

RI Community Medication Assistance Program
Procedures and Requirements

Revised 11/08

Table of Contents

I. History and Overview3

II. Client Eligibility4

III. CMHO Requirements6

IV. Participating Pharmacy Requirements8

V. Contacts9

VI. Frequently Asked Questions10

VII. Appendices12

 1. Requirements For CMAP Paperwork (REQ-11/08)

 2. Client Application Form (CA-08/07)

 3. CMAP Termination Notice (TERM-08/07)

 4. CMAP Dispense Report Requirements (Elect-08/07)

 5. Approximate ESH Drug Costs (Cost-11/08)

 6. Federal Poverty Level Chart (FPL-02/08)

I. History and Overview

The Rhode Island Community Medication Assistance Program (CMAP) provides psychotropic medications to community clients who cannot afford them. The program originated when the cost of medication was identified as a stumbling block to the process of deinstitutionalization in Rhode Island over 25 years ago. Initially, clients who were moved to community settings were required to come back to the pharmacy located on the grounds of the state hospital in Cranston to pick up their medications.

As the number of community clients grew, DBH changed the system to one in which individual private pharmacies in each catchment area were asked to stock “state purchased” medication on their shelves and to dispense it to clients. The system currently serves approximately 1,500 active clients at any given time.

For the bulk of the system, the MHRH Pharmacy purchases medication through an inter-state consortium at reduced cost and supplies it to the community pharmacies. The community pharmacies, in turn, dispense the medication to eligible individuals presenting with a CMAP prescription written by an authorized practitioner.

Community pharmacy stock is replenished by the MHRH Pharmacy on demand as evidenced by the submission of monthly dispense reports to the state. The dispense reports, which are entered into the state computer system for purposes of tracking and monitoring, also automatically trigger the generation of a payment to the individual pharmacy for every prescription dispensed.

II. Client Eligibility

The Community Mental Health Organizations, or other entities designated by the Department, are responsible for eligibility determination. These determinations are made through uniform application of the guidelines listed below.

1. Clients must be 18 years of age or older and be legal residents of the State of Rhode Island.
2. The client must have had a psychiatric hospitalization at one point in their lives OR be at risk of psychiatric hospitalization. This includes individuals who are currently stable but who, in the opinion of the practitioner, would be at risk of hospitalization without continued psychiatric medication.
3. The prescribing practitioner must determine that the medication is medically necessary.
4. The entity making the determination must review the client's insurance coverage and all other pharmacy benefits and determine that either:
 - a) those benefits do not pay for the required medication or;
 - b) that if those benefits do cover medication, out-of-pocket expenses required for a one-month supply of the medication being considered for inclusion in the CMAP program equals or exceeds 25% of the client's net monthly income.
5. Clients must have total household income less applicable deductions of less than or equal to 200% of the Federal Poverty Level in order to qualify for CMAP. There are no exceptions to this requirement.

For purposes of CMAP, "total household income" includes income from wages and tips; alimony or child support; and the gross amount of any pension or annuity (including private pensions; railroad retirement act benefits; payments received under the Federal SSA or State unemployment insurance laws; and Veterans disability pensions)

"Income" does not include capital gains and non-cash benefits such as public housing, Medicaid, and food stamps.

"Applicable deductions" are as follows:

- a) Documented court ordered payments going out of the household, e.g. alimony and child support;
 - b) Documented medical expenditures including out-of-pocket medical costs as well as medical insurance costs including premiums, deductibles and co-payments.
6. Full income verification must be repeated at least once every 12 months. Additionally, clients must be asked if there are any changes in their income level or insurance coverage at 6-month intervals and their status should be updated to reflect said changes, if any.
 7. Client assets (e.g. house, trust fund, bank account) are not normally considered in the determination of eligibility. However, the Department reserves the right to review any individual client's situation and deny eligibility in the event that available assets in an amount determined by the Department to be 'excessive' are found.

8. There may be restrictions on the medications that clients who have “Medicare only” are eligible for. This is determined as follows:
 - a) Medicare-only clients must apply for the Medicare Low Income Subsidy and present a determination letter from Medicare in order to be considered for CMAP.
 - i. Applicants who are found ineligible for the Part D Low Income Subsidy at the <135% FPL tier are eligible for all CMAP medication as determined by medical necessity assuming that they meet all other eligibility criteria.
 - ii. Applicants who are found eligible for the LIS at the <135% FPL are eligible to receive only those CMAP medications which are not able to be covered under Medicare Part D (e.g. benzodiazepines), again as determined by medical necessity.
 - b) A copy of the determination letter must be submitted to the Department along with the CMAP application.
 - c) A change in client status that indicates potential eligibility for LIS should trigger a repeat application with the results being submitted to the Department.

III. CMHO Requirements

1. All agencies that do not transmit prescriptions electronically must use prescription pads that meet the following specifications:
 - a) CMAP prescriptions may be written either on yellow or blue scrip.
 - b) Each prescription must be imprinted with the name, address and phone number of the agency and must contain the legend “CMAP” in at least 14-point type printed in the upper right-hand corner.
 - c) In addition to standard required information, scrip must contain pre-print areas for both the Client Record Number and the pharmacy that the client will use.
2. The use of phone, fax, or electronic prescriptions is permitted under the program subject to the standard practices of the individual pharmacies and the over-riding state and federal laws governing the prescription of medication. Rather than attempt to impose a standard approach statewide across systems, we are requiring that providers enter into a written agreement with the CMAP pharmacies that they will be initiating electronic interchange with. The agreement should contain an explicit description of the methodology that will be used to ensure that the pharmacy can clearly and easily determine that a given prescription should be filled using drugs provided through the CMAP program.

Agencies must insure that all necessary information from an electronic transaction is transmitted to the CMAP Coordinator in a timely manner.

3. The original prescription and all refills specified thereon must not result in a supply of the medication that will last more than 90 days from the date of the prescription.
4. All prescriptions must be completely filled out and include the client record number and the name of the pharmacy that the client will use. We suggest that the name of the pharmacy be elicited from the client by providing them with a list of participating CMAP pharmacies that the Agency deals with and asking them to choose one.

The agency must maintain this information on file for use in making appropriate notifications in the event of termination from the program.

5. Each agency must provide DBH with an initial list of prescribers eligible to sign CMAP prescriptions and must update that list within 10 working days of any change. Updated copies of the list must also be provided to all participating pharmacies with which the agency does business on an ongoing basis
6. The agency is responsible for issuing a Termination Notice using the format in the Appendix to the client, the pharmacy and DBH within 5 working days after a client becomes ineligible for CMAP. As an alternative to sending in an individual Termination Notice for each client to the pharmacies and DBH, agencies may substitute a weekly “Termination Roster” provided that it contains all information required on the Termination Notice. However, each client must still be provided with written notification of their termination from the program on an individual basis.
7. All CMAP forms (e.g., application, drug dispense, termination notice, etc.) must be typed or printed legibly and transmitted to the DBH CMAP Coordinator promptly.
8. Each agency must have a mechanism in place to insure that their internal CMAP Coordinator is kept up-to-date on all CMAP scrip and receives the necessary information to enroll and terminate clients, including the name of the pharmacy to be used.

9. All agencies must provide DMHRH Coordinator with a current copy of the policies and procedures that govern their internal CMAP operation and must update this copy as changes occur.
10. Drug costs and dispense fees for drugs dispensed to clients who are not appropriately certified at the time that the prescription is filled will be cross-charged to the agency which originated the scrip.

Exceptions will be made in instances where appropriate certification/termination materials were in the mail, as determined by the postmark on the envelope, at the time of dispense as well as for prescriptions dispensed on an emergency basis, either in person, by fax or by phone, provided that DBH receives complete materials required for certification within 5 working days of dispense.

Prior to assessment of a charge, DMHRH will cross check the patient name against the enrollment forms submitted by the agencies and will also check the name of the prescribing physician against the lists submitted by the agencies. If an agency feels that a charge is inappropriate, it may appeal in writing within the time specified by the Department.

11. Each provider must submit an updated list of eligible clients and their current medications in a format to be specified by the department on a periodic basis at the request of MHRH Pharmacy.
12. Each provider must make arrangements to directly provide clients with up to 2-month's worth of medications for which samples are available under the State's efficacy/effectiveness program. These samples should be used before giving the client a prescription to be filled at a pharmacy.
13. While prescribers are not required to use generics, they are strongly encouraged to do so in cases where patient care will not be affected. Please see the examples of brand vs. generic cost in Appendix 5.
14. Providers are also strongly encouraged to take per-tablet costs into account when prescribing. Please review Appendix 5 which lists a few of the more costly CMAP medications for which the cost per tablet does not necessarily increase proportionately with the strength.

IV. Community Pharmacy Requirements

1. The pharmacy must enter into an appropriate contractual relationship with the State of Rhode Island governing participation in the program.
2. If the pharmacy receives a supply of CMAP medications, it must keep them segregated from its regular inventory and may not use them for resale, but must use them solely for the filling of prescriptions for CMAP clients.
3. The pharmacy must provide the MHRH Pharmacy with a current inventory of the CMAP medications in stock, if any, in a format to be specified by the State upon request.
4. If a pharmacy finds outdated medications, they should contact the MHRH Pharmacy which will issue a pick-up order.
5. The State CMAP program is the payer of last resort. Pharmacies must first determine whether the client has other third-party coverage and follow the appropriate procedures for that payer before dispensing CMAP stock. In making that determination, a pharmacy should not consider the mere possession of a CMAP scrip to be evidence of a lack of other coverage.

These procedures include, but are not limited to, collecting appropriate co-pays for individuals who are covered by Medicare Part “D”.

6. Pharmacies are required to provide DBH with dispense reports in a format specified by DBH at least on a monthly basis within 15 working days of the end of the month. After processing by DBH, this report triggers reimbursement to the pharmacy as appropriate.

V. Contacts

DMHRH

Ron Tremper
Barry Hall 3rd Floor
14 Harrington Road, Cranston, RI 02920-3080
Phone: 401-462-6008
Fax: 401-462-0339

MHRH-Central Pharmacy

MHRH-Central Pharmacy
P.O. Box 8289
Hazard Building
600 New London Avenue
Cranston, RI 02920
Phone: 401-462-6211
Fax: 401-462-1499

Administrator of Pharmacy of Services

Cathy Hopkins
Acting Administrator of Pharmacy Services
Eleanor Slater Hospital
Regan Building P.O. Box 8269
Cranston, RI 02920
Phone: 401-462-3074
Fax: 401-462-3082

(11/10/08)

VI. Frequently Asked Questions

Q1. Can a prescriber not employed by a CMHO prescribe CMAP medication and, if so, how?

A1. As a general rule, clients are only enrolled in the CMAP program if they are being seen at a CMHO with a prescriber employed by the CMHO prescribing their medication.

However, CMHOs may choose to designate prescriber who is not in their employ as a CMAP prescriber. In this situation, the CMHO must submit a written request to the DMHRH to have the non-CMHO prescriber certified to prescribe under the auspices of the CMHO. It is important to note that the CMHO still retains ultimate responsibility for the actions of the prescriber with regard to the program, both clinically and fiscally. Misuse of the privilege conferred will be charged back to the CMHO.

Q2. Can we prescribe medications/dose forms that are not on the formulary and, if so, how?

A2. While the CMAP formulary is extensive, it does not include all possible medications and dose forms. Therefore, there might be infrequent instances in which the most clinically appropriate approach would be to utilize a medication/dose form that is off-formulary.

If a CMHO prescriber is facing a clinical situation in which utilization of a non-formulary item seems most appropriate, the physician should send a memo to the CMAP Coordinator requesting an alternate medication/dose form and provide clinical justification up for the prescription. The Department will review the request and a determination will be sent back to the originating party. Please allow 15 working days for this process.

Q3. Must clients have a trial on standard medications before receiving an atypical anti-psychotic?

A3. The Department allows the utilization of atypicals as first line medications for individuals who have not had a trial on standard medications as long as sufficient clinical justification is provided. This justification must be based on a comprehensive clinical review of a patient's prior exposure to, and current use of, the entire range of psychotropic medications.

While the Department has removed preauthorization requirements for the atypicals, providers are required to utilize samples, when available, for up to 2-months and to evaluate the client clinically at the end of the sample period to determine whether the medication has produced an improved clinical response. The result of this evaluation must be entered into the client record.

Clients who display an improved clinical response may continue to receive the medication under the CMAP program. Providers should consider alternative medications for those who do not exhibit an improved response during the sample period.

Q4. Are General Outpatient clients eligible for the CMAP program?

A4. Yes. The determination of eligibility for CMAP is based on clinical and financial need. Client 'type' is not a consideration.

Q5. Must we enroll a client in CMAP if we do not feel that it is appropriate?

- A5. There is no obligation for a provider to enroll someone in CMAP if they do not feel that the client is appropriate. While DBH has expended a great deal of time and effort to make the CMAP program available to individuals in the community experiencing mental health problems, the program is there as a resource for CMHOs to use and not as a mandate.

VII. Appendices

1. Requirements For CMAP Paperwork (REQ-11/08)
2. Client Application Form (CA-08/07)
3. CMAP Termination Notice (TERM-08/07)
4. CMAP Dispense Report Requirements (Elect-08/07)
5. Approximate ESH Drug Costs (Cost-11/08)
6. Federal Poverty Level Chart (FPL-02/08)

DIVISION OF BEHAVIORAL HEALTHCARE
CMAP PAPERWORK REQUIREMENTS FOR CMHCS

ALL DMHRH paperwork for the CMAP program must be sent to the DBH CMAP Coordinator at the address listed below.

Do **NOT** send any paperwork to the ESH Pharmacy.

CLIENT PAPERWORK

To Add or Re-Activate Clients:

A **NEW** Community Medication Assistance Program Client Application Form (CA-08/07) must be sent to the DBH CMAP Coordinator at the address listed below for **ALL** clients who are either new to CMAP or are returning after termination for any reason (e.g. needing to meet Medicaid spend-down requirements).

To Terminate Clients:

A CMAP Termination Notice (TERM-08/07) should be submitted to DMHRH for all clients who leave the program for any reason. A second copy of this form should be sent to the community pharmacy used by the client.

MEDICATION PAPERWORK

Effective November 10, 2008, it is not necessary to submit any paperwork regarding medications to DMHRH. It is, however, strongly recommended that prescribers provide adequate documentation in the client record to support their decisions regarding medications with special attention given to anything being prescribed for off-label use.

Contact Information: DMHRH CMAP Coordinator
Barry Hall 3rd Floor
14 Harrington Road
Cranston, RI 02920-3080
Phone: 462-6008 Fax: 462-0339

CMAP TERMINATION NOTICE

(Please type or print clearly)

ATTENTION: Pharmacist, DBH CMAP Coordinator

Please terminate this client from the CMAP program effective on the "Date of Ineligibility" shown below:

Client Name: _____ Client Record Number: _____

SS#: _____ Pharmacy Name: _____

Date of CMAP Ineligibility: _____

Reason for Ineligibility: _____

If ineligible due to gaining Medicaid, effective date of Medicaid coverage: _____

CMHC Name: _____

CMHC CMAP Coordinator: _____

Phone: _____

Signature: _____

Send 1 copy of the completed form to the pharmacy used by the client. The pharmacy can be found by looking at the CMHC's copy of the original prescription or from the CMHC's tracking database.

Send a second copy to: CMAP Coordinator
 Barry Hall 3rd Floor
 14 Harrington Road
 Cranston, Rhode Island 02920-3080

TERM-08/07

CMAP DRUG DISPENSE REPORT REQUIREMENTS

Electronic submissions must be readable by Microsoft Windows PC and be either in MS Excel or delimited ASCII format.

Field	Length	Description
PID	char 1	Pharmacy Id (Call Polina at 462-1565 for your ID.)
RPTDATE	date	Report's date (format yyyy/mmldd)
CID	char 10	Client record # from CMAP scrip
SOC	char 9	SS#
LNAME	char 15	Client's last name
FNAME	char 10	Client's first name
DOB	date	Date of birth (format yyyy/mmldd)
DRUG ID	char 6	Code number (from DMHRH Formulary)
DRUGDES	char 50	Name of drug dispensed (from DMIRH Formulary)
PRESDATE	date	Date dispensed (format yyyy/mm/dd)
QTYDISP	smallint	Quantity of medication dispensed
LTHPRES	char2	# of days quantity dispensed is scheduled to last
DID	char 5	Doctor's Id Code (from CMAP database)
DOCLNAME	char 20	Doctor's Last Name
DOCENAME	char 15	Doctor's First Name
RXNIJMBER	char 15	Prescription Number

Elect-08/07

Approximate ESH Medication Costs

DRUG #	DRUG DESCRIPTION	APPROX. \$/ TABLET
100357	ARIPERAZOLE 2 MG. (ABILIFY)	10.72
100359	ARIPERAZOLE 10 MG (ABILIFY)	10.72
100361	ARIPERAZOLE 15 MG (ABILIFY)	10.72
100360	ARIPERAZOLE 20 MG (ABILIFY)	15.16
100362	ARIPERAZOLE 30 MG (ABILIFY)	15.16
100810	ATOMOXETINE 25 MG (STRATTERA)	3.57
100812	ATOMOXETINE 40 MG (STRATTERA)	3.88
100814	ATOMOXETINE 60 MG (STRATTERA)	3.88
101896	DULOXETINE 20 MG (CYMBALTA)	2.92
101899	DULOXETINE 30 MG (CYMBALTA)	3.27
101898	DULOXETINE 60 MG (CYMBALTA)	3.27
103100	ESCITALOPRAM 10 MG (LEXAPRO)	2.34
103102	ESCITALOPRAM 20 MG (LEXAPRO)	2.44
103983	PALIPERIDONE 3 MG (INVEGA)	9.59
103985	PALIPERIDONE 6 MG (INVEGA)	9.59
103987	PALIPERIDONE 9 MG (INVEGA)	14.38
104003	LAMOTRIGINE 25 MG (LAMICTAL)	3.39
104007	LAMOTRIGINE 100 MG (LAMICTAL)	3.59
105437	OLANZAPINE 2.5 MG (ZYPREXA)	5.12
105432	OLANZAPINE 5 MG (ZYPREXA)	6.04
105435	OLANZAPINE 7.5 MG (ZYPREXA)	7.38
105440	OLANZAPINE 10 MG (ZYPREXA)	9.10
105442	OLANZAPINE 15 MG (ZYPREXA)	13.64
105444	OLANZAPINE 20 MG (ZYPREXA)	18.17
355441	OLANZAPINE ZYDIS 5 MG (ZYPREXA)	6.91
355442	OLANZAPINE ZYDIS 10 MG (ZYPREXA)	9.96
105652	PAROXETINE CR 12.5 MG (PAXIL CR)	2.73
105653	PAROXETINE CR 25 MG (PAXIL CR)	2.85
105654	PAROXETINE CR 37.5 MG (PAXIL CR)	2.66
106700	QUETIAPINE 25 MG (SEROQUEL)	1.85
106710	QUETIAPINE 100 MG (SEROQUEL)	3.10
106712	QUETIAPINE 200 MG (SEROQUEL)	5.67
106714	QUETIAPINE 300 MG (SEROQUEL)	7.27
106968	RISPERDAL M TABS 2MG	6.94
106959	RISPERIDONE 0.5MG (RISPERDAL)	3.27
106960	RISPERIDONE 1MG (RISPERDAL)	3.72
106963	RISPERIDONE 2MG (RISPERDAL)	6.21
106965	RISPERIDONE 3MG (RISPERDAL)	6.83
106967	RISPERIDONE 4MG (RISPERDAL)	9.17
108615	TOPIRAMATE 25 MG (TOPAMAX)	1.78
108612	TOPIRMATE 100 MG (TOPAMAX)	4.85
109056	VENLAFAXINE 25 MG (EFFEXOR)	1.51
109058	VENLAFAXINE 37.5 MG (EFFEXOR)	1.40
109060	VENLAFAXINE 50 MG (EFFEXOR)	1.44
109062	VENLAFAXINE 75 MG (EFFEXOR)	1.52
109064	VENLAFAXINE 100 MG (EFFEXOR)	1.61
109049	VENLAFAXINE XR 37.5 MG (EFFEXOR XR)	2.69

DRUG #	DRUG DESCRIPTION	APPROX. \$/ TABLET
109050	VENLAFAXINE XR 75 MG (EFFEXOR XR)	3.20
109054	VENLAFAXINE XR 150 MG (EFFEXOR XR)	3.49
109340	ZIPRASIDONE 20 MG (GEODON)	4.30
109342	ZIPRASIDONE 40 MG (GEODON)	4.51
109344	ZIPRASIDONE 80 MG (GEODON)	5.12
SAMPLE COSTS: GENERIC VS BRAND		
109105	WELLBUTRIN XL150 MG	3.39
101187	BUPROPION XL 300 MG	1.78
353304	FAZACLO 25 MG	1.09
352105	CLOZAPINE 25 MG	0.28
353305	FAZACLO 100 MG	2.98
352100	CLOZAPINE 100 MG	0.74

Cost-11/08

2008 HHS Poverty Guidelines

Family Size	100%			135%			200%		
	Annual	Monthly	Weekly	Annual	Monthly	Weekly	Annual	Monthly	Weekly
1	10,400	867	200	14,040	1,170	270	20,800	1,733	400
2	14,000	1,167	269	18,900	1,575	363	28,000	2,333	538
3	17,600	1,467	338	23,760	1,980	457	35,200	2,933	677
4	21,200	1,767	408	28,620	2,385	550	42,400	3,533	815
5	24,800	2,067	477	33,480	2,790	644	49,600	4,133	954
6	28,400	2,367	546	38,340	3,195	737	56,800	4,733	1,092
7	32,000	2,667	615	43,200	3,600	831	64,000	5,333	1,231
8	35,600	2,967	685	48,060	4,005	924	71,200	5,933	1,369

SOURCE: Federal Register Vol. 73, No. 15, January 23, 2008, pp. 3971–3972