Department of Behavioral Health, Developmental and Intellectual Disabilities
COMMUNITY MEDICATIONS SUPPORT PROGRAM
FOR ADULTS WITH A SEVERE MENTAL ILLNESS
GUIDELINES EFFECTIVE 7/1/17

The Community Medications Support Program for Adults (CMSPA) with a severe mental illness is a joint effort involving participating Community Mental Health Centers (Centers), community pharmacies, and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). The overall goal of the adult program is to assist adults with a severe mental illness, who have no other means of purchasing medications, to obtain prescribed psychotropic medications.

The Centers determine client eligibility. The Center physician prescribes psychotropic medications that are filled at a participating community pharmacy. The pharmacy is then reimbursed by the Center each month for the medications dispensed.

I. THE ADULT COMMUNITY MEDICATION SUPPORT PROGRAM SHALL:

- Assist adults with a severe mental illness, who have no other means of purchasing medications, to obtain prescribed psychotropic medications.
- Minimize or eliminate consumer complaints.
- Provide adequate consumer access to community pharmacies to obtain psychotropic medication.
- Assure that the only cost to the consumer is the prescription dispensing (fill) fee, which may not exceed the maximum of $6.
- Require that participating consumers meet the following basic eligibility requirements, or have a written, approved waiver:
  - Severe mental illness (age, diagnosis, disability, and duration),
  - Most current Health and Human Services Poverty Guidelines, and
  - not eligible for Medicare, not eligible for Medicaid, not capable of self pay, and do not have a third-party payer for psychotropic medication.

II. FUNDING

Annual allocations to the Community Mental Health Centers are based on available funding, population, utilization, and flexibility of funds. The following factors are also considered: hold harmless provision; percent of clients with Center approved waivers; prior and current year expenditures; use of pharmaceutical company indigent program samples and/or vouchers; and compliance with program guidelines.

A. Each fiscal year, DBHDID notifies the Centers of their annual allotment. **DBHDID CANNOT ASSURE ANY FUNDS ABOVE EACH CENTER'S FISCAL YEAR ALLOTMENT. Centers are responsible for managing their funds. When the annual allotment has been used, the Center must notify, in writing, DBHDID of the intention to reimburse them for any medication orders exceeding the Center allotment. The Center will submit a check to cover costs in excess of the allotment at the close of the state fiscal year (June 30th).**

B. **Centers shall make every effort to assist consumers to obtain medications from other available sources** such as the pharmaceutical company vouchers, samples or their indigent programs and Health Kentucky, Inc. (Kentucky Physicians Care) prior to using the Community Medications Support Program funds.

C. **The dispensing (fill) fee amount the consumer pays to obtain a prescription in this program shall not exceed six dollars ($6.00) per prescription**. If a pharmacy demands more than $6.00, a written waiver must be obtained from DBHDID. Centers are encouraged to negotiate the lowest dispensing fee possible for the consumer.

III. CLIENT ELIGIBILITY CRITERIA

The Center shall document, at least annually, that the clients participating in the CMSP meet the eligibility criteria that includes severe mental illness (age, diagnosis, disability, and duration) and finances, or have a Center approved waiver.

A**.** The Community Medications Support Program for Adults (CMSP) is an extremely limited source of funding intended to enable individuals with little or no resources the ability to obtain needed psychiatric medications. Individuals with access to pharmaceutical benefits from other sources are excluded from participation in the CMSP. Those excluded include:

- Individuals who are Medicare (Title XVIII) beneficiaries.
- Individuals who are Medicaid (Title XIX) beneficiaries.
- Individuals who have a pharmaceutical benefit as part of any third-party health insurance policy.
- Individuals who can obtain needed medications through samples or indigent support programs sponsored by pharmaceutical companies.
- Individuals who are under eighteen years of age (a separate medication program is available for children).

B**. Severe Mental Illness Criteria: Age, Diagnosis, Disability, and Duration**
Adult clients are eligible for the program if they meet the criteria for severe mental illness (SMI) which is determined by age, diagnosis, disability, and duration noted below and on the attached Adult ***with SMI Operational Description***:

1. **Age**: Age 18 or older

2. **Diagnosis**: Client has one of the following DSM-IV eligible codes:
   - Schizophrenia and Other Psychotic Disorders: 295.xx, 297.1, 298.9
   - Mood Disorders: 296xx
   - Other (DSM #_____) within state and federal guidelines for SMI

3. **Disability:** Clear evidence of functional impairment in **two or more** of the following domains:
   - Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores.

   - Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings.

- Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter, and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender, and culture.

- Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities, and illnesses/injuries.

- Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style, and memory in relation to what is common for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs, and logical thinking should all be considered in making this rating.

4. **Duration** - **One or more** of the following shall apply:
    - Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two (2) years.
    - The individual has been hospitalized for mental illness more than once in the last two (2) years.
    - There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period.

C. **Financial Eligibility Criteria for Adults**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES 2022 POVERTY GUIDELINES		
Person in Family or Households	Poverty Guideline	Monthly Income
1	$13,590	$1,132.50
2	$18,310	$1,525.83
3	$23,030	$1,919.17
4	$27,750	$2,312.50
5	$32,470	$2,705.83
6	$37,190	$3,099.17
7	$41,910	$3,492.50
8	$46,630	$3,885.83
* For each additional person, add	$4,720	

D. **Eligibility Waivers for Severe Mental Illness (diagnosis, disability, duration) or finances may be granted at the discretion of each Center and shall include at least the following information:**

- type of waiver: SMI (diagnosis, disability, duration) and/or financial; and
- a concise reason waiver is requested; and
- the length of time for which each waiver is granted (expiration date); and
- approval signatures of Center designated staff.

Each Center shall designate a staff person who is authorized to coordinate and approve client eligibility waiver requests.

Formulary Exception Requests can be made to the Department for the use and purchase of medications that are not on the CMSP formulary or available through a Patient Assistance Program (PAP). These requests will be reviewed by the DBHDID Formulary Committee and granted on a case by case basis. The Formulary Committee's pharmacist will maintain a record of the exception requests and will monitor, perform trend analysis, and make recommendations for formulary changes based on patterns.

Non-formulary drugs should be used only if the patient fails to respond to formulary drug therapy, has an adverse reaction to formulary drug, or has other special circumstances requiring the use of a non-formulary

drug. **To request an exception, please complete the CMSP Formulary Exception Form in its entirety and email to Katie Johnson at: katiem.johnson@ky.gov; or via fax: (502) 564-2386. A hard copy can be mailed to: DBHDID, Attn: Katie Johnson, CMSP Formulary Exception, 275 East Main Street, 4 C-D, Frankfort, KY 40621.**

Requests will be reviewed by the Formulary Committee. You will be notified of a decision within 5 business days.

Reasons why a physician may grant an exception include:

- Allergy/adverse reaction of the member to formulary product
- Treatment failure with a formulary drug
- The choices available in the drug formulary are not suited for the present patient care need and the drug selected is required for patient safety
- The use of a formulary drug product may provoke an underlying medical condition, which would be detrimental to patient care

IV. Medications

The **State Community Medications Support Program Formulary Committee (CMSPFC) will maintain a dated, approved Community Medications Support Program Statewide Formulary using generic and trade names**. Only medications listed on the current CMSP Statewide Formulary may be utilized unless they are approved through an exception request. The State CMSP Formulary Committee shall be comprised of the following members or their designees: the DBHDID Medical Director, DBHDID Consultant Pharmacist, as well as contracted medical staff. The DBHDID Medical Director or designee will be responsible for convening & conducting meetings as necessary and will serve as the administrator of the Formulary Committee. The DBHDID Consultant Pharmacist will maintain the CMSP statewide formulary, track formulary exception requests, and make recommendations for formulary changes based on trending analysis.

A. **Participating community pharmacies** will keep track of CMSP medications dispensed and send a bill to their Center's **CMSPA Coordinator** for the actual **acquisition cost** of these medications (no markup) at the end of each month. This should also include the medication name, dose, and quantity for which they are billing.

B. **Centers** shall review the bills from each participating community pharmacy to ensure formulary compliance before reimbursement is sent.

V. DOCUMENTATION and REPORTING REQUIREMENTS

A. Community Mental Health Centers

1. **Client Eligibility**: **The Center must assure and document that each participant meets the eligibility criteria (age, SMI diagnosis, disability and duration, and financial) or has an approved waiver at least once during each state fiscal year** (July 1 – June 30). The original completed form should be filed in the client's record. (Sample form attached)

2. **Eligibility Waivers for SMI (for diagnosis, disability, and/or duration, not age) or finances may be granted at the discretion of each Center** and shall include at least the following information:
   - type of waiver: SMI (diagnosis, disability, duration) and/or financial; and
   - a concise reason waiver is requested; and

- the length of time for which each waiver is granted (expiration date); and
- approval signatures of Center designated staff
- non-formulary waiver requests

3. **CMSPA Coordinator**: **Centers shall provide DBHDID with the name** of the staff person chosen to be the CMSPA Coordinator for Adults.

4. **CMSPA Guidelines**: **Each Center shall adopt these guidelines and may develop their own written Community Medications Support Program guidelines within the scope of these policies**. Center specific guidelines must **receive written approval** by DBHDID prior to implementation.

5. **CMSPA Central File**: **The Center shall maintain a Community Medications Support Program central file (hardcopy or electronic) which shall contain at least the following**:

   - copies of completed client eligibility forms (Sample Form attached); and
   - copies of all Center approved waivers; and
   - the method of differentiating Community Medications Support Program prescriptions and refills from other prescriptions written by the Center; and
   - the process to identify when a CMSP participant becomes eligible for Medicaid or another third-party payer and to discontinue their CMSP participation; and
   - the approved Center guidelines for this program, if applicable; and
   - copies of reimbursement bills from each participating local pharmacy

6. **Compliance**: Failure to meet documentation requirements may result in funds being withheld. All files should be maintained for a period of two years.

7. **Reporting**: All **Centers** shall submit a **monthly financial report** detailing pharmacy reimbursement (electronic or hard copy) to DBHDID by the 15th day of the following month:

Mail to:
Katie Johnson
Department for Behavioral Health,
Developmental and Intellectual Disabilities
Division of Program Integrity
Program Support Branch
275 East Main Street, 4 C-D
Frankfort, KY 40621
Or E-mail: katiem.johnson@ky.gov

VI. Monitoring

Monitoring of the Community Medications Support Program is vested in the Department for Behavioral Health, Developmental and Intellectual Disabilities or its designee. The monitoring of this program will be based on compliance with the guidelines of the Community Medications Support Program. DBHDID will monitor CMSP expenditures on a monthly basis. On site monitoring will occur at DBHDID's discretion. The Center will be notified if problems exist and will be responsible for correcting each problem.

ADULT WITH SERIOUS MENTAL ILLNESS
Operational Description

All Four (4) criteria are typically met:

Criteria	Notes
AGE	o Age 18 or older
DIAGNOSIS	o Major Mental Illness • Schizophrenia (DSM 295.xx, 297.1, 298.9) • Mood Disorder (296.xx) • Other (DSM _____) within State and Federal Guidelines for Severe Mental Illness
DISABILITY	o Clear evidence of functional impairment in <u>two or more</u> of the following domains: • Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores. • Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings. • Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter, and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender, and culture. • Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries. • Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style, and memory in relation to what is common for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs, and logical thinking should all be considered in making this rating.
DURATION	o One or more of these conditions of duration: • Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two (2) years. • The individual has been hospitalized for mental illness more than once in the last two (2) years. • There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period.

COMMUNITY MEDICATION SUPPORT PROGRAM for ADULTS
CLIENT ELIGIBILITY CRITERIA

_____ ____/_____/_____ _____
Client ID DOB Center

A. Exclusions

Client is currently eligible for Medicaid, Medicare or other third-party medication insurance coverage
____ Yes ____ No

Client may <u>not</u> receive CMSPA medications if the answer to A is Yes. If yes, you can stop completing this form, client is not eligible for CMSPA.

B. Meets Adult with a Severe Mental Illness criteria (age, diagnosis, disability and duration)
____Yes ____No Criteria:

Yes	No	
____	____	Age 18 or older
____	____	Diagnosis (DSM IV) a. Schizophrenia _____ b. Mood Disorder _____ c. Other, within state and Federal Guidelines for Severe Mental Illness (SMI) #_____
____	____	Disability (clear evidence of functional impairment in two or more domains in CMSPA guidelines)
____	____	Duration (meets one or more criteria in CMSPA guidelines)

B. **Meets financial eligibility criteria:** most current Health & Human Services Poverty Guidelines.

____ Yes ____ No

C. **Waiver**: The Center may document and approve a waiver if any item in Section B or C above has "NO" checked. Waiver documentation requirements are listed in Section III of the CMSPA Guidelines.
_____Yes _____No

_____ _____
Person who determined eligibility Date

_____ _____
Center Approval Date

PLEASE KEEP THIS INFORMATION in Center's CENTRAL CMSPA FILE

CMSP Formulary Exception Request Form

Please provide the information below: request will NOT be considered unless ALL sections are complete.

The following criteria are used in reviewing non-formulary medication requests ***(CHECK APPROPRIATE BOX)***

- ☐ The use of formulary drug is contraindicated for the patient *(allergy/adverse reaction to formulary drug).*
- ☐ The patient failed an appropriate trial of the formulary drug alternatives or related agents.
- ☐ The choices available on the CMSP drug formulary are not suitable for this patient due to specific medical condition and/or drug is required for optimal medication safety and therapeutic efficacy.
- ☐ The use of a formulary drug may provoke an underlying medical condition, which would be detrimental to patient safety.

Patient Name:	**CMHC Name & Region Number:**
Patient Address:	**Physician Name/Specialty:**
Patient DOB:	**Physician ID#/DEA#:**
Pharmacy Name & Address:	**Physician Area Code & Telephone Number & Fax Number:**
Diagnosis:	**Physician Address:**
Drug Requested:	**Quantity** ***(per month):***
Dose:	**Length of Treatment** ***(please be specific):***
Strength:	**Dosage Form** ***(e.g. Oral Injection):***
Reason for Medication Request ***(please be specific, give details*****):**	
Other Medications Tried and/or Failed ***(please be specific, give details):***	
Other Pertinent Medical History ***(relative or pertaining to this request):***	
Physician's Signature:	**Date:**

FOR INTERNAL USE ONLY

☐ Approved

☐ Denied

Name:

Date: