gap
Low-income subsidy	Beneficiaries with limited income and assets receive assistance with Part D cost-sharing requirements, including premium, deductible, coverage gap, and coinsurance. Level of subsidy depends on dual eligibility for Medicaid, income, and assets.
Pharmacy network	Varies by plan
Formulary	Varies by plan • All plans are required to meet minimum formulary requirements established by CMS, which include covering at least two drugs in each therapeutic category.
Exceptions and appeals process	• There is expedited, 24-hour review of exception requests for drugs deemed necessary for the health of the beneficiary. • Review of other drugs must be completed within 72 hours. • Up to five additional levels of appeal are available.

Private health plans administer the Part D prescription drug benefit either through stand-alone prescription drug plans (PDPs) or through Medicare Advantage prescription drug (MA-PD) plans that also cover other Medicare benefits. Beneficiaries pay a monthly premium to enroll in a Part D plan. Enrollees are only permitted to change plans during the annual open enrollment period, with some exceptions for dual eligibles, as described later in this report.

Plans are permitted to define their benefit packages within parameters established by Congress and CMS. The MMA mandated a standard Part D benefit design that includes an annual deductible, coinsurance, and a coverage gap (see Exhibit 3). Plans can modify this benefit design as long as their benefit is actuarially equivalent to the standard benefit, or enhanced. For example, rather than charging a uniform 25 percent copayment below the coverage gap, most

plans charge tiered copayments that differ for generic drugs, brand-name drugs on a preferred list, and non-preferred brand-name drugs.

Medicare beneficiaries with low incomes and assets receive subsidies for Part D cost-sharing requirements through the low-income subsidy, also known as the Extra Help program. Dual eligibles are automatically eligible for Extra Help. The low-income subsidy substantially reduces or eliminates beneficiaries' out-of-pocket payments for PDP premiums, deductibles, coinsurance, and drugs needed during the coverage gap. The level of subsidy depends on an individual's income, assets, and dual eligibility for Medicaid. The low-income subsidy for dual eligibles is described in the following section.

Plans also vary in the drugs included in their formularies, the tier of coverage a drug has, and the features of their utilization management plans. However, all plans are required to meet minimum formulary requirements established by CMS, which include coverage of at least two drugs in each therapeutic category of Part D drugs. Plans are required to have a process for requesting exceptions to coverage decisions and, if a plan denies an exception request, a beneficiary can proceed through up to five levels of appeal.

Plans also must have a procedure to provide temporary coverage of medications not on their formulary for individuals who are taking them at the time of enrollment. This policy allows time to obtain an exception to the formulary or to arrange for a prescription for an alternative medication covered by the formulary. In 2006, CMS recommended, but did not require, that plans provide a 30-day transition supply of nonformulary medications. As of 2007, CMS requires all plans to provide 30-day transition coverage.

Special Features of Part D for Dual Eligibles

Part D includes several features to ensure that dual eligibles do not experience interruptions in their access to prescription drug coverage and to assist them with the cost-sharing requirements. These features are summarized in Exhibit 4.

All dual eligibles are automatically enrolled in Part D and randomly assigned to one of the PDPs in their region that has a premium below the subsidy benchmark.[14] This benchmark is the ceiling for the premium subsidy available through the low-income subsidy program. If beneficiaries are not satisfied with their assigned plan, they can switch plans as often as monthly throughout the year. The option to find a plan that best meets their needs initially, and to change plans as plan formularies change or as their medications change, is an important protection for dual eligibles, many of whom have extensive medication needs.

Dual eligibles receive assistance with Part D cost-sharing requirements through the low-income subsidy in three ways. First, they are not required to pay a premium if they enroll in a PDP with a premium below the subsidy benchmark. Those who enroll in a higher-cost plan have to pay the difference between the plan's premium and the subsidy benchmark. PDPs available to dual eligibles with no premium may change from year to year, because some PDPs may no longer participate in Part D or their premium may exceed the subsidy benchmark in the new contract year. In these cases, CMS automatically reassigns dual eligibles if they are still enrolled in the PDP to which they were assigned previously. Those who switch from their assigned plan are not automatically moved, even if their PDP's premium no longer falls below the benchmark.[15]

Exhibit 4. Part D Provisions for Dual Eligibles

Provision	Description
Part D enrollment	Dual eligibles are automatically enrolled in Part D.
Plan enrollment	▪ Dual eligibles are automatically assigned to a PDP with a premium below the subsidy benchmark. ▪ Dual eligibles can switch from an assigned plan to any of the plans available in their region. ▪ Dual eligibles can switch plans monthly.
Premium	None if enrolled in a plan with a premium below the subsidy benchmark.
Annual deductible	None
Coverage gap	None
Copayment[a] based on income	
Income <100% of federal poverty level	▪ $1 for generic and $3 for brand-name drugs below the upper limit of the coverage gap. ▪ None above the upper limit of the coverage gap.
Income >100% of federal poverty level	▪ $2 for generic and $5 for brand-name drugs below the upper limit of the coverage gap. ▪ None above the upper limit of the coverage gap.

[a] Institutionalized dual eligibles are not responsible for copayments.

Second, dual eligibles do not have to pay the annual Part D deductible. Third, their copayments are limited. In 2006, those with incomes below 100 percent of the federal poverty level (FPL) paid only $1 per prescription for generic drugs and $3 for brand-names. Those with incomes above 100 percent of the FPL paid $2 for generic drugs and $5 for brand-names. Dual eligibles are not subject to the coverage gap and do not have to make copayments when total drug costs exceed the upper limit of the coverage gap ($5,100 in 2006).

Part D Coverage of Psychotropic Medications

Although plans are generally required to cover two medications in each therapeutic class, CMS requires that plan formularies include "all or substantially all" medications in six protected classes, including antidepressants and antipsychotics.[16] CMS recognized that maintaining ongoing access to current psychotropic medications is particularly important because the medications' effectiveness varies substantially across individuals, and successful prescribing often results from an extended process of trial and error. For medications in these classes, plans are permitted to apply utilization management tools, including prior authorization requirements, step therapy, quantity or dosage limits, and higher copayments for higher-tier prescriptions. However, plans also are required to provide continuing "grandfathered" coverage of

prescriptions in the six protected classes for patients who are on a stable medication regimen at the time of enrollment, without additional requirements for prior authorization or step therapy.

The MMA excluded certain drugs and drug classes from coverage under Part D. Most significantly for dual eligibles with SMI, Part D excludes coverage of benzodiazepines.[17] State Medicaid programs vary in their coverage of many of the Part D excluded drugs, but most states cover benzodiazepines. Prior to Part D implementation, approximately 24 percent of dual eligibles had Medicaid-covered prescriptions for benzodiazepines.[18] Although state Medicaid programs no longer receive federal financial participation for most outpatient prescription drugs provided to dual eligibles, they have the option of covering these excluded drugs for dual eligibles and receiving federal matching payments.

III. Federal Implementation of Part D for Dual Eligibles

CMS developed a multipronged strategy to assist dual eligibles in making the transition from Medicaid prescription drug coverage to Part D.[19] In addition to program design features intended to ensure continuity in drug coverage and additional protections for people using psychotropic medications, CMS' transition strategy included outreach and education activities to inform dual eligibles about the new program. This section describes these activities, as well as transition challenges that remain.

Outreach and Transition

In May 2005, CMS sent a letter to dual eligibles about the upcoming change in their prescription drug coverage. A second mailing in November 2005 informed dual eligibles of the PDP to which they had been assigned and of their right to change plans. Both letters referred to educational materials available to all Medicare beneficiaries, including the "Medicare & You" handbook, Web sites (www.Medicare.gov), and toll-free phone lines.

CMS coordinated its outreach and transition activities for dual eligibles with the states. All state Medicaid programs were required to notify dual eligibles about the change in their prescription drug benefits, and CMS worked with states to develop language for a model state letter. CMS also developed a document describing model state activities for Part D implementation in order to assist states in developing transition programs for the dual eligible population.[20] This document lists best practices for state Medicaid programs and examples of state activities. The best practices include providing outreach and education, providing wraparound coverage of copayments and medications not covered under Part D, establishing work groups and coordinating with other government programs, planning to ease transition for dual eligibles, and preparing a monthly low-income subsidy file to identify dual eligibles for CMS.

Other CMS activities included

- Initiating a State Issues Workgroup to increase communication between CMS, the Social Security Administration (SSA), and state Medicaid agencies regarding the transition.

- Conducting a series of conference calls, meetings, and workshops to keep states informed about federal implementation activities.

- Working with nonprofit organizations, community-based organizations, and providers in outreach activities for dual eligibles and other low-income Medicare beneficiaries.

- Sponsoring the Access to Benefit Coalition, a coalition of beneficiary and patient support organizations that targets the population eligible for the low-income subsidy.

- Implementing the Regional Education About Choices in Health (REACH) campaign—a nationally coordinated campaign (implemented by CMS regional offices in partnership with local community organizations) to educate low-income Medicare beneficiaries about the low-income subsidy.

- Informing providers about the transition of dual eligibles through its Medlearn Matters Web site, provider mailings, professional associations, and open door forums.

- Offering training on Part D—in conjunction with staff from the SSA—to state staff, beneficiaries, providers, and advocacy groups.

The CMS-funded State Health Insurance Assistance Programs (SHIPs) also offered information and counseling about Part D to all Medicare beneficiaries.

Maintaining Access to Prescription Drugs

Completing dual eligibles' enrollment in PDPs and enabling them to obtain Part D benefits at a pharmacy requires multiple steps and data exchanges among several parties, including the SSA, state Medicaid agencies, CMS, PDPs, beneficiaries, and pharmacies. Every time a dual eligible changes plans, updated plan enrollment information must be conveyed to CMS, the affected PDPs, the beneficiary, and pharmacies. Exhibit 5 summarizes the role played by each of these organizations, as well as the data exchanges required for dual eligibles to obtain Part D benefits.

Exhibit 5. Agency and Organizational Roles in Dual Eligible Enrollment in Part D

Organization	Role and Required Data Exchange
SSA	Sends information on Medicare beneficiaries to CMS and states that automatically grant Medicaid eligibility to Medicare beneficiaries who receive SSI.
State Medicaid agency	Identifies dual eligibles using data on Medicare eligibles received directly from SSA or via CMS. Sends list of dual eligibles to CMS.
CMS	Assigns new dual eligibles to a PDP and transmits enrollment information to PDPs.
PDP	Sends PDP card to enrollees.
Dual eligible	Presents PDP card at pharmacy to obtain benefits.
Pharmacy	Uses enrollment information on dual eligible's PDP card or accessed through CMS to bill PDP for prescriptions.

A U.S. Government Accountability Office (GAO) report found that it can take at least five weeks from the time an individual first becomes a dual eligible and qualifies for Part D until PDP enrollment information is communicated to pharmacies and a card is sent to the individual.[21] In its analysis of the reasons for this time gap, GAO found that, in addition to the numerous steps and parties involved in the process, batch processing rather than real-time processing systems are used. Ensuring timely data exchanges for dual eligibles who change plans is particularly challenging because the enrollment change takes effect on the first day of the following month, regardless of how late in the month the change is requested.

Even before Part D was implemented, CMS anticipated that there might be gaps in dual eligibles' prescription drug coverage when transitioning from Medicaid to Part D. The reason cited for these gaps is the time required to transmit information about their dual eligibility status and plan enrollment among state Medicaid agencies, CMS, PDPs, and pharmacies. While CMS expected this problem to arise most often during the initial implementation of Part D, when all current dual eligibles transitioned to Part D coverage, CMS recognized that it also would be an ongoing problem for new dual eligibles and for dual eligibles who switch plans during the year.

To address this situation, CMS contracted with a vendor to provide coverage for medications at point of sale if evidence is provided to verify that the individual is a dual eligible, even though PDP enrollment cannot be identified through a query to a centralized eligibility database. In these cases, the pharmacist can enroll the dual eligible in a PDP operated by WellPoint (the point-of-sale vendor), fill the prescription, and bill WellPoint for the drugs. WellPoint was chosen as the point-of-sale plan because it has PDPs and pharmacy networks in all 50 states.

Even with the point-of-sale system, which has been in place since the inception of Part D, dual eligibles have encountered significant problems obtaining their Part D benefits when they first become eligible and when they switch plans. Pharmacies find it difficult to obtain information on dual eligibles' plan enrollment in a timely and accurate manner, particularly for those dual eligibles that switched from the plan to which they were assigned. Some individuals are not identified as being dual eligibles and are inappropriately charged deductibles and higher copayments. PDPs also have not consistently followed CMS' transition protocol, which requires them to cover a single refill of an existing prescription that is not on the plan's formulary.[22]

During the early months of implementation, when these problems were most widespread, CMS regional office staff intervened to help resolve dual eligibles' eligibility and enrollment problems, and many states passed emergency laws to address them. These emergency laws allowed Medicaid programs to provide temporary prescription drug coverage for dual eligibles who were not able to receive their medications through their PDP. As the extent of these problems became evident in the first weeks of Part D operation, CMS stepped in to alleviate this unanticipated financial burden on states. CMS implemented a demonstration program that allowed Medicare to reimburse state Medicaid programs for medications covered for dual eligibles, if the states were not able to receive payment from a PDP.[23] The demonstration covered costs incurred only through March 31, 2006. Since that date, states are responsible for all Medicaid expenditures for Part D-covered medications provided to dual eligibles.

CMS has developed two other procedures to help address ongoing challenges that dual eligibles have faced in obtaining Part D benefits. First, CMS created an eligibility query system that

provides PDP billing information to pharmacies when dual eligibles do not have their PDP card. Second, in August 2006, CMS implemented a new prospective enrollment system intended to eliminate enrollment gaps for Medicaid beneficiaries who are expected to become dual eligibles in the near future, either because of their age or because they are near the end of their 24-month disability waiting period. States can include these beneficiaries on the monthly dual eligible file that is sent to CMS before they become dual eligibles. CMS assigns these beneficiaries to a PDP 2 months prior to the date they are expected to become dually eligible. This early assignment is intended to enable all enrollment information exchanges to be completed by the eligibility date for individuals whose impending dual eligibility can be identified in advance.

Additional Transition Challenges

Despite federal efforts aimed at addressing transition and enrollment challenges for dual eligibles generally, states anticipated that dual eligibles with SMI would face additional challenges in their transition to Part D prescription drug coverage. The challenges involve (1) understanding the change in their prescription drug coverage from Medicaid to Part D, (2) selecting and enrolling in a PDP that meets their medication needs, (3) obtaining needed medications, and (4) meeting Part D copayment requirements. Exhibit 6 describes the anticipated challenges in each of these areas. The case studies in the next chapter of this report describe the study states' efforts to address these challenges.

Exhibit 6. State-Identified Transition Challenges for Dual Eligibles with Serious Mental Illness

Challenge	Description
Understanding change in prescription drug coverage	▪ Communication with dual eligibles with SMI can be very challenging, because many have cognitive impairment or low literacy levels. ▪ Traditional communications methods, such as mailings, are of limited utility because this population may have transient living arrangements. ▪ Many, if not most, individuals in this population are unlikely to have access to computers. If they do have access, they may lack the ability to use the tools on the CMS Web site.
Selecting and enrolling in a PDP	▪ Selecting a PDP that will ensure the best possible coverage is a complex process, particularly for those who take many medications. Which PDP is best depends on several factors: whether the PDP covers the medications currently used, whether utilization management controls are applied to these medications, whether the PDP network includes customarily used pharmacies, and whether network pharmacies are easily accessed. ▪ Because the assignment process does not take into account an individual's medication history or whether the PDP's network includes pharmacies that are readily accessible to the individual, some individuals are likely to switch from the plan to which they are assigned. ▪ Individuals with cognitive limitations and low literacy levels in this population will need assistance selecting and enrolling in a new plan.
Obtaining needed medications	▪ Individuals in this population with cognitive limitations and low literacy levels will also need assistance complying with formulary utilization management requirements, completing exceptions and appeals processes, and resolving enrollment problems that lead to coverage denials. ▪ Because costly antidepressants and atypical antipsychotics are likely to require prior authorization or step therapy, individuals likely will need assistance completing exceptions procedures. ▪ Some individuals may need benzodiazepines, which are excluded from Part D coverage.
Meeting Part D copayment requirements	▪ Individuals with SMI often have prescriptions for many medications, particularly if they use medications for both physical and psychiatric conditions. For individuals taking multiple medications, even reduced cost-sharing obligations can be unaffordable.

Chapter 2
State Implementation of Part D Benefits for Dual Eligibles with Serious Mental Illness

CMS anticipated that the introduction of Part D coverage of prescription medications would pose special challenges for dual eligibles who would be transitioning into Part D coverage from prescription drug coverage under their state's Medicaid program. CMS also expected that unique issues might arise for people with SMI. As described in Chapter 1, federal implementation of Part D included a number of provisions to address challenges for these populations. Nonetheless, state agencies and local entities expected additional challenges for dual eligibles with SMI. These challenges, also described in Chapter 1, include ensuring that dual eligibles with SMI are able to

- Understand the change in their prescription drug coverage from Medicaid to Part D.
- Select and enroll in a PDP that meets their medication needs.
- Obtain needed prescription medications without disruptions in coverage.
- Meet Part D copayment requirements.

This chapter describes efforts in the six case study states to address challenges that arose in each of these areas. Activities within these states occurred at the state and local provider agency level and, in some cases, involved the support of various statewide organizations. Local providers included case managers and care providers at mental health agencies, staff at case management agencies, staff at county mental health departments, and pharmacists. Some of the study states' activities were aimed at assisting all Medicare beneficiaries, some were aimed at dual eligibles—including those with SMI—and some were targeted solely to dual eligibles with SMI.

I. Activities to Help Dual Eligibles with SMI Understand the Change from Medicaid to Part D

Although Part D is a federal program, state agencies and local entities recognized that they would be affected by the introduction of the new benefit and would need to develop plans for the transition of prescription drug coverage for dual eligibles with SMI. In all of the study states, state agencies recognized that federal efforts to inform Medicare beneficiaries as a whole about the Part D benefit were unlikely to meet the needs of this group of individuals. In response, they developed state-level initiatives to inform dual eligibles with SMI, their providers, and other people who support them about the change in prescription drug benefits. State staff believed targeted efforts were required to ensure that dual eligibles with SMI were aware of the change in their prescription drug benefits and understood what they needed to do to obtain their medications.

Planning

Each of the study states began planning for the transition of all dual eligibles to Part D well before the program's implementation. This planning was often coordinated across state agencies

and sometimes included providers and other groups. Several of the states undertook particularly comprehensive planning efforts. These coordinated activities had an additional benefit of strengthening communication across state agencies and among entities that would not normally be in contact, such as SHIPs and state mental health agencies.

Massachusetts' Executive Office of Health and Human Services (EOHHS), which houses both the Office of Medicaid and the Department of Mental Health (DMH), organized a steering committee to prepare for Part D implementation. The steering committee, co-led by staff from the Office of Medicaid and the Office of Elder Affairs, included representatives from nearly all EOHHS agencies that serve the Medicare population. DMH staff focused on issues specific to dual eligibles with SMI. State staff viewed the steering committee as an effective vehicle for making connections across agencies within EOHHS, as well as a valuable source of information on Part D.

Subcommittees addressed topics such as coordination of benefits and wraparound coverage, information systems issues, and communications. The communications subcommittee comprised state staff and representatives from outside organizations, including CMS, SSA, and MassMedLine (a partnership between the Office of Elder Affairs and the Massachusetts College of Pharmacy and Health Sciences, which provides information on insurance and discount programs for prescription drugs, as well as clinical information on medications).

New Jersey created a collaborative cross-agency team that also included stakeholders and advocates. This team identified issues that needed to be addressed and advocated for action to address them at the state and federal levels. At the state level, the team advocated with the state legislature for wraparound coverage of medications and copayments. The team advocated with federal policy makers for coverage of "all or substantially all" medications in the six protected classes. The collaborative team also identified system needs related to Part D implementation and developed training on Part D. After implementation of Part D, New Jersey continued to address Part D topics through regular meetings of groups that included mental health agency medical directors and state hospital staff. The state also established a listserve that included providers, the New Jersey Mental Health Association, the National Alliance on Mental Illness (NAMI) in New Jersey, the New Jersey Association of Mental Health Agencies, and the Arc of New Jersey.

The other four study states developed similar state-level interagency committees. North Carolina created a Medicare Partners Committee, sponsored by the Department of Medical Assistance (the state's Medicaid agency). The committee brought together stakeholders from various agencies and divisions and forged new alliances, including one between the mental health community and the North Carolina SHIP. In Texas, the Health and Human Services Commission, the Department of State Health Services, and the Department of Aging and Disability Services formed an implementation work group in 2003 to start preparing for Part D. Oregon's Department of Human Services (which includes the state's Medicaid agency and the state mental health authority) and the state insurance commissioner collaborated on developing strategies to minimize adverse effects on dual eligibles pertaining to the transition from Medicaid to Part D coverage of prescription drugs. Missouri's Medicaid program, the Division of Medical Services, and the Missouri DMH collaborated to review mailings sent to clients and health professionals who prescribe psychotropic medications.

Information Dissemination

As required by CMS, the Medicaid agencies in the six study states sent a letter to dual eligibles informing them that their prescription drug coverage would change from Medicaid to Medicare Part D on January 1, 2006. Similar letters were sent to dual eligibles with SMI who were receiving services from state mental health agencies.

SHIPs in all six study states offered information sessions on Part D, although these typically were oriented toward all Medicare beneficiaries and did not focus on the specific needs of dual eligibles in general or the subset with SMI. North Carolina's SHIP, which receives additional state funding, was the exception, playing a crucial role in Part D outreach and education for dual eligibles. The North Carolina SHIP also became involved more actively with dual eligibles as an outgrowth of Part D implementation. The North Carolina SHIP established a toll-free number that is considered especially helpful to consumers living in rural areas.

In contrast, SHIP staff in most of the other study states were not educated about the special provisions for dual eligibles, such as their option to enroll in certain plans without paying a premium. SHIP staff also lacked experience in communicating with people with SMI. Compared to working with other Medicare beneficiaries, assisting dual eligibles with SMI often requires a great deal more patience, simpler explanations, and the ability to respond appropriately to high anxiety or to questions and responses that may seem illogical.

Four of the six study states—Missouri, North Carolina, Oregon, and Texas—developed Web sites with information about Part D. Some Web sites target beneficiaries, while others target providers. Texas' Department of Aging and Disability Services operates a continuously updated Web site that provides information about Part D policies and procedures. Through September 2007, 194 notices concerning Part D were posted on this Web site. However, local providers and advocates noted that Web sites are not effective for reaching dual eligibles directly because many lack access to the Internet.

Training

The study states recognized that dual eligibles with SMI would require individualized assistance that could only be provided at the local level. To address this need, state training activities focused primarily on providers who have direct contact with beneficiaries and could provide one-on-one assistance. All of the study states developed and offered training on Part D to educate mental health and other provider agency staff about its implications for their clients. For example, during 2005, Oregon conducted 51 training and orientation sessions around the state. These sessions targeted county and provider agency staff who support elderly persons and people with disabilities, including those with SMI. An estimated 5,000 individuals attended these sessions.

All of the study states used a train-the-trainer approach, enabling attendees to educate their staff. Most training was conducted prior to Part D implementation, although some states conducted ongoing training. Once trained, local provider agency staff were able to take an active role in informing their clients about the new program and helping them review their PDP assignment. In

response to high staff turnover, a provider in Massachusetts developed an online training curriculum about Part D to eliminate the need to continually conduct in-person training.

New Jersey was especially active in the training area. The state conducted many Part D training sessions and conferences specifically targeting the mental health advocacy community and providers. Separate training sessions were offered to staff at state psychiatric hospitals, providers of state-funded community mental health services, health professionals who prescribe medications (hereafter, prescribers) in the state-funded mental health system, and pharmacists. Forums were presented to the mental health advocacy community, legislative staff, and hospital- and community-based providers in private practice. A brochure was developed specifically for pharmacists, funded by a CMS Medicaid Infrastructure Grant. The state mental health agency also met monthly with county mental health administrators to educate them and obtain information about how Part D was working for their clients.

North Carolina's SHIP conducted training sessions and continues to serve as an information resource for health department staff, pharmacies, mental health providers, local social service agencies, and legal aid staff. Prior to Part D implementation, five SHIP regional managers conducted 17 train-the-trainer sessions across the state that were attended by about 2,000 participants. Stakeholders praised the role that North Carolina's SHIP played in conducting education and training about Part D, as well as its ongoing assistance to dual eligibles.

Missouri capitalized on its capacity to analyze Medicaid claims data and identified all prescribers of psychotropic medication for dual eligibles. The state sent these prescribers information on Part D, including the enrollment process and each PDP's coverage of the antipsychotics most commonly prescribed to dual eligibles under Medicaid. The Division of Medical Services also sent pharmacies a list of dual eligibles who would be transitioning to Part D so that the beneficiaries could be identified in advance.

Both professional and advocacy associations were also involved in training their members. The Missouri Coalition of Community Mental Health Centers conducted training sessions for its members using information provided by pharmaceutical companies, NAMI, the St. Louis Mental Health Association, and the Missouri Social Work Association. The Missouri Pharmacy Association conducted training sessions for pharmacists and pharmacy technicians. The Arc of New Jersey communicated information about Part D to the developmental disability community through a series of seminars, a listserve, a Web site, and a biannual newsletter.

II. Activities to Help Dual Eligibles with SMI Select and Enroll in a PDP

In 2006, each of the study states had many PDPs in which dual eligibles could enroll without paying a premium—11 in Massachusetts, 10 in Missouri, 14 in New Jersey, 13 in North Carolina, 15 in Oregon, and 16 in Texas. However, the prescription drugs covered by each PDP did not always include those needed by a given individual. State agency staff and local providers recognized that some dual eligibles would need to switch from their assigned PDP to one offering better coverage of their current medications or one with better pharmacy access. Switches also may have been required during the year because of medication changes, the development of new conditions that require additional medication, or changes in a PDP's formulary.

Dual eligibles might also need to change plans at the end of the contract year if their current plan left Part D or if their plan was no longer premium free because it exceeded the benchmark subsidy in the new year. State agencies and local providers anticipated that reviewing PDP assignments to ensure continuity of drug coverage and accessibility of pharmacies would be particularly important for dual eligibles with SMI. Because many in this population have cognitive impairment or low literacy levels, it was expected that dual eligibles with SMI would need individual assistance with PDP selection, particularly given the multiple factors to consider and the numerous options to choose from.

State-Level Support for Plan Selection

State-level efforts to assist dual eligibles with plan selection included securing funding for state staff to provide direct assistance and distributing information to local providers to support their efforts to assist dual eligibles. North Carolina and Oregon both provided additional funding for state staff to assist with plan enrollment. Missouri and New Jersey each gave information on dual eligibles' prior prescription drug use to local providers to support efforts aimed at helping dual eligibles select a plan.

Unlike other states, the North Carolina legislature augments federal funding for its SHIP. The state's SHIP staff were actively involved with dual eligibles, assisting them in selecting plans and serving as a resource about Part D for community agency staff. In contrast, advocates and local providers in the other study states reported that SHIP staff were a less effective resource for dual eligibles, because they did not have adequate resources to meet the increased demand for assistance with Part D. Case workers in the community mental health system in other states, who might have turned to SHIP staff for information, were not consistently aware of this resource.

Oregon also provided additional funding for enrollment assistance, although not to its SHIP. In advance of Part D implementation, the Oregon legislature approved funding during the 2005-2007 biennium for 24 permanent and 33 temporary positions to assist Oregon's 70,000 dual eligibles with the transition to Part D. Most of these positions were dispersed to local Department of Health Services programs for seniors and persons with disabilities and Area Agencies on Aging offices. Oregon budgeted $5.2 million during the 2007-2009 biennium for ongoing state and local staffing. These additional staff are assisting dual eligibles with plan changes, as well as with enrollment and drug coverage problems.

Missouri has a strong history of analyzing Medicaid prescription drug utilization data to support its Medicaid disease management program and the Missouri Mental Health Medicaid Pharmacy Partnership. The Partnership seeks to improve prescribing practices for mental health medications by monitoring—and targeting educational messages to—prescribers. The Division of Medical Services capitalized on this capacity and provided information to community mental health centers (using a Web-based tool) about medications used by their dual eligible clients under Medicaid. Information about all medications, including psychotropics, was provided to help providers assist clients with plan selection.

New Jersey gave prescribers in the state-funded mental health system handheld computers that were loaded with ePocrates—software that identifies whether a drug is covered by a specific

PDP's formulary. This information could be used to support decisions about plan selection, as well as prescribing decisions after an individual is enrolled in a PDP.

Local Provider Support for Plan Selection

Direct assistance with selecting a PDP is provided mainly at the local level, such as by community mental health center case workers. Local mental health provider agencies in all of the study states provided extensive support with plan selection and enrollment to dual eligibles with SMI.

Most assistance by local providers occurred in the months leading up to implementation, when PDP assignments were reviewed for current dual eligibles transitioning to Part D coverage. However, providers noted an ongoing need for their assistance. Staff need to review PDP assignments throughout the year for new dual eligibles and for current dual eligibles because they may need to switch plans.

Typically, case workers or other staff set up in-person meetings with clients to review plan assignments. Dual eligibles are asked to bring all of their medications to the meeting in order to assess how well the assigned PDP covers their medications. Although mental health provider agencies are familiar with their clients' psychotropic medications, they do not have access to information about their medications for nonpsychiatric conditions. Having this information is particularly critical in selecting a plan, because these medications usually are not covered by the "all or substantially all" requirements and, therefore, are more likely than psychotropic medications to be entirely excluded from PDP formularies.

Provider agency staff use information from the CMS Medicare Prescription Drug Plan Finder Web site or other sources to determine whether clients' medications are covered by their assigned PDPs and whether they are subject to any utilization management controls. Those interviewed noted that dual eligibles are unlikely to have access on their own to the computer-based tools, like the Medicare Prescription Drug Plan Finder, that are available on the CMS Web site. Agency staff first need to determine whether any of an individual's medications are not covered or are subject to coverage limits; if so, staff then need to review the formularies of all other plans available to the individual to identify the best match. Individuals with more complex medication profiles are more likely to need to change from their assigned plans. Depending on the complexities of an individual's medication regimen, this review process can take several hours.

Provider agency staff also assist clients with switching plans, if needed. Although beneficiaries can complete the process for changing plans by telephone, agency staff reported that many of their clients would be unable to do this by themselves for a variety of reasons. For some, working through recorded messages, speaking with a stranger, and being placed on hold for long periods cause considerable anxiety. Others lack access to a phone for long periods, and the switching process can take 45 minutes to an hour. Although some of the case workers interviewed reported that some PDPs permit enrollees to designate someone—such as a case worker—to represent them in the enrollment process, many PDPs do not, so both the client and staff person must be on the call to make the switch.

Although staff in most provider agencies absorbed these new responsibilities into their ongoing workload, additional resources were made available in a few cases. For example, a mental health agency in New Jersey hired a temporary worker to review client medications across PDP formularies. A Texas local mental health authority (LMHA) added seven benefit staff positions to manage Part D enrollments. Another LMHA in Texas used an enrollment broker to assist its clients with plan selection. Although these efforts required additional costs, the LMHAs believe that managing the enrollment process helped avoid later coverage problems and that the costs would be offset by savings on medications that provider agencies might have had to cover out of their own funds.

In all study states, pharmacy staff also assisted dual eligibles with selecting a plan and understanding the transition to Part D. They checked enrollments for people who did not know to which PDP they had been assigned, either because they did not receive mailings, did not read them, or did not understand them. Pharmacies were particularly important sources of support for people with SMI who were not receiving ongoing case management services from community mental health agencies. In the early months of implementation, some pharmacies provided computer terminals that Medicare beneficiaries, including dual eligibles with SMI, could use to access the Medicare Prescription Drug Plan Finder on the CMS Web site.

III. Activities to Help Dual Eligibles with SMI Obtain Medications

State staff and local providers in the study states identified several factors that created challenges for dual eligibles with SMI seeking to obtain coverage of their prescription medications. These challenges arose despite requirements that PDPs cover “all or substantially all” antidepressants and antipsychotics, as well as efforts to enroll dual eligibles in PDPs that offer the best coverage of their medications.

First, it is not always possible to find a PDP that covers all of an individual’s medications. Second, local providers reported that obtaining medications in a PDP’s formulary can be challenging if they are subject to prior authorization, step therapy or other utilization management controls. These controls are particularly likely to be applied to costly medications, such as atypical antipsychotics and some antidepressants. Third, some patients require dosages that exceed limits established by PDPs. Additional coverage problems can arise during the course of the year if an individual’s medications change, if an individual develops a new condition that requires additional medication, or if the PDP formulary changes. Dual eligibles also encounter challenges obtaining medications because of delays in transmitting enrollment information.

The MMA explicitly excluded some medications from coverage under Part D, notably benzodiazepines. Although concerns exist about the appropriateness of prescribing these medications for elderly populations, they continue to be prescribed. They can be appropriate therapies for people with SMI, particularly those who qualify for Medicare based on disability rather than age.

The study states used several approaches to address these challenges.

State Wraparound Coverage of Medications[24]

Medicaid programs offered wraparound prescription drug coverage for dual eligibles to help fill some of the coverage gaps. The Medicaid programs in all six study states provide dual eligibles with wraparound coverage of medications excluded from Part D that are covered through the state's Medicaid program. Four of the six states cover all benzodiazepines, while Missouri and Texas cover some benzodiazepines. Although local providers reported that access to benzodiazepines has not been a problem, some were concerned that dual eligibles with SMI might be confused by PDP literature, which says that these drugs are not covered.

All of the states except North Carolina provided backup prescription drug coverage to dual eligibles who had difficulties receiving medication because of enrollment problems during the first months of Part D implementation. As described in Chapter 1, CMS implemented a demonstration that allowed Medicaid programs to apply for Medicare reimbursement of expenditures for backup coverage incurred through March 31, 2006. Massachusetts, New Jersey, and Oregon reported that CMS reimbursed them for most of these expenditures. Missouri did not apply for reimbursement because the state considered the documentation requirements too onerous, while Texas had not received any payments as of November 2006 because of problems with the claims file it submitted.

Massachusetts, Missouri, Oregon, and New Jersey continued to finance backup coverage of denied prescriptions after the demonstration ended in March 2006. While the states noted that this coverage provides potentially valuable protections to dual eligibles, the benefit has not been used as widely as anticipated. State staff do not know whether this reflects limited awareness of these programs or limited need for the benefit. Consumers usually are dependent on pharmacists' and prescribers' knowledge of the state's wraparound coverage to obtain these benefits.

Massachusetts' Medicaid program (MassHealth) began offering wraparound coverage of a one-time, 30-day supply of medications denied by the PDP in March 2006. An additional one-time, 72-hour supply was provided if coverage problems remained after the 30-day period ended. Coverage of a 30-day supply was offered through December 31, 2006. Since this date, MassHealth continues covering a one-time, 72-hour supply. Initially, MassHealth only covered medications denied because they were not on the PDP formulary, but this benefit was expanded to include any reason for denial. Delays in transmitting enrollment information have been the main reason that MassHealth has covered denied prescriptions for dual eligibles. From March 16 to October 30, 2006, MassHealth paid more than $3.3 million for prescriptions for dual eligibles that were denied by PDPs.

Missouri provides emergency transition prescription drug coverage for dual eligibles with Part D enrollment problems through its state pharmacy assistance program (SPAP)—the Missouri Rx Plan (MoRx). Missouri's SPAP was folded into Medicaid when Part D was implemented, and all dual eligibles were automatically enrolled in MoRx. Medicaid staff believe that pharmacists are aware of the wraparound coverage, but physicians and dual eligibles are not. As of October 2006, Missouri estimated that wraparound coverage had cost them several hundred thousand dollars.

New Jersey's wraparound coverage includes 6-day, on-the-spot-coverage to allow time for the physician to submit an exception request for a denied prescription to a PDP. Subsequent ongoing coverage is provided if a plan denies the exception request. Medicaid acts as a SPAP for prescriptions filled under the wraparound, which allows the state to qualify for manufacturer rebates. New Jersey appropriated $20 million for wraparound coverage for the first 6 months of 2006, although the full amount was not used. As a result, the appropriation for the 2007 fiscal year was reduced to $33 million, and the appropriation for fiscal year 2008 was reduced further.

Some in the state are concerned that lack of awareness limits the effectiveness of wraparound coverage as a safety net. Not all providers and dual eligibles understand that PDP-denied claims can be submitted to the state for reimbursement. Even when they are aware of the coverage, some providers consider the PDP exception process—which is a prerequisite to obtaining wraparound coverage for most drugs—too burdensome. Considerable confusion exists about coverage of benzodiazepines. Instead of being submitted directly to Medicaid, claims for these prescriptions sometimes are submitted to the PDPs and unnecessarily sent through the exceptions process after they are denied.

Oregon provides wraparound coverage of prescription drugs for dual eligibles who encounter problems securing medications. This coverage overrides state payment system blocks against paying for drugs covered by Part D. The state is continuing the program even though state officials report that only a small volume of claims ($4,000-$5,000 per month). In the 2007-2009 biennium, the state budgeted $240,000 for its wraparound coverage. State officials expected a larger volume of claims and speculate that the low volume may reflect lack of awareness of the wraparound benefit.

Local Provider Assistance

In all six study states, local provider agencies assist dual eligibles with SMI with submitting information required for prior authorization and coverage exception requests. Pharmacies in the study states report that they provide substantial support to providers with these processes, which vary across PDPs. In some cases, consumer advocacy groups and CMS regional offices also have offered assistance. Although assistance with the PDP appeals process was available as well, state staff, local providers, and advocates were aware of only a few cases in which appeals were submitted. Those at the state and local levels did not know whether there was such a small number of appeals because appeals were not needed or because people were not aware of the appeals process or did not want to bother going through it.

Local agencies also sometimes help clients obtain medications that are denied by their PDP. Some agencies reported that they instruct physicians to make prescribing decisions based on clinical judgment and then find a way to provide noncovered medications. Agencies use free samples when available, but sometimes medications are purchased with program funds or charitable contributions. Some pharmacies reported dispensing prescribed medications without PDP approval with the expectation they eventually will be reimbursed. Independent pharmacies with strong ties to their communities sometimes dispense prescribed medications without PDP approval as part of their community support mission.

IV. Activities to Help Dual Eligibles with SMI Meet Copayment Requirements

Although dual eligibles have reduced cost-sharing obligations under Part D, the Part D copayments are a new or greater financial obligation for many dual eligibles compared with the cost requirements under Medicaid. Two of the six states—New Jersey and Texas—do not charge copayments for prescription medications. Although Oregon's Medicaid program charges copayments for prescription medications, people that live in community residences are exempted. In addition, by federal law, pharmacists in all 50 states must dispense prescriptions to Medicaid beneficiaries who are not able to make copayments.[25] However, this requirement does not apply to prescriptions for dual eligibles covered under Part D.

As a result, states and local providers were concerned that even the reduced copayment requirements under Part D might create barriers to obtaining medications, which did not exist under Medicaid for some dual eligibles, particularly those who use many prescription medications. Individuals with SMI are especially likely to require multiple medications in order to treat both their psychiatric condition(s) and their medical conditions. There were also concerns that unaffordable copayments could trigger nonadherence to treatment regimens for people with psychiatric conditions who are already ambivalent about taking their prescribed medications.

State Wraparound Coverage of Copayments

To address the potentially higher copayment liability under Part D, three of the states provide state-financed wraparound coverage of Part D copayments for dual eligibles. New Jersey, which does not have copayments for prescription drugs under its Medicaid program, covers the entire Part D copayment. Most pharmacists in New Jersey are aware of the copayment wraparound coverage. However, community mental health center staff report that they sometimes have to remind pharmacists not to charge copayments to dual eligibles because large, chain pharmacies' software systems have difficulty accommodating state-specific coding, such as creating a flag to indicate that dual eligibles in New Jersey should not be charged copayments.

Massachusetts' provides wraparound coverage of copayments for dual eligibles with incomes above 100 percent of the FPL. The individuals receive coverage of Part D copayment amounts that exceed the copayment requirement under Massachusetts' Medicaid program ($1 for generic and $3 for brand name drugs). Because the Medicaid copayment is the same as the Part D copayment requirement for dual eligibles with incomes under 100 percent of the FPL, these individuals do not receive wraparound coverage of copayments. Massachusetts also provides wraparound coverage of copayments if dual eligibles are erroneously charged amounts in excess of the Part D mandated levels. From March 16 to October 30, 2006, Massachusetts paid about $800,000 for wraparound coverage of copayments. More than three-quarters of the amount paid for copayments was for erroneous charges in excess of the maximum amounts mandated for dual eligibles. The state is not able to recover these excess charges from pharmacies or PDPs, because they were incurred under Part D.

Missouri's Medicaid program covers 50 percent of the Part D copayments for dual eligibles through MoRx, Missouri's SPAP. In part, Missouri covers Part D copayments so that it will continue to receive prescription drug claims for dual eligibles. These claims are used in Missouri's retrospective drug utilization review program, which that state considers critical to

disease management efforts in its Medicaid program. This claim information is also vital for the Mental Health Medicaid Pharmacy Partnership. Missouri makes a nominal payment ($0.06) to pharmacists as an incentive to submit claims for copayments to MoRx. Missouri's Medicaid agency believes that it receives nearly complete claims information for dual eligibles residing in the community as a result of this policy. Through October 2006, Missouri had paid about $2.5 million for copayments and incentive payments to pharmacies.

Local Assistance with Copayments

In addition to wraparound Medicaid coverage, local mental health provider agencies, pharmacies, and/or charitable organizations in all six study states have provided assistance with Part D copayments. Local providers in Oregon reported covering copayments for some dual eligibles with SMI, particularly those living in community residences who were exempt from copayments under Medicaid but are required to make copayments under Part D. One provider received a sizable private donation to establish a special fund to provide financial assistance for copayments, which was nearly depleted 8 months after Part D was implemented.

Although dual eligibles in New Jersey are not liable for Part D copayments because of the state's wraparound coverage, mental health providers reported assisting dual eligibles with SMI who were incorrectly charged copayments until these problems were resolved. While Missouri's Medicaid program covers half of the Part D copayment amounts, community mental health centers and residential care facilities sometimes provide financial assistance to individuals who cannot afford their remaining copayment responsibility. The Missouri Medicaid agency also has referred dual eligibles to charitable organizations, such as the Salvation Army, for help with copayments.

Pharmacies have been an additional source of support for dual eligibles who have difficulty covering the Part D copayments, even in states that offer wraparound coverage. Pharmacists in Massachusetts reported waiving copayments for dual eligibles who are not able to afford the Medicaid copayment levels for which they are still responsible. Pharmacies in Missouri have also waived copayments, although they sometimes have been told by PDPs that they are not permitted to do so.

Conclusion

Although outpatient prescription drug coverage for dual eligibles became a federal responsibility with the implementation of Medicare Part D, state agencies and local providers in the six study states have played active roles in ensuring that dual eligibles with SMI continue to receive needed medications. In many cases, state agencies and local providers have undertaken similar initiatives and instituted similar policies to ensure access to prescribed medications. However, some approaches differed among the study states, reflecting variation in their Medicaid programs, mental health systems, and political environments.

State agencies were critical in developing plans for the transition to Part D coverage and educating local providers about how Part D would affect their dual eligible clients. The study states vary in the extent to which they provide wraparound coverage of dual eligibles' copayments and medications not covered by a PDP. Local providers offer dual eligibles with

SMI intensive one-on-one support, reviewing each dual eligible's PDP assignment, evaluating alternative PDPs, making changes when needed, and resolving enrollment problems. Local providers also assist dual eligibles with SMI in complying with PDP coverage requirements, including submitting requests for prior authorization and exceptions when needed. Despite their efforts, state agencies and local entities were not able to resolve some challenges that dual eligibles with SMI face in obtaining prescribed medications. These challenges are discussed in the next chapter.

Chapter 3
Remaining Challenges to Implementing the Part D Benefit for Dual Eligibles with Serious Mental Illness

As noted, prior to implementation of Part D, CMS anticipated that all dually eligible beneficiaries—particularly those with SMI—were likely to face unique challenges in transitioning to Medicare coverage of prescription drugs. CMS incorporated a number of features into the program's design to lessen these challenges, but some still arose that could not be resolved fully through the program's design or that were not anticipated.

Chapter 2 described state agency and local provider activities in the study states intended to ameliorate some of the problems faced by dual eligibles with SMI as they transitioned to Part D prescription drug coverage. Despite their efforts, state agency staff and local providers identified additional challenges that they were not able to address. Although these challenges were identified during the initial implementation of Part D, they are ongoing. This chapter reviews remaining challenges that were identified by state administrators and local providers in the following areas:

- Informing dual eligibles with SMI about Part D.
- Assisting with plan selection and enrollment.
- Ensuring the best PDP coverage.
- Helping with copayments.
- Monitoring the effects of Part D.

Some of the problems described apply specifically to individuals with SMI, but many apply to dual eligibles generally; however, the effects of these problems are likely to be greater for dual eligibles with SMI, whose emotional problems and cognitive impairment make it more difficult for them to negotiate a complex system. These characteristics may also have isolated them from family members, who are an important source of assistance to other dual eligible beneficiaries. These five problems are discussed in more detail below.

I. Informing Dual Eligibles with SMI about Part D

CMS and PDPs provide information to beneficiaries about plan enrollment, benefits, and other issues, primarily by mail. State staff and local providers noted that it is difficult to reach dual eligibles, particularly those with SMI, through the mail. Some simply throw away mail if they do not recognize it as important. Those with low literacy levels or cognitive impairment find it difficult to understand the materials they receive. In other cases, mail does not reach people because they are in transient housing or are homeless.

Although case managers alert their dual eligible clients with SMI to the importance of bringing them any mail they receive related to Part D, they believe that it would be more effective to have PDPs send copies of all notices to a third-party designated by the client. Doing so would alert

case managers or other people who support dual eligibles with SMI about issues affecting their benefits so that they can intervene as necessary. CMS recognizes "authorized representatives" for Medicare beneficiaries when they are permitted under state law. These authorized representatives may include court-appointed legal guardians, individuals holding a general power of attorney for financial matters, or a durable power of attorney for health care decisions. Such representatives may receive all notifications from PDPs. While some dual eligibles with SMI may need an authorized representative, many do not. The case managers for dual eligibles with SMI interviewed for this study typically were not authorized representatives for their clients and thus were unable to receive notices.

Case managers also noted that notices from PDPs are often not customized for dual eligibles. For example, case managers reported that some dual eligibles received an Explanation of Benefits statement from their PDP explaining that their expenditures had reached the maximum level of coverage for Medicare beneficiaries generally, even though this limit does not apply to dual eligibles. Such notices can evoke confusion and anxiety in individuals with SMI.

II. Assisting with Plan Selection and Enrollment

In all six study states, dual eligibles with SMI with strong ties to the mental health system received extensive support in reviewing their PDP assignments, evaluating which plans provided the best coverage of their medications, switching to another plan if needed, and resolving enrollment problems. While this support addressed the needs of people served by the formal mental health system, there are some dual eligibles with SMI who are not supported by this system and lack other supports. Both state staff and local providers viewed the Part D enrollment process as too complex for people with SMI to manage without assistance. They expressed concern that dual eligibles with SMI who are not well connected to the mental health system may not have received needed assistance with plan selection and enrollment.

Local providers reported several challenges in providing support with plan selection and enrollment, even for those dual eligibles with SMI connected to the mental health system. These challenges include difficulty obtaining information about all of the prescription medications clients are taking, restrictions on third parties—such as case managers—handling plan changes, strains on resources from providing assistance to clients, and problems obtaining benefits because of delays in the enrollment process due to lags in data exchange. Each of these challenges is discussed in turn.

Gathering Information about Current Medications

It is necessary to review every medication an individual is taking to determine which PDP provides the best coverage for that person. However, those who assist dual eligibles with SMI to review plans do not always have access to complete information about their medications. Case managers find it difficult to obtain information about medications for their clients' nonpsychiatric health conditions, which, unlike psychotropic medications, are not prescribed by the mental health provider agency. The Missouri Medicaid program has data on both types of medications used by dual eligibles and gave this information to community mental health centers. However, the other study states lack this data capability, and their providers had to rely on clients to provide complete information, which they were not always able to do.

Restrictions on Third Parties Handling Plan Changes

Requests to change plans are made by telephone. Local providers reported that most PDPs require beneficiaries to request the change, although a third party such as a case manager can provide assistance. Currently, beneficiaries can designate a third party to represent them in the exceptions and appeals process. However, PDPs generally do not permit third parties to speak for beneficiaries when they want to switch plans or address problems that do not rise to the level of an exception or appeal.

Although CMS requires that PDPs work with enrollees' authorized representatives if they are permitted under state law—as described above—case managers and other staff at local provider agencies usually do not act in this capacity for their clients. Providers noted that, for many dual eligibles with SMI, making a call to change plans provokes anxiety and, in other instances, the logistics of having the client present when the case manager can make the call are challenging and sometimes difficult to overcome.

Strains on Provider Resources

Providers reported that assisting dual eligibles with reviewing PDP assignments and changing plans required substantial staff resources. The greatest responsibility fell to mental health provider agencies, although pharmacists and other local providers also have offered support. Most local providers did not receive funding for Part D implementation activities; they were just added to the workload of current staff, diverting them from their primary roles of providing care and routine support to people with SMI.

The initial review of PDP assignments prior to Part D implementation placed a significant strain on case managers because of the large number of cases that had to be reviewed in a short time period. Although the demands are less intense now than during the initial implementation, they are ongoing: New dual eligibles with SMI need their plan assignments reviewed, and current dual eligibles with SMI may need to switch plans if their medication regimen changes, if they develop a new condition that requires medication, if a PDP changes its formulary,[26] or if the PDPs with premiums below the subsidy benchmark change with the new contract year. In Texas, six of the plans that were below the subsidy benchmark in 2006 no longer qualified in 2007, which triggered reassignment of approximately 34,000 people at the end of 2006.

Delays in the Enrollment Process

State staff and local providers reported that dual eligibles, including those with SMI, often faced problems obtaining benefits because it can take several weeks before new enrollment in a PDP is completed because of the need for sequential steps and data exchanges between multiple organizations. While problems are not as severe as they were in the first few months of implementation, they remain for those newly qualified as dual eligibles and those who change plans. Although fewer steps are required when changing plans, this process also takes a long time. As a result of the time lag, pharmacies trying to fill a prescription may not be able to identify the PDP in which a dual eligible is enrolled or determine if the dual eligible qualifies for reduced cost-sharing. These problems can result in dual eligibles going without essential medications. The consequences of going without needed medications can be especially severe for dual eligibles with SMI.

Local providers reported that CMS regional offices and state Medicaid agencies often played key roles in resolving problems, particularly in the early months of implementation. As described in Chapter 1, CMS has developed procedures to reduce the lags in data exchange, but they have not been eliminated. For example, an eligibility query was developed to provide PDP billing information to pharmacies when dual eligibles do not have their PDP card. However, the eligibility query does not always produce an enrollment match and, when it does, the response does not always include the needed billing information.[27] While the prospective enrollment system implemented in August 2006 (described in Chapter 1) should eliminate enrollment delays for Medicaid beneficiaries who are expected to become dual eligibles in the near future, the GAO estimates that this procedure will identify only one-third of new dual eligibles in advance.[28]

III. Ensuring the Best PDP Coverage

Although the Medicaid programs in some of the study states have PDLs and require prior authorization for certain medications, prescribers for dual eligibles with SMI found it difficult to adapt to Part D because each PDP has its own formulary and prior authorization procedures. Prescribers who serve dual eligibles with SMI reported that they are able to learn and adjust their prescribing to Medicaid's preferred drugs and prior authorization requirements. However, it is more difficult to do this under Part D because of the large number of PDPs in each state. Providers reported that they are sometimes unaware that a medication requires prior authorization or that a PDP has changed its formulary midyear until the prescription is denied at the pharmacy. Even if a provider is aware of the formulary change, the required 30-day notice period does not provide adequate time to taper off some medications.[29]

When providers learn that a medication requires prior authorization, some reported that they are reluctant to go through the prior authorization process because of the work required to learn each PDP's procedures and to fulfill their requirements. The large number of prescriptions requiring prior authorization further increased the workload for providers.

As described in Chapter 2, state agencies and local providers have adopted policies to help dual eligibles continue to receive prescribed medications. However, the effectiveness of these policies has been limited, in some cases. Several of the study states provide wraparound coverage of medications that are denied by a PDP, although coverage usually is provided only on a time-limited, emergency basis. The states with these programs report that utilization of wraparound coverage has been lower than expected. While this may indicate less need than anticipated, they are concerned that wraparound coverage is underutilized because pharmacists and providers are unaware of it or do not understand the procedures required to obtain the benefit. Some local providers have used their own funds to provide uncovered medications to dual eligibles with SMI, either because their state does not provide wraparound coverage or because they are unaware of the benefit. However, this reduces the funds available to provide other needed services and medications for clients who do not have Medicare Part D or other insurance coverage for prescription drugs.

Part D includes several provisions to help ensure that beneficiaries have access to prescription drugs. These include exception and appeals processes; the "all or substantially all" coverage requirement for antidepressants, antipsychotics, and certain other medications; the continuation

of coverage of medications that individuals are taking at the time of enrollment in a PDP; and point-of-sale coverage through a national contractor for new dual eligibles whose enrollment has not been completed. While each of these provisions offers important protections, state and local providers noted limitations to their effectiveness. These limitations are described in the remainder of this section. Two additional challenges to obtaining prescribed medications are also described: (1) confusion about responsibility for covering injectable and infusible medications and (2) PDPs' inability to provide unit-dose dispensing.

Exceptions and Appeals

Local providers reported few cases where exceptions or appeals were filed. While this might indicate that serious coverage problems had not arisen, advocates were concerned that it might be due to beneficiaries' lack of knowledge about their rights to apply for an exception or to appeal when they are denied coverage of a prescribed medication. There is no guarantee that beneficiaries will be informed of these rights or that prescribers will be willing to take on the extra work required for the exception or appeal process. Advocates noted that dual eligibles with SMI are particularly unlikely to be aware of and able to advocate for these rights.

"All or Substantially All" Coverage Requirement

Part D requires that PDPs include "all or substantially all" antidepressants and antipsychotics in their formularies—as well as medications in four additional protected classes. While local providers viewed this as an important protection, they felt that its effectiveness has been limited, because prior authorization and step therapy requirements, as well as quantity limits, can still be applied to these classes of medications. Expensive medications, such as atypical antipsychotics, are especially likely to require prior authorization. As described above, prior authorization can pose a barrier to coverage. Local providers reported that quantity limits also can be problematic. For example, some individuals require two prescriptions for the same drug so that they can take different doses in the morning and evening.

Transition and Grandfathered Coverage

Part D includes several provisions to protect the stability of drug therapies for new enrollees. While these provisions were particularly important when Part D was first implemented, they continue to provide important protections for individuals who newly qualify as dual eligibles or who change plans. PDPs are required to provide transition coverage of a single 30-day refill of a previously filled prescription for new plan enrollees, regardless of whether the medication is on the plan formulary. This transition coverage is intended to allow time to switch to an alternate medication that is covered by the PDP formulary or to apply for an exception to the formulary. PDPs are also required to "grandfather" coverage of medications in the "all or substantially all" classes without prior authorization or step therapy protocols if the enrollee was stabilized on this medication regimen at the time of enrollment in the PDP.

Several limitations to these policies were described during the site visits. State and local agency staff reported that beneficiaries (including dual eligibles with SMI), providers, and pharmacists are not always knowledgeable about these policies. As a result, beneficiaries who are eligible for transition or grandfathered coverage do not always receive it. Awareness of grandfathered coverage was particularly low among providers interviewed during the site visits. Beneficiaries

who receive transition coverage do not always understand that they should use the transition period to switch to another medication, obtain an exception to the PDP's formulary, or switch to another plan. As a result, they do not understand why they cannot refill their prescriptions at the end of the transition period, and intervention by a third party is likely needed to resolve the problem.

Finally, as noted previously, 30 days of transition coverage is not always adequate time to taper off a medication, particularly psychotropics. Although CMS requested that PDPs provide 90 days of transition coverage during initial implementation of Part D, this additional coverage was only extended through the end of March 2006. However, those newly eligible since that time also need this protection.

Point-of-Sale Coverage

CMS entered into a contract with a national contractor, WellPoint, to provide point-of-sale coverage in cases where new dual eligibles are not yet enrolled in a PDP. However, local providers reported that coverage through the WellPoint system is not always offered as an option by pharmacy staff, partly because of problems receiving reimbursement from WellPoint.

Injectable and Infusible Medications

Confusion about payment responsibility for injectable and infusible drugs has been a problem for all Part D enrollees, not just dual eligibles. Medicare Part B covers injectable and infusible drugs that are not generally self-administered and are administered as part of a physician service or through a piece of durable medical equipment, such as a nebulizer or a pump that is also covered by Part B. Part D covers injectable medications, such as insulin, that are self-administered. Depending on the circumstance, either Part B or Part D is responsible for some medications that can be delivered as part of a physician service or that can be self-administered.[30]

An example relevant to people with SMI is Risperdal Consta, a long-acting antipsychotic administered by injection. Consumers can purchase the medication at a retail pharmacy and bring it to a mental health center for administration. In this case, Part D will pay for the medication. The medication also can be provided as part of a visit to a mental health center, in which case Part B is responsible. This grey area has led to uncertainty about who is responsible for covering some medications. Local providers reported that PDPs sometimes deny coverage of these prescriptions or require prior approval and letters of medical necessity before covering them. They also noted that, when claims for medications covered by Part B are rejected by a PDP, beneficiaries are not always informed that the medication is in fact covered by Medicare and that the claim should be submitted under Part B.

Unit-Dose Dispensing

Informants in several states discussed problems with PDPs accommodating unit-dose dispensing requirements for people living in community residences, including some dual eligibles with SMI. In some states, prescription drugs are dispensed in unit-dose bubble packs to individuals who live in community residences to ensure accurate and economical dispensing. The PDPs that contract with Medicare have limited experience serving populations in congregate settings and were not prepared to dispense medications in this way. Oregon was able to negotiate agreements

with some PDPs to cover unit-dose dispensing in bubble packs. Outside of Oregon, PDPs' inability to provide unit-dose dispensing was a challenge for residential treatment facilities.

IV. Helping with Copayments

Although Part D copayment requirements for dual eligibles are substantially lower than those for other Medicare beneficiaries, dual eligibles in the six study states still face higher copayments under Part D than they did under Medicaid. Of the six states, only New Jersey offers complete wraparound coverage of Part D copayments; Massachusetts and Missouri offer partial wraparound coverage.

Some people interviewed for this study felt that the reduced copayment levels were affordable and did not pose an access barrier for dual eligibles, including those with SMI. Others noted that even the reduced Part D copayment levels can sum to prohibitively expensive amounts for dual eligibles if they take multiple medications. People with SMI, some of whom need medications for nonpsychiatric as well as psychiatric conditions, are particularly likely to have numerous prescriptions. For example, one community agency reported that many of their dual eligible clients with SMI have 8 to 10 prescriptions, including medications that address the side effects of the psychotropic medications. Dual eligibles with prescriptions for 10 brand-name medications could have $30 to $50 in copayments each month, depending on their income. For those eligible for SSI, this represents a significant portion of their monthly benefit—$603 at the time of this study in 2006.

A number of local providers considered Part D treatment of dual eligibles served in community-based residences (including those with SMI) inequitable compared with those living in nursing homes and other institutional settings who are exempt from copayments under Part D.[31] The copayment exemption for institutionalized dual eligibles recognizes that those people in institutions must turn over all of their income minus a small monthly personal needs allowance (PNA) to the facility to satisfy substantial copayment requirements. States and local providers reported that dual eligibles residing in board and care homes or residential care facilities also have to use most or all of their income—minus the PNA—for room and board. States set the amount of the PNA, and about 75 percent of states set it lower than $54 per month in 2006. The highest PNA was $90.[32] Given these low amounts, copayments can consume the entire PNA for dual eligibles on multiple medications, leaving no money for other personal needs.[33] Although they also have only a small PNA to cover other expenses, community-residing dual eligibles are not exempt from Part D copayment requirements.

V. Monitoring the Effects of Part D

Study informants reported little anecdotal evidence of serious clinical effects caused by the transition from Medicaid to Part D prescription drug coverage, although local providers described the program as a source of increased stress that can be difficult for dual eligibles with SMI to handle. However, these informants only had direct contact with a small portion of this population. None of the states had provisions for the routine monitoring needed to detect the clinical effect of Part D in the overall population of dual eligibles with SMI or among dual eligibles generally. As a result, no systematic information is available about the effect of Part D.

States noted that Medicaid programs' ability to monitor and manage dual eligibles' care is restricted because they no longer have information on their prescription drug utilization. As described in Chapter 2, Missouri developed a mechanism to continue receiving prescription drug data by covering a portion of dual eligibles' Part D copayments. The state developed a plan for analyzing clinical effects using these data but, at the time of the site visit in October 2006, funds were not available to conduct the analyses. States continue to have data on dual eligibles' use of services other than prescription drugs, which could be used to monitor clinical effects. However, states reported that they lack the resources to analyze these data.

VI. Epilogue

This study was conducted during the first year of Part D implementation. As expected when a program of Part D's magnitude is implemented, unanticipated problems arose despite advance planning. Some of these problems affected dual eligibles with SMI. Since the program's implementation, CMS has continued to work to streamline procedures, reduce obstacles, and fulfill the intent of the Part D benefit to provide coverage of prescription medications for Medicare beneficiaries, including dual eligibles with SMI.

Some of the remaining challenges described during the site visits for this study were subsequently addressed by CMS. Because these initiatives were implemented after the site visits for this study were completed, their effect on implementation of Part D for dual eligibles with SMI within states cannot be assessed.

Several developments aim to reduce delays in enrolling dual eligibles in Part D plans as a result of data processing lags. CMS reports substantial improvement in the timeliness and accuracy of files sent by state Medicaid agencies to CMS to identify dual eligibles, and CMS also is working to enhance its data processing capabilities. Most importantly for dual eligibles, CMS expects to be able to process state files and auto-enroll individuals continuously by mid-2008. Currently, these processes occur monthly. As of mid-2007, CMS redesigned the point-of-sale facilitated enrollment process administered through WellPoint in order to substantially decrease the burden on pharmacies and reduce their risk of not receiving reimbursement for prescriptions from WellPoint.

CMS also has taken steps to increase the clarity of information about Part D that is provided to beneficiaries and providers. Incorporating input from beneficiary focus groups, CMS revised the model Explanation of Benefits statements that have been provided to PDPs. The revisions include customized options for beneficiaries that receive the low-income subsidy, including dual eligibles. CMS issued the revised model Explanation of Benefits statements to PDPs in September 2007.

CMS has improved the standardization and transparency of prior authorization, exceptions, and appeals processes by making a standardized exceptions form available to PDPs. In addition, in advance of the 2009 open enrollment period, PDPs will be required to use a standardized format to submit their prior authorization criteria to CMS for review and to post their approved prior authorization criteria on their Web sites.

APPENDIX A

CASE STUDY METHODS

RTI International and its subcontractor, Human Services Research Institute (HSRI), conducted site visits to six states to learn about the role of states and local entities in implementing the Medicare prescription drug benefit for dual eligibles with behavioral health disorders. This appendix describes the methods used to conduct the case studies, including the criteria used to select the six study states, the types of individuals interviewed during the site visits, and the topics discussed during site visit interviews. An advisory panel of technical experts provided guidance to RTI and HSRI on the design of these case studies.

RTI and HSRI staff conducted the site visits between September and December 2006, the latter part of the first year of Part D implementation. The site visits, which were scheduled to allow time for resolution of some of the initial implementation problems that were anticipated when a program as large as Medicare Part D first comes on line, provide a look at sites' early experiences with Part D. As such, these findings reflect both transition challenges, some of which have been resolved, and ongoing challenges. All interviews were completed in 2006 so that comparison of findings across states would not be confounded by issues that might arise with the start of the new contract year in January 2007. Each site visit took place over a 2-day period. In some cases, additional telephone interviews were conducted with people who were not available at the time of the site visit. The site visit teams consisted of two members each.

I. State Selection

RTI and HSRI staff conducted site visits in six states—Massachusetts, Missouri, New Jersey, North Carolina, Oregon, and Texas. Selection of states for the case study took into account variation across a number of factors expected to affect the transition of dual eligibles to Part D prescription drug coverage. These included the generosity of prescription drug coverage under the state's Medicaid program, early Part D implementation activities within the state, characteristics of the state public mental health care system, population characteristics, and Centers for Medicare & Medicaid Services (CMS) region.

- Characteristics of state's Medicaid program:
  - Whether Medicaid required cost-sharing for prescription drugs prior to Part D.
  - Whether Medicaid has a formulary.
  - Whether Medicaid uses managed care for behavioral health services.
  - Whether the state covers Part D copayments for dual eligibles.
  - Whether Medicaid offers wraparound coverage of drugs not covered by Part D.
  - Whether the state had a temporary assistance plan for covering Part D drugs for dual eligibles.
  - State perception of problems with Part D transition for dual eligibles.
- State characteristics
  - CMS region.
  - Urban/rural population mix.
  - Percentage of state population that is minority.

- State ranking on report card issued by the National Alliance on Mental Illness (NAMI).[1]
- Level of collaboration between Medicaid and state mental health and substance abuse agencies.

Exhibits A1-A3 display state characteristics along these dimensions. These exhibits reflect information available at the time states were selected for the case study (April 2006) and may differ from information gathered during the site visits. For example, during the site visit, state staff reported that Massachusetts offers partial coverage of Part D copayments for dual eligibles and provides wraparound coverage of prescriptions denied by prescription drug plans (PDPs).

II. Interview Participants

Individuals in the following categories, representing a range of perspectives on implementing Part D for dual eligibles with serious mental illness (SMI), were contacted for site visit interviews.

- State agency staff:
  - Medicaid.
  - Mental health.
- Providers:
  - Community mental health provider agency administrators, clinicians, and case managers.
  - State pharmacy association or community pharmacists.
- Advocates

Staff from state substance abuse and developmental disability agencies were interviewed in some states. However, staff from these agencies in most states felt they did not have enough information on Part D to participate.

III. Discussion Guide

To ensure thorough and uniform data collection during site visits, RTI and HSRI staff developed a discussion guide listing topics to be covered during the interviews. The discussion guides distinguished between early transition problems and ongoing problems, as well as between transitional and long-term state plans and policies related to the Part D benefit.

The discussion guide included the following topics:

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[1] NAMI issues periodic reports that rate state public mental health care systems for adults with SMI. A state's overall grade is calculated from 39 criteria in 4 categories: infrastructure, information access, services, and recovery supports. For the full report, see http://www.nami.org/Content/NavigationMenu/Grading_the_States/Full_Report/GTS06_final.pdf.

- Background on the state's Medicaid and mental health agencies, including Medicaid prescription drug coverage and provision of publicly funded mental health services.
- Part D outreach and educational activities related to dual eligibles and the population with SMI.
- Assistance with PDP selection and enrollment for dual eligibles who have SMI.
- Assistance with meeting Part D cost-sharing requirements.
- Assistance with receiving prescribed medications.
- Impact of Part D on access to prescription drugs, particularly psychotropic medications, and clinical outcomes.

The discussion guides were tailored for staff from state agencies, community mental health providers and case managers, and pharmacists. A modified version of the discussion guide for community mental health providers and case managers was used for advocates. Copies of these discussion guides are in Appendix C.

Exhibit A1. Selected Characteristics of State Medicaid Programs

	Medicaid Cost Containment Policies for RX				Medicaid and Part D				
	Copayments	Preferred Drug List	Any Prior Authorization	Mental Health Carve-out in Medicaid	Dual Eligibles Auto-Enrolled into PDPs (2/11/06)	Covers Part D Copayments	Covers Non-Formulary Drugs	Temporary Coverage for Dual Eligibles	Medicaid Director's View on Problems with Part D Transition
Alabama	n/a	No	No	No	82,691	No	No	Yes	Widespread
Alaska	Yes	Yes	Yes	No	11,360	No	No	Yes	Some
Arizona	No	No	Yes	Yes	50,785	No	No	Yes	Widespread
Arkansas	Yes	Yes	Yes	No	60,331	No	No	Yes	Widespread
California	Yes	Yes	Yes	Yes[d]	876,932	No	No	Yes	Widespread
Colorado	Yes	No	Yes	Yes[d]	41,124	No	No	No	Some
Connecticut	No	No	Yes	Yes	66,719	Yes	No	Yes	Widespread
Delaware	n/a	No	No	No	9,476	No	No	No	Some
District of Columbia	Yes	No	Yes	No	15,123	No	No	Yes	Widespread
Florida	Yes	Yes	Yes	Yes	331,988	No	No	Yes	Some
Georgia	n/a	No	No	No	137,167	No	No	Yes	Some
Hawaii	n/a	No	No	Yes	23,219	No	No	Yes	Some
Idaho	No	Yes	Yes	No	18,047	No	No	Yes	Some
Illinois	Yes	Yes	Yes	No	248,624	No	No	Yes	Widespread
Indiana	Yes	Yes	Yes[a]	No	94,945	No	No	No	Some
Iowa	Yes	Yes	Yes	Yes	54,813	No	No	No	Some
Kansas	Yes	Yes	Yes	No	39,136	No	No	Yes	Widespread
Kentucky	n/a	No	No	No	78,434	No	No	No	Widespread
Louisiana	Yes	Yes	Yes	No	133,014	No	No	No	No significant
Maine	n/a	No	No	No	45,263	Yes[e]	No	Yes	Widespread
Maryland	Yes	Yes	Yes[b]	Yes	57,041	No	No	Yes	Some
Massachusetts	Yes	Yes	Yes	Yes	184,196	No	No	Yes	Widespread

(continued)

Exhibit A1. Selected Characteristics of State Medicaid Programs (continued)

	Medicaid Cost Containment Policies for RX				Medicaid and Part D				
	Copayments	Preferred Drug List	Any Prior Authorization	Mental Health Carve-out in Medicaid	Dual Eligibles Auto-Enrolled into PDPs (2/11/06)	Covers Part D Copayments	Covers Non-Formulary Drugs	Temporary Coverage for Dual Eligibles	Medicaid Director's View on Problems with Part D Transition
Michigan	Yes	Yes	Yes[a]	No	191,397	No	No	No	Not significant
Minnesota	Yes	Yes	Yes	Yes	58,986	No	No	Yes	Widespread
Mississippi	Yes	Yes	No	No	129,167	No	No	No	Widespread
Missouri	Yes	Yes	Yes	Yes	145,031	Yes[e]	No	Yes	Widespread
Montana	n/a	No	No	Yes	14,774	No	No	Yes	Widespread
Nebraska	Yes	No	Yes	Yes	31,519	No	No	No	Widespread
Nevada	n/a	No	No	No	17,286	Yes[e]	No	Yes	Widespread
New Hampshire	Yes	Yes	Yes	No	19,030	No	No	Yes	Widespread
New Jersey	No	No	Yes	Yes	138,541	Yes	Yes	Yes	Widespread
New Mexico	n/a	No	No	Yes	31,522	No	No	Yes	Widespread
New York	No	No	Yes	Yes	509,513	No	Yes	Yes	Some
North Carolina	Yes	No	Yes	No	216,899	No	No	No	Some
North Dakota	Yes	No	Yes[a]	No	10,492	No	No	Yes	Widespread
Ohio	n/a	No	No	Yes	173,726	No	No	Yes	Widespread
Oklahoma	Yes	Yes	Yes	No	73,851	No	No	No	Some
Oregon	Yes	Yes	Yes	Yes	32,653	No	No	Yes	Widespread
Pennsylvania	Yes	No	Yes	Yes[d]	149,964	No	No	Yes	Widespread
Rhode Island	n/a	No	No	No	26,192	No	No	Yes	Widespread
South Carolina	Yes	Yes	Yes[a]	No	113,588	No	No	No	Some
South Dakota	Yes	No	Yes	No	11,564	No	No	Yes	Widespread
Tennessee	n/a	No	No	Yes	213,417	No	No	Yes	Some
Texas	No	Yes	Yes	Yes	296,588	No	No	Yes	Widespread

(continued)

Exhibit A1. Selected Characteristics of State Medicaid Programs (continued)

	Medicaid Cost Containment Policies for RX				Medicaid and Part D				
	Copayments	Preferred Drug List	Any Prior Authorization	Mental Health Carve-out in Medicaid	Dual Eligibles Auto-Enrolled into PDPs (2/11/06)	Covers Part D Copayments	Covers Non-Formulary Drugs	Temporary Coverage for Dual Eligibles	Medicaid Director's View on Problems with Part D Transition
Utah	Yes	No	Yes	Yes	20,028	No	No	Yes	Widespread
Vermont	n/a	No	No	No	15,771	No	No	Yes	Widespread
Virginia	Yes	Yes	Yes	Yes	102,798	No	No	Yes	Widespread
Washington	Yes	Yes	Yes	Yes	95,777	No	No	Yes	Some
West Virginia	No	No	No	No	41,045	No	No	No	Some
Wisconsin	Yes	Yes[c]	No	No	109,026	No	No	Yes	Widespread
Wyoming	Yes	Yes	No	No	5,443	No	No	No	Some

[a] Mental health drugs excluded.

[b] Atypical antipsychotics excluded.

[c] Antidepressants excluded.

[d] Only certain counties.

[e] Copayments for dual eligibles covered through SPAP.

SOURCES:

Kaiser Family Foundation, www.statehealthfacts.org.

Kaiser Commission on Medicaid and the Uninsured, "State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update."

Smith, V., K. Gifford, S. Kramer, and L. Elam, "The Transition of Dual Eligibles to Medicare Part D Prescription Drug Coverage: State Actions During Implementation," Kaiser Commission on Medicaid and the Uninsured, February 2006.

Fox, K. and L. Schofield, "The Pharmacy Coverage Safety Net: Variations in State Responses to Supplement Medicare Part D," Muskie School of Public Service, University of Southern Maine, February 2006.

Crowley, J.S., D. Ashner, and L. Elam, "State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey-2005 Update," Kaiser Commission on Medicaid and the Uninsured, October 2005.

Exhibit A2. Medicaid Coverage of Benzodiazepines for Dual Eligibles, as of January 1, 2006

State	Benzodiazepines Covered	Notes
Alabama	Some	Categorically needy only. Benzodiazepines (including, but not limited to) Clonazepam, Temazepam, Diazepam
Alaska	All	Categorically needy only
Arizona	All	
Arkansas	All	
California	All	Pending CMS approval
Colorado	All	Categorically needy only
Connecticut	All	
District of Columbia	All	
Delaware	All	Categorically needy only
Florida	All	
Georgia	Some	Categorically needy only. Prior authorization required beyond 3 scripts. Benzodiazepines: generic anxiolytics, Librium, Valium, Xanax, Ativan, Serax, Tranxene for adults
Hawaii	All	
Idaho	All	Categorically needy only
Illinois	Some	No clarification, see www.hfs.illinois.gov
Indiana	All	Categorically needy only
Iowa	All	
Kansas	Some	Pending CMS approval. Benzodiazepines: Clorazepate, Temazepam, Lorazepam, Alprazolam, Diazepam
Kentucky	All	
Louisiana	All	
Maine	All	
Maryland	All	
Massachusetts	All	
Michigan	All	
Minnesota	All	Pending CMS approval
Mississippi	All	Categorically needy only
Missouri	Some	Categorically needy only. No clarification. See http://dss.missouri.gov/dms/pages/frequpdat.htm

(continued)

Exhibit A2. Medicaid Coverage of Benzodiazepines for Dual Eligibles, as of January 1, 2006 (continued)

State	Benzodiazepines Covered	Notes
Montana	All	
Nebraska	All	
Nevada	All	Categorically needy only
New Hampshire	All	
New Jersey	All	
New Mexico	Some	Categorically needy only. Benzodiazepines: Triazolam, Temazepam, Diazepam, Chlordiazepoxide, Alprazolam, Lorazepam
New York	All	
North Carolina	All	
North Dakota	All	
Ohio	All	Categorically needy only
Oklahoma	All	Categorically needy only
Oregon	All	Categorically needy only
Pennsylvania	All	
Rhode Island	All	
South Carolina	All	
South Dakota	All	Categorically needy only
Tennessee	None	www.state.tn.us/tenncare/pharmainfo.html
Texas	Some	Benzodiazepines: Estazolam, Flurazepam, Temazepam, Triazolam. Nonpreferred agents require prior authorization: Dalman, Doral, Halcion, Prosom, Restoril.
Utah	All	
Vermont	All	
Virginia	All	
Washington	All	
West Virginia	All	
Wisconsin	All	
Wyoming	All	Categorically needy only

SOURCE: National Mental Health Association, based on information obtained from the CMS Web site, "Medicaid Outpatient Drug Coverage Excluded Drug Coverage Information by State January 1, 2006."

Exhibit A3. Selected State Characteristics

State	CMS Region	% Rural (2000)	% Nonwhite (2000)	State Ranking on NAMI Report Card	Interagency Cooperation between State Mental Health Agency and Medicaid[a]
Alabama	4	44.6	28.9	D	2
Alaska	10	34.3	30.7	D	2
Arizona	9	11.8	24.5	D	2
Arkansas	6	47.6	20.0	D	2
California	9	5.5	40.5	C	2
Colorado	8	15.5	17.2	N/A	N/A
Connecticut	1	12.3	18.4	B	2
Delaware	3	20.0	25.4	C	2
District of Columbia	3	0.0	69.2	C	2
Florida	4	10.7	22.0	C	2
Georgia	4	28.3	34.9	D	2
Hawaii	9	8.4	75.7	C	2
Idaho	10	33.6	9.0	F	1
Illinois	5	12.2	26.5	F	2
Indiana	5	29.2	12.5	D	2
Iowa	7	38.9	6.1	F	2
Kansas	7	28.6	13.9	F	1
Kentucky	4	44.3	9.9	F	1
Louisiana	6	27.3	36.1	D	2
Maine	1	59.8	3.1	B	2
Maryland	3	13.9	36.0	C	2
Massachusetts	1	8.6	15.5	C	2
Michigan	5	25.3	19.8	C	2
Minnesota	5	29.1	10.6	C	2
Mississippi	4	51.2	38.6	D	2
Missouri	7	30.6	15.1	C	2
Montana	8	46.0	9.4	F	2
Nebraska	7	30.3	10.4	D	2
Nevada	9	8.4	24.8	D	2
New Hampshire	1	40.8	4.0	D	2
New Jersey	2	5.7	27.4	C	2
New Mexico	6	25.0	33.2	C	2
New York	2	12.5	32.1	N/A	N/A
North Carolina	4	39.8	27.9	D	2
North Dakota	8	44.2	7.6	F	2
Ohio	5	22.7	15.0	B	2
Oklahoma	6	34.7	23.8	D	2
Oregon	10	21.3	13.4	C	2
Pennsylvania	3	23.0	14.6	D	2

(continued)

Exhibit 3. Selected State Characteristics (continued)

State	CMS Region	% Rural (2000)	% Nonwhite (2000)	State Ranking on NAMI Report Card	Interagency Cooperation between State Mental Health Agency and Medicaid[a]
Rhode Island	1	9.1	15.0	C	1
South Carolina	4	39.5	32.8	B	2
South Dakota	8	48.1	11.3	F	2
Tennessee	4	36.4	19.8	C	2
Texas	6	17.5	29.0	C	2
Utah	8	11.7	10.8	D	2
Vermont	1	61.8	3.2	C	2
Virginia	3	27.0	27.7	D	2
Washington	10	18.0	18.2	D	2
West Virginia	3	53.9	5.0	D	2
Wisconsin	5	31.7	11.1	B	2
Wyoming	8	34.8	7.9	D	1

[a] Maximum score = 2

SOURCES: U.S. Census Bureau, 2000.
NAMI, "Grading the States, 2006."

APPENDIX B

BACKGROUND ON MEDICAID PROGRAMS AND PUBLICLY FUNDED MENTAL HEALTH SERVICES IN CASE STUDY STATES

This appendix presents an overview of the Medicaid programs and publicly funded mental health services in the six study states in order to provide context for the case study findings. For each state, the placement of the Medicaid agency and the mental health authority within the state government is described. Eligibility requirements and the service delivery system used for dual eligibles in each state's Medicaid program are described. Medicaid coverage of prescription medications, including copayment and formulary requirements, is also reviewed. Finally, the range of publicly funded mental health services available in each state, and the delivery system for these services is discussed.

I. Massachusetts

Medicaid Program

MassHealth, the Massachusetts Medicaid program, is administered by the Office of Medicaid in the Executive Office of Health and Human Services (EOHHS). MassHealth provides Medicaid benefits to individuals through a variety of coverage categories determined by income, disability, employment status, and other factors. MassHealth provides full Medicaid benefits to dual eligibles with incomes up to 100 percent of the federal poverty level (FPL). As part of an eligibility expansion through its 1115 waiver program, MassHealth covers working and nonworking disabled individuals with no income limit. However, nonworking disabled individuals must satisfy a one-time deductible before becoming eligible, and people with family incomes greater than 150 percent FPL must pay a monthly premium. Massachusetts also has a medically needy program through which people can spend down to Medicaid eligibility.

MassHealth enrolls just over 200,000 full-benefit dual eligibles. Of these, slightly less than half are disabled. Approximately 20 percent of all MassHealth beneficiaries are disabled, and about 40 percent of these are dual eligibles. Data are not available on the number of dual eligibles with SMI.

Nearly all dual eligibles receive Medicaid services on a fee-for-service basis, although a small percentage of aged dual eligibles are enrolled in an integrated Medicare/Medicaid managed care plan through the Senior Care Options Program. MassHealth has a managed care carve-out for behavioral health services, the Massachusetts Behavioral Health Partnership. However, dual eligibles are exempt from this carve-out program and receive behavioral health services on a fee-for-service basis.

Medicaid Coverage of Prescription Drugs

MassHealth does not have a preferred drug list (PDL), although some drugs are subject to prior authorization. Prescription drug coverage includes some over-the-counter generic medications. A $1 copayment is charged for generic and over-the-counter medications, and $3 is charged for brand-name drugs.

Mental Health Services

The Massachusetts Department of Mental Health (DMH) is the state mental health authority. Like the Office of Medicaid, it is housed in EOHHS. DMH provides publicly funded services to

about 24,000 adults, adolescents, and children annually. About half of the 19,000 adults are dual eligibles.

DMH provides case management, residential treatment, day treatment, and outpatient services. Most emergency and acute mental health care services are provided by MassHealth's behavioral health contractor through an interagency agreement. DMH-funded services are provided by state-operated and contracted providers. State-operated facilities include four state psychiatric hospitals, five community mental health centers with inpatient units, and adult inpatient units at two public health hospitals. DMH funding is allocated to six geographic areas. Each of these areas is subdivided into local service sites, which oversee service delivery for the local area.

II. Missouri

Medicaid Program

The Division of Medical Services (DMS) at the Missouri Department of Social Services (DSS) operates the Missouri Medicaid program. In Missouri, children and nondisabled adults are required to enroll in managed care plans. Dual eligibles and other Medicaid eligibles with disabilities, who are exempt from mandatory enrollment in a managed care health plan, receive services on a fee-for service basis.

Missouri provides full Medicaid benefits to dual eligibles with incomes up to 85 percent FPL. Missouri is a Section 209(b) state and applies a more stringent asset test than the federal Supplemental Security Income (SSI) program in determining eligibility for Medicaid.[2] Missouri does not have a buy-in program for working disabled individuals. Individuals who have higher incomes may qualify for Medicaid medically needy coverage by spending down to the categorical income limit.

Missouri provides Medicaid coverage to about 145,000 dual eligibles. About 17 percent of all Medicaid enrollees are disabled and, of these, approximately 40 percent are dual eligibles. Medicaid data for the October-December 2004 period, show that just over 77,000 dual eligibles (about half of all dual eligibles) had at least one prescription for a behavioral health medication during this time. Prior to Part D implementation, dual eligibles accounted for more than 40 percent of Medicaid beneficiaries who utilized behavioral health medications and almost half of Medicaid expenditures for these medications. Two-thirds of the dual eligibles that used behavioral health medications were prescribed antidepressants, half were prescribed anxiolytics or sedative hypnotics, and almost 30 percent used atypical antipsychotics. Atypical antipsychotics accounted for 45 percent of spending on behavioral health medications among dual eligible beneficiaries.

Medicaid Coverage of Prescription Drugs

By state law, the Missouri Medicaid program does not restrict access to behavioral health medications. However, there is a PDL and prior authorization requirements for other types of medications. All prescriptions are subject to retrospective drug utilization review. Prescription

[2] The Missouri asset limit is $1,000, while the SSI limit is $2,000.

drugs are subject to nominal copayments (from $0.50 to $2.00 depending on the price of the drug).

State officials regard access to mental health medications as essential to securing positive clinical outcomes for people with SMI, as well as avoiding the substantially higher costs associated with inpatient hospitalization and use of crisis services. DMS and the Missouri DMH have a strong history of collaboration through the Missouri Mental Health Medicaid Pharmacy Partnership. This program monitors practitioner prescribing practices in Medicaid through pharmacy claims analysis and seeks to improve prescribing practices for behavioral health medications through targeted education messages to prescribers.

Mental Health Services

DMH is a cabinet-level department comparable with the Missouri DSS. DMH includes the Division of Comprehensive Psychiatric Services (DCPS) (the Missouri state mental health authority), the Division of Alcohol and Drug Abuse, and the Division of Mental Retardation and Developmental Disabilities. DCPS serves about 50,000 individuals annually. About one-third of the individuals served through the DCPS are dual eligibles.

DCPS operates nine inpatient facilities. DMH contracts with community mental health centers to provide outpatient psychiatric services to individuals in need. The community mental health centers are designated as the DCPS local administrative agent. As such, they serve as the primary entry and exit point for state mental health services. They are responsible for assessment and service delivery for both adults and children in their assigned areas and for providing follow-up services for individuals released from state-operated inpatient hospitals.

III. New Jersey

Medicaid Program

The New Jersey State Medicaid Agency is housed within the Department of Human Services. New Jersey's Medicaid program serves about 140,000 dual eligibles. Although most Medicaid recipients in New Jersey are enrolled in managed care, dual eligibles continue to receive fee-for-service coverage. New Jersey provides full Medicaid benefits to dual eligibles with incomes up to 100 percent FPL. New Jersey has a medically needy program through which people can spend down to Medicaid eligibility. The state also provides Medicaid buy-in for working disabled people with incomes up to 250 percent FPL. About 16 percent of Medicaid beneficiaries in New Jersey are disabled and, of these, about one-third are dual eligibles. Information is not available on the number of dual eligibles with SMI.

Medicaid Coverage of Prescription Drugs

New Jersey's Medicaid pharmacy benefit has no copayment requirements, no PDL, no step therapy protocols, and few prior authorization requirements. Because Medicaid beneficiaries who are not dually eligible for Medicare are enrolled in mandatory managed care, fee-for-service Medicaid coverage of prescription drugs in New Jersey was applied primarily to dual eligibles prior to Part D implementation. Prior to implementation of Part D, New Jersey Medicaid processed approximately 1 million pharmacy claims per week.

Mental Health Services

Like the Medicaid agency, New Jersey's Department of Mental Health Services (DMHS) is housed within the Department of Human Services. DMHS operates five psychiatric hospitals, monitors and helps fund psychiatric services provided by a number of county hospitals, and contracts with more than 120 agencies for a wide range of community mental health services. Each year, DMHS serves over 6,500 people who require intensive inpatient treatment in state psychiatric hospitals for some period of time and over 270,000 community residents. About 6,300 dual eligibles reside in state-run mental health facilities or facilities for the developmentally disabled. The number of community-residing dual eligibles that receive DMHS services is unknown.

IV. North Carolina

Medicaid Program

The North Carolina Department of Health and Human Services (DHHS) Division of Medical Assistance is the State Medicaid Agency. North Carolina extends full Medicaid benefits to dual eligibles with incomes up to 100 percent FPL. Individuals with incomes above 100 percent FPL may qualify for Medicaid through the state's medically needy spend-down eligibility category. North Carolina added a Medicaid buy-in program for working people with disabilities in July 2007. North Carolina serves about 200,000 dual eligibles. Of the approximately 215,000 nonaged persons with disabilities covered under its Medicaid program, about 38 percent (81,000 individuals) are dual eligibles. Information about how many dual eligibles have SMI was not available.

Medicaid services mainly are delivered through fee-for-service arrangements. Primary care case management is used throughout the state. In addition, care management models and networks are being implemented in several areas of the state.

Medicaid Coverage of Prescription Drugs

Although North Carolina's Medicaid program does not have a PDL, the Prescription Advantage List was developed as a voluntary tool to guide drug prescribing practices. In June 2006, the state implemented a new policy that limits adults to eight prescriptions per month. However, pharmacists can override the limit for up to three additional prescriptions per month based on consumer need. North Carolina imposes a $3 per prescription copayment for both brand-name and generic medications.

Mental Health Services

The DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services is the North Carolina state mental health authority. In 2006, North Carolina furnished publicly funded mental health services to 177,427 adults.

North Carolina launched a mental health system reform initiative in 2001. The aim of this initiative was to refocus the provision of services on state-specified priority populations and emphasize person-centered service delivery practices. As part of this system reform initiative, the state consolidated and restructured its network of local area programs. Area programs were

repositioned as local management entities (LMEs). There are 30 LMEs, each of which serves one or more North Carolina counties. As part of the restructuring, LMEs were required to spin off their direct-service delivery operations and develop local provider service delivery networks. This spin-off included LME divestiture of case management services. There are more than 1,500 service providers in the LME networks.

In 2005-2006, North Carolina revamped its Medicaid coverage of mental health services. The new Medicaid Rehabilitation Option coverage stresses delivery of evidence-based mental health services, including coverage of community support services. The combination of mental health reform and the implementation of the new Medicaid coverage resulted in some turmoil in the service delivery system. This turmoil posed some additional challenges for the implementation of Part D, especially because of the dispersion of case management services away from the LMEs to service providers.

V. Oregon

Medicaid Program

Oregon's Medicaid program is administered by the Division of Medical Assistance Programs in the Oregon Department of Human Services. Oregon operates its Medicaid program, the Oregon Health Plan (OHP), under a Federal Section 1115 waiver. OHP has been in operation since 1993. Under the waiver, the Oregon Health Plan Plus (OHP+) component serves Medicaid beneficiaries, including dual eligibles. Other low-income individuals and families who are not eligible for Medicaid are served through OHP Standard, which covers a more limited benefit package than OHP+.

In March 2007, 342,620 individuals were enrolled in OHP+, about 11 percent of whom were dual eligibles. There were 61,285 OHP+ enrollees who were nonaged individuals with disabilities (16 percent of all Medicaid beneficiaries); of these, 23,289 were full-benefit dual eligibles. Oregon extends full Medicaid benefits to dual eligibles with incomes up to 100 percent FPL. Oregon also operates a Medicaid buy-in program for working people with disabilities who have incomes less than 225 percent FPL. It is not known how many OHP+ dual eligible beneficiaries have SMI.

Starting in 2002, Oregon experienced major budgetary shortfalls. These shortfalls resulted in major reductions in OHP Standard enrollment and significant reductions in the scope of OHP-covered services. In 2003, Oregon terminated its Medicaid coverage of medically needy individuals, including people with disabilities. The state also pared back eligibility for home- and community-based services (HCBS) for older persons and individuals with disabilities.

Most OHP+ beneficiaries are enrolled in 1 of 15 fully capitated managed health care plans. About two-thirds of dual eligibles are enrolled in fully capitated health plans. The remainder receive services through fee-for-service arrangements. Medicaid-financed mental health services are furnished under a separate mental health carve-out arrangement. (These arrangements are discussed in greater detail in the section on mental health services.) Long-term care services (i.e., nursing facilities and HCBS) are delivered on a fee-for-service basis.

Medicaid Coverage of Prescription Drugs

OHP+ beneficiaries who are enrolled in a fully capitated health plan receive their prescription drugs through their health plan. Since the implementation of Part D, health plans are responsible only for drugs not covered by Medicare for OHP+ dual eligibles. In 2001, Oregon initiated a Pharmacy Management Program and launched a PDL for OHP+ beneficiaries who receive drugs on a fee-for-service basis. Drugs are added to the PDL using an evidence-based evaluation. The PDL may be overridden based on physician certification of medical necessity. At the time of the site visit, the PDL did not encompass mental health drugs. The Division of Medical Assistance Programs recommended the addition of mental health drugs to the PDL in the biennium that begins in July 2007, which resulted in the addition of antipsychotics, mood stabilizers, antidepressants, and anxiolytics to the PDL (http://pharmacy.oregonstate.edu//drug_policy/prescriber_tools/POCKETFinal.pdf).

OHP instituted copayments for prescription drugs in 2003. The copayment amounts are $2 for generics and $3 for brand-name drugs. People who receive long-term care services (whether in an institutional setting or through a HCBS waiver) are exempt from copayments.

Mental Health Services

The Oregon Department of Human Services Addictions and Mental Health Division is the state mental health authority. Community mental health programs in all 36 Oregon counties provide mental health services for low-income adults and children who have serious emotional and psychiatric disorders or are a danger to themselves or others, are unable to meet their basic needs, or are in danger of being removed from their homes because of emotional disorders. Services include acute inpatient treatment, residential treatment, adult foster care, outpatient therapy, support for successful community living, medications, case management, assistance finding and maintaining housing, and work and social support.

As previously noted, Medicaid mental health services are furnished under the Section 1115 waiver through a separate carve-out arrangement. OHP+ beneficiaries obtain mental health benefits through a network of nine mental health organizations. These include OHP+ fully capitated health plans, county or regional government organizations that directly provide or contract for community mental health services, and private mental health organizations. The mental health carve-out covers the full range of mental health services. Mental health drugs are not included in the carve-out.

VI. Texas

Medicaid Program

The Health and Human Services Commission (HHSC) is the Texas Medicaid agency. HHSC administers the Medicaid state plan, has responsibility for determining Medicaid eligibility, and directly manages Medicaid acute care, prescription drug, and managed care programs. HHSC contracts with other state agencies to operate some components of the Medicaid program. For example, the Department of Aging and Disability Services has operational responsibility for Medicaid long-term services, including nursing facility services, services for persons with developmental disabilities, and HCBS waiver programs. The Department of State Health

Services (DSHS) has operational responsibility for Medicaid rehabilitative and targeted case management services for persons with SMI.

Texas extends Medicaid eligibility to aged and disabled individuals who receive SSI cash assistance. In addition, Texas has a buy-in program that enables people with disabilities who work and have incomes up to 250 percent of FPL to obtain Medicaid coverage by paying a premium. Texas has a medically needy program, but limits the program to children and pregnant women. In May 2007, there were 409,388 nonaged Medicaid beneficiaries with disabilities in Texas. About one-third of these individuals were dual eligibles. Dual eligibles comprised about 16 percent of all Medicaid beneficiaries in Texas. Information is not available about how many of these individuals had SMI.

Although Texas has been expanding the use of managed care arrangements for the delivery of Medicaid services, dual eligibles are generally excluded from enrollment in the state's capitated Medicaid managed care program (STAR), which operates in most urban areas. However, dual eligibles and other disabled Medicaid beneficiaries in selected areas of the state are required to enroll in a managed care plan under the STAR+PLUS program, which integrates the delivery of acute and long-term services. STAR+PLUS, which previously only covered the Houston area, was expanded to 29 counties in 2007.

Medicaid Coverage of Prescription Drugs

Texas limits most adult Medicaid beneficiaries to three outpatient prescriptions per month. Persons served in long-term care facilities and through HCBS waivers are not subject to this limit. Also, individuals who are enrolled in a capitated managed care plan are not subject to the limit. The state allows prescriptions for up to a 90-day supply. This permits Medicaid beneficiaries to have as many as nine prescriptions in effect during a 3-month period. The state does not require copayments for prescription drugs. Texas has a PDL that is administered through a contracted vendor. The PDL encompasses some classes of mental health drugs (e.g., antidepressants and atypical antipsychotics). Prior authorization must be obtained for drugs not on the PDL.

Mental Health Services

DSHS is the Texas state mental health authority. It contracts with 39 local mental health authorities (LMHAs) to deliver mental health services in communities across Texas. DSHS also contracts with NorthSTAR, a Medicaid managed care plan that operates under a federal §1915(b) Medicaid waiver and serves seven counties in the Dallas Medicaid service region. In addition to providing direct services, LMHAs are responsible for planning; policy development; and coordinating, allocating, and developing resources for mental health services in their local service areas. With respect to adults, LMHAs concentrate on supporting individuals with SMI. As a general rule, LMHAs support lower-income individuals (most with incomes that are less than 150 percent FPL). An estimated 10,000 dual eligibles are served by LMHAs.

Through its Medicaid program, Texas covers rehabilitative and targeted case management services for adults with severe and persistent mental illness. The state also covers mental health practitioner and outpatient services. Mental health services are furnished by private practitioners and the LMHAs.

APPENDIX C

SITE VISIT DISCUSSION GUIDES

I. State Agency Discussion Guide

Background

- Describe the size and characteristics of the dual eligible population with behavioral health disorders (i.e., mental disorders, substance abuse disorders, dual diagnoses—mental health and substance abuse, if possible).

- Describe the relationship between mental health, substance abuse, and Medicaid agencies (i.e., the organizational relationship and services available through each).

- Describe the Medicaid program structure, including description of prescription drug coverage and cost-sharing before Part D, transition coverage, and wraparound coverage under Part D. Is wraparound coverage a long-term benefit or a short-term response to Part D?

- Describe the prescription drug plans in this state that qualify for low-income subsidy.

- How do prescription drug plans' formularies compare with Medicaid?

- What is the role of Medicare Advantage plans in serving dual eligibles?

- What types of data and system changes were needed for Part D? Have they been implemented? Are there needed data or system changes that haven't been implemented? Is the state negotiating data exchanges with the plans?

- Has Part D imposed new burdens on your staff? Are these ongoing or did they occur mostly around the initial transition? Have you had to add new staff?

Outreach, Education, and Enrollment

- Describe outreach, education, and enrollment activities in your state: state agencies, federal, community based. Were any targeted to dual eligibles? To people with mental health and substance abuse conditions? To minority populations?

- Do state, federal, and community-based organizations collaborate in these activities? Who has taken the lead?

- Have these activities been adequate? Are they ongoing? Are new efforts planned for the new contract year?

- Do dual eligibles receive help in determining if the plan they have been assigned to is a good match and in selecting a new plan if needed? From whom? Is this help adequate?

- Are there ongoing problems with enrollment lags and data transfers? What are the causes of these problems? What are the impacts? How are they handled?

- Has there been ongoing confusion about plan enrollment and cost-sharing requirements for dual eligibles (plan switchers, new duals)?

- Has there been much plan switching? Do you anticipate switching with the new contract year?

- Do plans do anything to discourage dual eligibles with mental health/substance abuse problems from selecting their plans or remaining enrolled?

Part D Impacts

- Does your agency or other state agencies do anything to monitor beneficiary problems and Part D impacts?

- Has Part D had an impact on access to needed medications and patient compliance (e.g., plan formularies, copayment requirements, dosage limits, restrictions on off-label use, other administrative requirements)? If beneficiaries switched plans, did it affect their access to original medications (e.g., were medications not grandfathered and now come under prior authorization or other control mechanisms)?

- Have beneficiaries had to switch their medications?

- Have the special protections worked (e.g., grandfathering provisions, coverage of "all or substantially all" antidepressants and antipsychotics)?

- Do beneficiaries that need barbiturates or benzodiazepines receive these medications? Do beneficiaries/providers/pharmacies understand the wraparound coverage?

- Are the plan exceptions and appeals processes working? Do you assist beneficiaries with this process?

- Does your agency intervene in any other way to ensure that beneficiaries continue to receive necessary medications? What happens if a plan doesn't cover a needed medication?

- Has Part D had an impact on patient outcomes?

- Has Part D had an impact on use of other services (emergency room, inpatient hospital, mental health, etc.)?

- Has Part D had an impact on care coordination? Do prescription drug plans and mental health and substance abuse providers interact?

- How does the experience of dual eligibles in Medicare Advantage plans compare with those in stand-alone plans?

Wrap Up

- Do you see any benefits of Part D for dual eligibles?
- What have been the most serious problems encountered under Part D? To what extent were they anticipated versus unanticipated?
- Which problems have been resolved? How did you respond to these problems? Did you develop creative solutions that others could learn from? Did they require permanent versus temporary responses? Did they require legislative or programmatic changes?
- What problems have not been resolved? Why couldn't they be resolved?
- Have you done anything to inform CMS or policy makers about problems that have arisen?
- Do you expect new problems to arise in the future (with the new contract year and after)?
- Does the Part D model work for this population?
- Do have recommendations for changes to the Part D program?

II. Provider/Case Manager Discussion Guide

Background

- Describe the size and characteristics of the dual eligible population that you serve.
- Describe the services you provide and your organization's relationship with the state mental health, substance abuse, and Medicaid agencies.
- What types of data and system changes were needed for Part D? Have they been implemented? Are there needed data or system changes that haven't been implemented?
- Has Part D imposed new burdens on your staff? Are these ongoing or did they occur mostly around the initial transition?

Outreach, Education, and Enrollment

- Did your organization do anything to inform your dual eligible clients about Part D?
- Did you collaborate with state agencies, federal agencies, or other community-based organizations in outreach and educational activities?

- Have the outreach and educational activities been adequate? Are they ongoing? Are new efforts planned for the new contract year?

- Do you help your dual eligible clients determine if the plan they have been assigned to is a good match and help them select a new plan if needed? What type of help do you provide? Do other agencies or organizations provide this assistance? Has it been adequate?

- Are there ongoing problems with enrollment lags? How are these lags handled?

- Has there been ongoing confusion about plan enrollment and cost-sharing requirements for dual eligibles (plan switchers, new duals)?

- Has there been much plan switching? Do you anticipate switching with the new contract year?

- Do plans do anything to discourage dual eligibles with mental health/substance abuse problems from selecting their plans or remaining enrolled?

Part D Impacts

- Does your organization do anything to monitor clients' problems and Part D impacts? Do you interact with prescription drug plans? With state agencies?

- Has Part D had an impact on clients' access to needed medications and patient compliance (e.g., plan formularies, copayment requirements, dosage limits, restrictions on off-label use, other administrative requirements)?

- Have beneficiaries had to switch their medications?

- If beneficiaries have switched medications because of formulary limitations, were these drugs covered under Medicaid? Do you know how prescription drug plan formularies compare to Medicaid?

- Have the special protections worked (e.g., grandfathering provisions, coverage of "all or substantially all" antidepressants and antipsychotics)?

- Do clients that need barbiturates or benzodiazepines receive these medications? Do beneficiaries/providers/pharmacies understand the wraparound coverage?

- Are the plan exceptions and appeals processes working? Do you assist clients with this process?

- Does your organization intervene in any other way to ensure that clients continue to receive necessary medications? What happens if a plan doesn't cover a needed medication?

- Has Part D had an impact on patient outcomes?

- Has Part D had an impact on use of other services (emergency room, inpatient hospital, mental health, etc.)?

- Has Part D had an impact on care coordination?

Wrap Up

- Has Part D benefited your clients in any way?

- What have been the most serious problems encountered under Part D? To what extent were they anticipated versus unanticipated?

- Which problems have been resolved? Any particularly creative solutions that others could learn from? How did you respond to these problems? Did they require permanent versus temporary responses? Did they require legislative or programmatic changes?

- What problems have not been resolved? Why couldn't they be resolved?

- Have you done anything to inform state or federal agencies about problems that have arisen?

- Do you expect new problems to arise in the future (with the new contract year and after)?

- Does the Part D model work for this population?

- Do have recommendations for changes to the Part D program?

III. Pharmacy Discussion Guide

Background

- Describe the prescription drug plans in this state that qualify for low-income subsidy.

- How do prescription drug plans' formularies compare with Medicaid?

- What types of data and system changes did pharmacies need to adopt for Part D? Have they been implemented? Are there needed data or system changes that haven't been implemented?

- Has Part D imposed new burdens on your staff? Are these ongoing or did they occur mostly around the initial transition?

Outreach, Education, and Enrollment

- Describe outreach, education, and enrollment activities in your state: state agencies, federal, community based. Were pharmacies involved in these activities? Were any

targeted to dual eligibles? To people with mental health and substance abuse conditions? To minority populations?

- Do state, federal, and community-based organizations collaborate in these activities? Who has taken the lead?

- Have these activities been adequate? Are they ongoing? Are new efforts planned for the new contract year?

- Do dual eligibles receive help in determining if the plan they have been assigned to is a good match and in selecting a new plan if needed? From whom? Is this help adequate?

- Are there ongoing problems with enrollment lags and data transfers? What are the causes of these problems? What are the impacts? How do pharmacies handle them?

- Has there been ongoing confusion about plan enrollment and cost-sharing requirements for dual eligibles (plan switchers, new duals)?

- Have any problems arisen because not all pharmacies participate in Part D?

Part D Impacts

- Has Part D had an impact on access to needed medications and patient compliance for dual eligibles with mental health and substance abuse disorders (e.g., plan formularies, copayment requirements, dosage limits, restrictions on off-label use, other administrative requirements)?

- Have beneficiaries had to switch their medications?

- Have the special protections worked (e.g., grandfathering provisions, coverage of "all or substantially all" antidepressants and antipsychotics)?

- Do beneficiaries that need barbiturates or benzodiazepines receive these medications? Do beneficiaries/providers/pharmacies understand the wraparound coverage?

- Are the plan exceptions and appeals processes working? Does anyone assist beneficiaries with this process?

- What happens if a plan doesn't cover a needed medication?

- What impact has Part D had on pharmacies? Have you experienced any problems in receiving payments from the plans?

Wrap Up

- Do you see any benefits of Part D for dual eligibles?

- What have been the most serious problems encountered under Part D? To what extent were they anticipated versus unanticipated?
- Which problems have been resolved? Are there creative solutions that others could learn from? How did you respond to these problems? Did they require permanent versus temporary responses? Did they require legislative or programmatic changes?
- What problems have not been resolved? Why couldn't they be resolved?
- Have you done anything to inform federal or state agencies or policy makers about problems that have arisen?
- Do you expect new problems to arise in the future (with the new contract year and after)?
- Does the Part D model work for this population?
- Do have recommendations for changes to the Part D program?

Endnotes

[1] Other categories of dual eligibles receive Medicaid coverage of Medicare cost-sharing only through the Medicare Savings Programs. These include Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualified Individuals (QIs). Depending on their income and assets, either all of their Medicare cost-sharing requirements are covered or just their Part B premium.

[2] Authors' calculation based on data reported in http://www.statehealthfacts.org/comparetable.jsp?ind=303&cat=6 and http://www.statehealthfacts.org/comparetable.jsp?ind=304&cat=6, accessed March 31, 2008.

[3] Authors' calculation based on data reported in http://www.statehealthfacts.org/comparetable.jsp?ind=303&cat=6 and http://www.statehealthfacts.org/comparetable.jsp?ind=305&cat=6, accessed March 31, 2008.

[4] Holohan, J. and A. Ghosh (July 2005). "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003." Available from http://www.kff.org/medicaid/ 7346.cfm. Includes full- and partial-benefit dual eligibles.

[5] Estimate is from the Medicare Current Beneficiary Survey, CY2003 Cost and Use Public Use File reported in *Health and Health Care of the Medicare Population: Data from the 2003 Medicare Current Beneficiary Survey*, Table 2.8. Available from http://www.cms.hhs.gov/mcbs/downloads/HHC2003section2.pdf. Includes full- and partial-benefit dual eligibles.

[6] Kasper, J., R. Elias, and B. Lyons (March 2004). "Dual Eligibles: Medicaid's Role in Filling Medicare's Gaps." Available from http://www.kff.org/medicaid/7058.cfm. Estimate is from the Medicare Current Beneficiary Survey, CY2000 Cost and Use Public Use File. Includes full- and partial-benefit dual eligibles.

[7] Irvin, C.V. and C. Johnson (March 2007). "Medicaid Populations with Chronic and Disabling Conditions: A Compilation of Data on Their Characteristics, Health Conditions, Service Use, and Medicaid Payments." Table VI.5. Mathematica Policy Research, Cambridge, MA. Based on analysis of Social Security Administration data on eligibility for SSDI and SSI merged with Medicaid Analytic Extract (MAX) data on Medicaid enrollees in 1999 and 2000. Most individuals who are concurrently eligible for SSI and SSDI are full-benefit dual eligibles.

[8] Mental retardation is the primary disabling condition for 12%.

[9] Bagchi, A.D., D. Esposito, and J.M. Verdier (Summe 2007). "Prescription Drug Use and Expenditures Among Dually Eligible Beneficiaries." *Health Care Financing Review* 28(4):43-56.

[10] In addition to this qualitative study, RTI designed a plan for quantitative analyses of Part D effects on dual eligibles with SMI using existing data sources. This quantitative analysis plan is described in a separate memo submitted to the Assistant Secretary for Planning and Evaluation.

[11] Closed formularies do not cover the cost of drugs that are not included in the formulary unless a medical exception is granted.

[12] Koyanagi, C., S. Forquer, and E. Alfano (March-April 2005). "Medicaid Policies to Contain Psychiatric Drug Costs." *Health Affairs*, 24(2):36-44.

[13] Sullivan, G., D.M. Perry, W. Grimes, and H. Wetherbee (February 2004). "Benefit Coverage of Novel Antipsychotics in Medicaid Programs and the Veterans Health Administration." *American Journal of Medical Quality*, 19(1):37-40.

[14] The subsidy benchmark, which is defined for each of 34 Part D regions of the country, is the enrollment weighted average of PDP premiums in the region. In 2006, the benchmark was defined as the simple average of PDP premiums, because the Part D program was new and no enrollment data were available to set the weights.

[15] CMS has adopted policies to minimize dislocations due to changes in the plans that have premiums below the subsidy benchmark from year to year. CMS implemented a demonstration that changed the formula for calculating the benchmark premium and reduced the amount of variation from year to year. In addition, beneficiaries are allowed to remain in their current plan without paying a premium if their PDP's premium exceeds the benchmark by less than a $2 *de minimus* amount.

[16] The other classes of drugs covered by the "all or substantially all" requirements are anticonvulsant, anticancer, immunosuppressant, and HIV/AIDS medications.

[17] Other exclusions include barbiturates; drugs when used for anorexia, weight loss, or weight gain; drugs when used to promote fertility; drugs when used for cosmetic purposes or hair growth; drugs when used for the symptomatic relief of cough and colds; prescription vitamins and mineral products; nonprescription (over-the-counter) drugs; and drugs used for smoking cessation. However, Part D covers smoking cessation drugs for dual eligibles because many states had covered these drugs under Medicaid.

[18] Bambauer, K.Z., J.E. Sabin, and S.B. Soumerai (September 2005). "The Exclusion of Benzodiazepine Coverage in Medicare: Simple Steps for Avoiding a Public Health Crisis." *Psychiatric Services*, 56(9):1143-1146.

[19] CMS' plan is described in "A Strategy for Transitioning Dual Eligibles from Medicaid to Medicare Prescription Drug Coverage – May 2, 2005," accessed November 21, 2007, from http://www.cms.hhs.gov/States/Downloads/strategyfortransitioningDE.pdf.

[20] See http://www.cms.hhs.gov/States/Downloads/modelstates.pdf.

[21] General Accountability Office (GAO) (May 2007). "Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries."

[22] Kaiser Commission on Medicaid and Uninsured (January 2006). "Dual Eligibles and Medicare Part D. An Implementation Update."

[23] Centers for Medicare & Medicaid Services (CMS) (24 January 2006). "Fact Sheet: State Reimbursement for Medicare Part D Transition."

[24] Wraparound coverage refers to state-provided benefits to enhance or supplement Part D coverage. This includes covering medications excluded from Part D, denied prescriptions, and beneficiary cost-sharing obligations.

[25] The Deficit Reduction Act of 2005 created some exceptions to this requirement.

[26] PDPs are only permitted to make midyear formulary changes that remove Part D drugs from their formulary, move covered Part D drugs to a less preferred tier status, add utilization management requirements, or remove dosage if enrollees currently taking the affected drug are exempt from the formulary change for the remainder of the plan year. Although this policy protects beneficiaries from needing to switch plans during the current contract year because of midyear formulary changes, local provider agency staff generally were not aware of this policy.

[27] GAO, op cit.

[28] Ibid.

[29] As noted previously, local providers interviewed were not aware of Part D policy that exempts enrollees currently taking a medication from midyear formulary changes for the remainder of the plan year.

[30] See CMS notice at http://www.cms.hhs.gov/partnerships/downloads/determine.pdf.

[31] The exemption takes effect after a person has been institutionalized for 30 days.

[32] Houser, A, W. Fox-Grage, and M.J. Gibson (2006). "Across the States 2006: Profiles of Long-Term Care and Independent Living." AARP Public Policy Institute Retrieved March 20, 2008, from http://assets.aarp.org/rgcenter/health/d18763_2006_ats.pdf.

[33] Federal Medicaid policy does not permit states to claim federal financial participation in the cost of room and board for people who receive services in noninstitutional settings. Individuals who are served in community residences where Medicaid dollars support the provision of supervision, care, and treatment typically are required to turn over their income to the provider agency to defray the costs of room and board, retaining only a small personal needs allowance. Some people with SMI receive services through home and community-based services (HCBS) waiver programs. States may provide HCBS to individuals with incomes as high as 300 percent of the SSI Federal Benefit Rate (about 225 percent of the federal poverty level) under a special eligibility category. In general, people who qualify under this special income category are subject to additional cost-sharing requirements that require them to pay some of their income to the state in excess of the allowance for room and board.