MAX BAUCUS
MONTANA

WASHINGTON, DC
(202) 224-2651

MONTANA TOLL FREE NUMBER
1-800-332-6106

United States Senate
WASHINGTON, DC 20510-2602

INTERNET:
max@baucus.senate.gov
http://www.senate.gov/~baucus

January 12, 2006

The Honorable Michael O. Leavitt
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Secretary,

As you know, last week the Medicare Part D drug benefit became operational, providing outpatient drug coverage under Medicare for the first time. I was proud to help write the 2003 Part D law, because Medicare drug benefits were long overdue.

But after Congress passes a law, it is up to federal regulatory agencies to implement it. In the case of Part D, that task falls to the Centers for Medicare and Medicaid Services (CMS), within the Department of Health and Human Services. CMS has spent the last two years implementing Part D, and I appreciate their diligent efforts under tight timelines. But I am disappointed with some of the results, including CMS' approval of over 40 drug plans in my state of Montana. I am also disappointed and extremely concerned with CMS' planning and handling of the transition of the dual-eligibles from Medicaid to Medicare drug coverage.

CMS has long recognized the need for a smooth transition to Part D for those dually-eligible for Medicare and Medicaid. Switching drug benefits from 50 state-based Medicaid programs to dozens of Medicare prescription drug plans (PDPs) would be complicated under any circumstances. But this task is particularly challenging since these individuals are among the sickest and most vulnerable of all Medicare beneficiaries. Yet despite the awareness of potential problems, CMS has failed to adequately protect these beneficiaries.

For example, reports from Montana indicate that the dually-eligible have not been properly identified in the computer system used by pharmacists to fill prescriptions. As a result, many low-income Medicare beneficiaries are being charged co-payments that are far higher than those established by Congress. Montana's Medicaid department has received hundreds of calls from individuals confused over how much they should pay for their prescriptions or whether a particular drug is covered at all.

BILLINGS (406) 657-6790 | BOZEMAN (406) 586-6104 | BUTTE (406) 782-8700 | GREAT FALLS (406) 761-1574 | HELENA (406) 449-5480 | KALISPELL (406) 756-1150 | MISSOULA (406) 329-3123

This type of problem is not occurring in Montana alone. In Alabama, many low-income seniors have been required to pay the full Part D deductible of $250, even though federal law states that these individuals should pay no deductible. In Indiana, a disabled woman was faced with paying more than $340 for her medications. She was able to pay the correct – and much lower – amount only after spending nearly five hours with a counselor who helped her enroll in the correct plan. So far, an estimated 10 states have responded to these problems by restarting Medicaid prescription drug coverage, even though states are ineligible for federal Medicaid matching payments.

Many of the breakdowns appear to stem from CMS' over-reliance on the efforts of community pharmacists to implement the dual-eligibles' transition from Medicaid to Medicare drug coverage. For example, CMS established a system known as an "E-1" transaction, in which pharmacists are supposed to identify the drug plan in which a dually-eligible individual is enrolled. The E-1 transaction may provide pharmacists with enough information to fill a prescription and submit a claim for reimbursement, or it may yield only enough information for the beneficiary to learn in which drug plan he or she is enrolled. In any case, CMS did not make sure that all pharmacists were informed of this system, or that pharmacists had the proper equipment and software to perform an E-1 transaction.

CMS also established a national "point of sale" (POS) enrollment system to ensure that medications can be obtained by dual-eligibles who were not assigned a Medicare drug plan. Under this system, pharmacists are responsible for enrolling beneficiaries who have slipped through the cracks. If successful, a POS enrollment should allow the pharmacist to fill the beneficiary's prescription and submit a claim for reimbursement from the national plan contractor (Wellpoint). But, as with the E-1 system, CMS did not ensure that all pharmacists were informed of and able to conduct the POS transaction, even though the Government Accountability Office (GAO) warned of this very concern in a recent report. As a result, some dual-eligibles have not received their drug benefits under Medicare as Congress intended.

In addition, the computer systems needed by pharmacists have repeatedly failed. Pharmacists report errors and shutdowns in the CMS-contracted software, busy signals and long waits on 1-800-MEDICARE. In some cases, pharmacists are simply giving prescriptions away when they do not know how to correctly bill.

Even dual-eligibles who were properly identified have experienced serious problems accessing drugs not listed on their plan's formulary. Under CMS requirements, all plans must provide new enrollees with at least a one-time fill of drugs not on formulary. Several plans have not complied with this requirement, either by not informing their own customer service representatives of the policy or by not allowing pharmacists to override the data system to charge the appropriate co-payment. CMS must vigorously monitor and enforce plan compliance with the formulary requirements, many of which are designed to protect enrollees from unfair or unsafe practices. This is especially important in the case of dual-eligibles who, by no choice of their own, were switched out of Medicaid drug coverage on January 1.

In short, Part D has experienced major setbacks in its first week. CMS must do more to ensure that Medicare beneficiaries receive the benefits Congress intended, by redoubling efforts to fix Part D problems as they arise. To that end, CMS must improve the information technology systems crucial to delivering the drug benefit. CMS must be able to electronically process enrollments with plans within a matter of a few days, not weeks. And it must be able to allow pharmacists to electronically verify beneficiary eligibility and co-payment status in a matter of seconds, not hours. In today's world, pharmacists are accustomed to adjudicating customer claims in real time. But Medicare's data systems do not yet appear up to these standards. CMS must improve its capability to process and verify enrollments with each drug plan and to provide pharmacists with immediate and accurate information, so that access to medicines is not needlessly delayed for any beneficiary enrolled in Part D.

I stand committed to ensuring that Part D works. While the Part D benefit is not perfect, it will provide critically needed and long overdue drug coverage to millions of elderly and disabled Americans. I urge you to act quickly to remedy the problems outlined above, and I look forward to working with you in the coming year.

Sincerely,

Max Baucus