Consultation Corner

# Obtaining Medications After January 1, 2006: Considerations for Dual Eligibiles

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## Introduction

On January 1, 2006, individuals who were covered by both Medicare and Medicaid (known as dual eligibles) lost their Medicaid drug benefit and have been thrust into the new environment of Medicare Part D. These individuals, the sickest and most vulnerable members of our society, represent the unwilling pioneers of the most sweeping change in the American health care system in decades. The question on the minds of many dual eligibles is: How do I get my medications in 2006?

## Background

Centers for Medicare and Medicaid Services (CMS) developed a program to automatically enroll dual eligible individuals randomly among dozens of Medicare Part D plans. After consumer advocates and others pointed out that some individuals would inevitably be missed during automatic enrollment, CMS released a 14-step fallback plan to ensure access to needed medications for any dual eligible who may have been missed during the auto-enrollment.[1]

## Potential Obstacles to Medication Access for Dual Eligibles

In the final days of 2005, 4 critical areas arose as obstacles for some dual eligibles being able to obtain medications in 2006. The first area was the online database that pharmacies are supposed to use to look up enrollment and billing information for dual eligibles who do not have letters or identification cards from their Part D plan. Although CMS originally announced that this database would be completed by November 15, 2005, hundreds of thousands of dual eligibles still have not been entered into the database. Known errors in the database remain to be corrected, and testing and verification of the data are still underway.[2] For dual eligibles who could not be located in the database by January 1, 2006, the 14-step fallback plan was the only way to provide access to necessary medications to these persons.

The second obstacle was that the 14-step fallback plan put pharmacies at risk for not being paid for medications dispensed when this system is used. Although pharmacies initially can bill a government contractor for the dispensed medications, in some cases, a second government contractor later may have the claim reversed. This would leave the pharmacist with the responsibility of trying to collect from other payers, and payment in these cases is uncertain.* In cases where the 14-step fallback plan is supposed to be used, the question remains: will pharmacies be willing to assume the financial risk of dispensing expensive medications without payment?

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To reduce their risk, some pharmacies already have plans to limit dispensed medications to only a few days' supply in these situations. If the government had assumed the financial risk for their own delays, errors, and omissions, dual eligibles would have had much more assurance of receiving their medications.

The third barrier was that since the assignment of dual eligibles to Part D plans was done on a random basis, some individuals were placed in plans that do not have their pharmacy benefit included in the pharmacy network. Because of the huge number of Part D plans in most of the country, many pharmacies are not participating in the networks of every plan. This is especially true of independent pharmacies and rural pharmacies, which may not have the staff and/or resources to obtain and review dozens of agreements and negotiate terms with all the plans.

The final problem was that a dual eligible may have walked into their regular pharmacy in January 2006, only to find that they could not obtain their medications because the pharmacy did not participate in the plan to which the individual was randomly assigned. CMS has made no provision for these out-of-network situations for dual eligibles. The normal policy is for the beneficiary to pay out of pocket and get reimbursed from their Part D plan.[†] This clearly will not work for dual eligibles.

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## Overcoming Potential Obstacles

Leslie Norwalk, CMS Deputy Administrator, recently described 4 options for handling these situations.[3] "First, the pharmacist may choose to dispense a couple of days' supply of the drug and instruct the dual eligible to resolve the issue with their Part D plan." There is no mention of who pays for this limited drug supply, but the implication is that the patient pays and then seeks reimbursement from the Part D plan.

Norwalk's second option is for the pharmacy or patient to call 1-800-MEDICARE to find another pharmacy for the patient. This places a burden on the patient to locate and find transportation to an unfamiliar pharmacy to which the prescription refill information must be transferred by telephone, increasing the risk for medication errors.

The third option is for the patient's pharmacy to sign up on the spot to be in the network of the plan to which the patient was randomized. However, pharmacies will not sign agreements with Part D plans without reviewing them or having their attorneys do so. This out-of-network problem could be a significant obstacle, especially for dual eligibles in rural areas.

Norwalk's fourth option relates to the formularies (lists of covered drugs) of the various Part D plans. Some dual eligibles were randomized to plans that did not have their medications on the formulary. CMS allows each company to establish its own transition policies on how to handle nonformulary medications, but this ruling was not released by CMS until the evening of December 22, 2005.[4] It appears that most plans seem to be provide only an initial limited supply of 15 to 30 days of nonformulary medications. After that, the patient's physician must change to a covered medication or assist the patient with a request to the plan for continued use of the needed medication. With 6.4 million individuals falling under these formulary limitations for the first time on January 1, 2006, and with only 15 to 30 days to comply in most cases, physicians may have been too overwhelmed to handle all the telephone calls, FAXes, and office visits that were required to ensure continued drug therapy for all dual eligible individuals.

## Conclusion

Now that January 1, 2006 has past, many dual eligibles are at risk of not being able to obtain needed medications from their pharmacy. Reasons for this problem include:

- CMS is behind schedule in developing the online database that pharmacists need to look up billing information for dual eligibles;
- the 14-step fallback plan established by

CMS to provide medications to dual eligibles who "fall through the cracks" of autoenrollment depends on the willingness of pharmacies to assume the risk of not getting paid for dispensed medications;

- some dual eligibles have been assigned to Part D plans in which their pharmacies do not participate; and
- some dual eligibles have been assigned to plans that do not cover all of their medications, and the transition policy of the plan may have been too brief to allow adequate time for the dual eligible beneficiary to work with their physician to ensure continued therapy.

Dual eligibles have legitimate reasons to be concerned about continued access to medications in 2006. MPM

* Steps 12 and 13 of the CMS 14-step fallback plan involve reversing the pharmacy claim if the government contractor determines that the individual was not actually missed in the autoenrollment process. Step 13, for example, instructs the pharmacy to bill Medicaid instead; however, the pharmacy already did so in step 2 and had the claim rejected. Thus, the pharmacy is caught between the federal and state governments both telling the pharmacy to bill the other.

† See CMS' final rule concerning the implementation of the Medicare drug benefit, along with the preamble language on this topic. The author has these excerpts available in a Microsoft Word document that will be e-mailed upon request (tclark@ascp.com).

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### References

1. American Society of Consultant Pharmacists. CMS Question and Answer Database. The CMS 14-step plan. December 12, 2005. Available at: http://www.ascp.com/medicarerx/docs/CMSQnADualTrans.pdf. Accessed December 24, 2005.

2. NDC Health®. Medicare Rx prescription drug coverage. About Medicare Part D. From CMS true out-of-pocket (TrOOP) facilitator contractor system: business/functional requirements. Available at: http://medifacd.ndchealth.com/home/MediFacd_home.htm. Accessed December 24, 2005.

3. Norwalk LV. Declaration, Medicare Rights Center vs. Leavitt, December 19. 2005. Available from Thomas R. Clark, RPh, MHS, Director of Policy & Advocacy, American Society of Consultant Pharmacists (tclark@ascp.com).

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## Letters

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### Transition Policies

As you are well aware, prescription drug plans are required to have transition policies in place to ensure beneficiaries get their needed first prescriptions filled at the point of sale when transitioning to a Part D plan. This is especially important in the long term care setting. On January 6, CMS issued guidance reemphasizing this important requirement. I am now instructing Part D plans to establish an expedited process for pharmacists to obtain appropriate authorizations to override any edits that would apply in the absence of their transition policies. Some plans are fully automating their systems as well. This should ensure that beneficiaries receive the drugs they are entitled to, that the burden on pharmacists is reduced and that pharmacists can expedite claims processing at the plan.

### Casework

To assist individual beneficiaries who are experiencing problems at the pharmacy counter, CMS has established a network of hundreds of caseworkers across the country. These caseworkers are working closely with plans, beneficiaries, states and congressional offices to expedite any processing issues and to get beneficiaries their prescriptions. If you are aware of beneficiaries in need of assistance, please encourage them to contact their closest CMS regional office or to call 1-800-MEDICARE. Pharmacists can also call our special toll-free pharmacist line to get assistance for a beneficiary who is having any difficulty.

I am, as I know you are, absolutely committed to ensuring that this program works for all people with Medicare. Please know how much I value our partnership and I hope you will not hesitate to contact us with concerns and observations.

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