Key Information – Center for Medicare and Medicaid Services
(January 13, 2006)

- Prescription drugs are a critical component of 21st Century medicine and the lack of prescription drug coverage has been a flaw in the Medicare program for too many years.

- The passage of a prescription drug benefit is the most significant change in Medicare since its inception. Since coverage became effective on January 1:

    - Early data show that about 40,000 prescriptions an hour are being filled.
    - Retail pharmacists have filled over 6 million prescriptions with many more being dispensed in nursing homes.

- Ordinary start-up issues expected at the beginning of a new benefit affecting millions of beneficiaries at one time have contributed to some problems; CMS is committed to resolving each and every issue.

- Despite the best efforts of everyone involved in the new program, there is a group of especially vulnerable people who have been turned away or overcharged at the pharmacy counter. CMS is committed to making sure that every beneficiary gets the medications he/she needs.

- CMS believes that this group of people includes some 300,000 dual eligible individuals who either elected to enroll in a different plan than the one into which they were auto-enrolled in the last few weeks of December, or were switched by the state agency acting on behalf of these beneficiaries.

CMS Actions to Improve the Situation

- **CMS is ensuring plans have necessary and complete information about dual eligible beneficiaries.** On January 12, CMS sent a file to each plan with information about its dual eligible enrollees along with instructions on how to process these files. Plans should be able to use this information to cross-check their own data systems over the next few days. Once these data are processed by plans, this should substantially reduce the work load of the pharmacists and assist the vast majority of dual eligible beneficiaries in getting their drugs. Providing this information will enable pharmacists to identify plans in which dual eligible beneficiaries are enrolled and ensure that correct and appropriate copayments are charged to the beneficiary.

- **CMS is addressing issues between plans and pharmacists:** CMS is working to address a number of issues that will improve the efficiency of the process at the pharmacy counter and assure that all beneficiaries get the medications they need. Among the steps being taken by the agency are: a) increasing the capacity of plan help lines; b) providing direct plan-to-pharmacist technical support; and c) streamlining the data submission and reporting procedures from plans to CMS. Additionally, on January 6, 2006, CMS sent a second letter to plans requesting that they enforce their own transition plans by educating their customer service representatives (CSRs) and ensuring that their data systems have the appropriate information to implement their transition plans. A third letter will be sent to the plans within the next few days providing further

clarification. CMS is now in the process of conducting one-on-one calls with the plans to identify issues and solutions. CMS is in constant communication with the plans on issues as they arise, and has developed a collaborative process whereby CMS organizes calls with plans and their pharmacists to resolve problems as quickly as possible.

- **CMS is improving the pharmacy query system:** The new computer tool CMS has provided pharmacists for real time enrollment and eligibility look-up is functioning well. Working with a CMS contractor, the response time to the system has improved to less than one second with no delays. Data continue to be loaded into this system from information obtained on individuals' enrollment in late December, which will help pharmacists to obtain complete enrollment and billing information on more beneficiaries when they use the electronic eligibility ("E1") system at the pharmacy counter. CMS is seeing improvements on a daily basis. In fact, pharmacists already report that they are seeing improvements in their ability to query and obtain information from the E-1 eligibility transaction system.

- **CMS is increasing CMS toll-free pharmacy support phone lines:** CMS has significantly increased the capacity of the dedicated toll-free pharmacy support phone lines by adding many more Customer Services Representatives (CSRs). The line is now available 24 hours a day, 7 days a week. The wait time is being reduced daily, and CMS expects continued progress in reducing the wait times.

- **CMS is communicating with the pharmacies:** CMS is holding weekly conferences with pharmacy associations including NCSPAE, APhA, NCPA, NACDS, ASAP and FMI. These groups help CMS distribute information and educate pharmacists to ensure that they have the most complete and up-to-date information possible. In addition, CMS is communicating on a daily basis with both chain and independent pharmacies. Pharmacists in CMS's ten regional offices are also working directly with local pharmacies, pharmacists and pharmacy associations to identify troubling trends and specific problems. CMS hosted a technical support teleconference for pharmacists across the country on January 5 and also hosted a national open door forum for pharmacists on January 10 to provide answers to as many questions as possible. In addition, CMS utilizes the National Association of Chain Drug Stores (NACDS) and the American Society of Automation in Pharmacy (ASAP) groups to help communicate with and educate their membership.

- **CMS is ensuring that dual eligible individuals who need emergency fills of their prescriptions receive their needed medications.** If any dual eligible beneficiaries need prescriptions immediately, and the other mechanisms have not worked, CMS can help them get the drugs they need. Many pharmacies are filling prescriptions for the duals that present at the pharmacy counter when enrollment and billing information cannot be confirmed. However, if the individual is unable to get needed medicine in an emergency situation, the pharmacist should call 1-800-MEDICARE (1-800-633-4227) and tell the CMS customer service representative that a beneficiary has an emergency situation. CMS casework staff will be alerted and help the person obtain his/her life-saving medication.

- **CMS is communicating with the states.** CMS is hosting conference calls with State Medicaid Directors about Part D implementation challenges and solutions several times

each week. CMS is also talking to individual states, and is helping them communicate with plans and pharmacists.

WellPoint Point-of -Sale (POS) Solution for Dual Eligible Beneficiaries Not Currently Enrolled in a Plan

- In anticipation of the shift of dual eligible individuals' drug benefits from the Medicaid to the Medicare program, CMS developed a solution by contracting with WellPoint, a national prescription drug plan. The relationship with WellPoint is specifically designed to ensure that full benefit dual eligible individuals who had not been previously enrolled in a Part D plan can be enrolled in a plan at the point-of-sale (POS) until their enrollment information catches up with the data systems.

- The use of the WellPoint solution ensures that dual eligible beneficiaries who present at a pharmacy with evidence of both Medicaid and Medicare eligibility, but without information about current enrollment in a Part D plan, or whose enrollment information cannot be located in the E-1 system can have the prescription drug filled and the claim submitted to a single account for payment. Once the beneficiary leaves the pharmacy with a prescription, a CMS contractor immediately provides follow-up to validate eligibility and facilitate enrollment into a WellPoint plan.

- The WellPoint point-of-sale enrollment applies only to full-benefit dual eligible individuals, and not to the deemed (QMB, SLMB, and QI-1) population, or to Medicare-only beneficiaries.

- CMS has provided information on the WellPoint solution to pharmacy associations, plans, and individual pharmacies. This information described how the process of POS facilitated enrollment starts at the pharmacy with the pharmacist verifying dual eligibility and billing a special Wellpoint account in order to ensure that the beneficiary receives the prescription.

State Payment Reconciliation

- CMS wants to ensure all dual eligible beneficiaries are able to leave the pharmacy with the drugs they need. In addition, pharmacies need to continue to work with the plans to sort out these start-up issues as quickly as possible.

- However, many states are reporting that dual eligible beneficiaries have been charged the wrong cost sharing amounts when they have gone to the pharmacies and some have left the pharmacy without their drugs. Certain states have activated state billing systems to allow payment for these individuals' cost sharing or for the total cost of the prescription drugs using state funds from the state Medicaid agency during this transitional time.

- If a State implements such a solution, the State should make it clear to all parties, including pharmacists, that this action is time-limited and instituted for a specific, defined group of individuals.

- Under the MMA, it is the responsibility of prescription drug plans to provide drug coverage for the dual eligible beneficiaries who are enrolled in their plans.

- CMS wants to work with states that choose to accept billing for Part D claims and with Medicare prescription drug plans to facilitate the reconciliation of claims payments from the plans. In addition, CMS is eager to hear from the states about any dual eligible beneficiaries who have had difficulty in obtaining needed medications so that these situations can be resolved through its caseworker system.

- CMS suggests that the States act only as the "payer of last resort" as follows:

    - For those individuals that the pharmacist believes are dual eligible beneficiaries, the pharmacist should continue to first make an eligibility inquiry through the electronic query system at the pharmacy.

    - If the inquiry identifies the plan in which the person is enrolled, but there is not enough information to bill the plan, then the pharmacist should call the health plan.

    - If the pharmacist submits a claim to the plan and the plan returns the incorrect copayment information, then the pharmacist should bill the state system.

    - If the state's billing system accepts the claim, and as a result, the person is identified as a dual eligible, then the state pays the pharmacist the difference between the appropriate cost-sharing and the amount the pharmacist would have charged the beneficiary. The pharmacist can submit a claim to both the plan and the state and the beneficiary will be responsible only for the $2 or $5 copayment.

- This approach enables beneficiaries to get the prescriptions they need with only modest cost-sharing.

- This approach will also allow CMS to facilitate the reconciliation with the prescription drug plan's payment responsibilities.

- This approach also ensures that the state is paying the least amount possible while providing coverage to dual eligible individuals during this transition.