National Mental Health Association

Key Questions: Transition to the Medicare Prescription Drug Benefit

The new Medicare prescription drug program will take effect January 1, 2006, enabling millions of Americans eligible for Medicare to receive prescription drug coverage. States bear a significant administrative responsibility, and in many cases, financial burden in implementing the Medicare Rx benefit. In the coming months, mental health advocates have an important role in working with state policymakers to ensure that consumers – particularly those individuals with dual eligibility – are protected during their transition from Medicaid coverage to a Medicare prescription drug plan. More important, in 2006, there are many policy choices posed by this new program. This document highlights issues that need to be addressed to ensure that mental health consumers are protected during this time.

Enrollment Issues

- How is the state educating and reaching out to dually eligible beneficiaries to ensure enrollment in the most appropriate Medicare drug plan? What are potential roles that MHAs, or other consumer/family advocacy groups can play in this effort?
- What consumer tracking mechanisms (e.g., case managers, a patient hotline, ombudsman offices) will the state use to ensure that Medicare beneficiaries, especially dual eligibles and people with low incomes, get enrolled in a prescription drug plan?
- How will the state address the needs of individuals who have intermittent eligibility for Medicaid?

Continuity of Care Issues

- How will the state determine if access issues or continuity of care issues arise for the transitioning population?
- Will the state authorize transitional refill prescriptions (e.g., 60-day or 90-day refill) in December 2005 to give dual eligibles a supply of medication during the transition to accommodate possible plan changes or the need to seek exceptions to a plan's formulary? CMS guidance has indicated that it will pay the Medicaid match for early refills or for a 30-90 day supply of medications during the transition period.[1]
- Will the state cover the cost of medications excluded from the new prescription drug benefit -- such as benzodiazepines -- through its Medicaid program? Note that states can receive federal Medicaid matching funds for covering these prescription drugs according to CMS guidance.[2]

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[1] Centers for Medicare and Medicaid Services, *A Strategy for Transitioning Dual Eligibles from Medicaid to Medicare Prescription Drug Coverage*, May 2, 2005, available at http://www.cms.hhs.gov/medicarereform/strategyforduals.pdf

[2] Dear State Medicaid Director Letter, June 3, 2005, available at http://www.cms.hhs.gov/states/letters/smd060305.pdf

- Has the state signed any contracts with prescription drug plans to receive utilization data for dual eligibles to enable current disease management, provider education, or targeted case management programs to continue?

State Wraparound/SPAP Issues

- How will the state handle cost-sharing for individuals in inpatient psychiatric settings? Will dual eligibles in these settings have their co-pays waived?[3]
- Will the state consider providing dual eligibles or other Medicare beneficiaries with wraparound coverage of medications that are not on a prescription drug plan's formulary? If so, will such wraparound coverage be limited to a designated period?
- Will the state cover co-pays or premium costs for those subject to premiums? Note that if co-pays are covered through the SPAP, it would count as "true out-of-pocket (TrOOP) costs" for purposes of meeting the eligibility limit for catastrophic coverage (Premium coverage would not count toward TrOOP).
- Will states use savings in their SPAP programs or savings in their Medicaid program to cover populations not eligible for the Part D benefit (e.g., uninsured individuals who are not seniors, disabled individuals in the two-year waiting period before they are eligible for Medicare) or otherwise reinvest this funding in the state's health care system?

Budget Evaluation Issues

- How will states evaluate the total impact of the program on state budgets, including reductions in medication costs for dual eligibles, clawback payments, and cost-shifting in other budget areas (e.g., changes in doctor's visits, hospital visits, emergency room visits)?

NMHA has developed a range of resources for education and advocacy work around the Medicare Prescription Drug Benefit. Training modules, educational products and consumer-oriented materials to assist in navigating the enrollment process are available at www.nmha.org/medicare

For further information and assistance, contact the Advocacy Resource Center at shcrinfo@nmha.org or 1-800-969-6642 (Option 6).

[3] Dual eligibles who reside in long-term care facilities, as defined in the Medicare Part D regulations, will have their prescription drug co-pays waived. This definition includes skilled nursing facilities and any medical institution or nursing facilities as defined under § 1919(a) of the Medicaid Act. This includes ICFs/MR and inpatient psychiatric hospitals, provided that those facilities meet the requirements of a medical institution that receives Medicaid payments for institutionalized individuals under § 1902(q)(1)(B) of the Medicaid Act. This does not include IMDs.