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Medicare Prescription Drug Benefit: An Overview of Implementation for Dual Eligibles

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Summary

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a new voluntary prescription drug benefit under a new Medicare Part D. The new benefit was effective January 1, 2006. Prescription drug coverage is provided through private prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. This new benefit changes the coverage of prescription drugs for the approximately 6 million individuals who are dually eligible for both Medicare and full Medicaid benefits. In the past, these individuals had their drug costs paid by Medicaid. Effective January 1, 2006, their prescription drug costs are covered by the new Part D benefit instead of Medicaid.

In transitioning to the new Medicare benefit, the Centers for Medicare and Medicaid Services (CMS) established an auto-enrollment process for dual eligibles that was intended to assure there was no gap in coverage. The auto-enrollment process was random among Part D plans with premiums at or below the low-income benchmark premium (which is a weighted average of premiums in the area).

CMS made considerable efforts to have a smooth implementation of the new Part D benefit. It established a backup process for any dual eligible arriving at a pharmacy without necessary documentation. The process included establishing several contractual relationships for the following activities: 1) establishing a new electronic eligibility inquiry (E1) system for pharmacists; 2) providing a point-of-sale (POS) contractor to pay claims for dual eligibles who were not immediately identified as enrolled in a PDP; and 3) hiring an enrollment contractor to work with drug plans and pharmacists to follow up on dual eligibles who were not enrolled in a plan, and to ensure that claims were billed to the appropriate parties. CMS also required Part D plans to develop and implement transition policies for individuals whose previously covered drugs were not on the plan's formulary.

Despite CMS' efforts, the program experienced a number of problems during the initial days of operation — particularly related to the transition of dual eligibles. There have been a number of reports about individuals who were unable to fill prescriptions because eligibility could not be verified or the drug plan's transition policies were not applied. Pharmacists have also reported difficulty in getting timely and accurate information from the Medicare toll-free line, the PDP customer service representatives, and the newly established E1 system.

Since January 1, 2006, CMS has released additional guidance for drug plans and pharmacists, and has dedicated additional resources to try and resolve these issues. In addition, as of January 24, 2006, 25 states and the District of Columbia had decided to step in temporarily and pay for drugs for dual eligibles who would otherwise have a gap in coverage due to transition policy problems. The federal government will reimburse states for these costs. This report will be updated.

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Overview

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) establishes a new voluntary prescription drug benefit under a new Part D, effective January 1, 2006. Medicare beneficiaries will be able to purchase drug coverage through private plans offered by prescription drug plan (PDP) sponsors or managed care organizations offering Medicare Advantage prescription drug (MA-PD) plans. These private plans will bear some of the financial risk for drug costs. Federal subsidies covering the bulk of the risk will be provided to encourage participation.

As a result of MMA, Medicaid no longer covers prescription drug costs for persons eligible for both Medicare and Medicaid (i.e., the "full benefit dual eligible" population) for the categories of drugs that are covered under Part D. Effective January 1, 2006, drug coverage for full benefit dual eligible individuals transitioned from Medicaid to Medicare.

This report provides background information on the early stages of the implementation of the Medicare Part D outpatient prescription drug program. Because of recent challenges, the main focus of this report is the operational procedures and issues relating to the transition of full benefit dual eligibles from Medicaid to Medicare. This report describes certain policies and implementation issues related to those who are not dually eligible; however, a full discussion is outside the focus of this report.

Part D Enrollment

Under the new Part D benefit, prescription drug coverage provided through a PDP or MA-PD, at a minimum, must be "standard coverage" or alternative coverage with actuarially equivalent benefits. Beneficiaries are required to enroll in one of these private plans in order to obtain coverage.

General Rules

Persons first eligible for Medicare on or before January 31, 2006, have an initial enrollment period beginning November 15, 2005, and ending May 15, 2006.[1] If they enrolled by December 31, 2005, their coverage began January 1, 2006. If they enroll later in the initial enrollment period, their coverage will begin on the first day of the first month following the month of enrollment.

In general, an individual who does not enroll during his or her initial enrollment period will only be able to enroll during the annual open enrollment period, which will run from November 15 to December 31 each year. Coverage will begin the following January 1. Thus, individuals first eligible for Medicare on or before January 31, 2006, who fail to enroll by May 15, 2006, will not be able to enroll until the open enrollment period beginning November 15, 2006. If these individuals enroll at that time, their coverage will begin January 1, 2007.

Medicare beneficiaries who do not enroll in a plan during their initial enrollment period will have a delayed enrollment penalty if they enroll at a later date. However, they will not be subject to a penalty if they have maintained "creditable" drug coverage through another source. One source of possible creditable coverage is retiree health coverage offered by a former employer or union.

Special Rules for Low-Income Persons

Special enrollment rules apply to low-income persons. Generally, there is a two-step process for low-income enrollees. First, a determination must be made that they qualify for the assistance; and, second, they must enroll in a specific Part D plan. Special procedures have been established to make the process easier. The procedures are different for different categories of low-income enrollees.

Dual Eligibles. Dual eligibles are persons who are dually eligible for Medicare and *full* Medicaid benefits. In the past, they had their drug costs paid by Medicaid. Effective January 1, 2006, they have their prescription drug costs paid under the new Part D. Medicaid will no longer pay for drugs that could be covered under Part D.[2]

There were more than 6 million dual eligibles who needed to be enrolled in a Part D plan. CMS established an auto-enrollment process, which was intended to assure there was no gap in coverage. The auto-enrollment process was random among plans with premiums at or below the low-income benchmark premium (which is a weighted average of premiums in the area). (See the discussion below, on the implementation of the auto-enrollment process.)

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[1] For further information, see CRS Report RL33136, *Medicare: Enrollment in Medicare Drug Plans*, by Jennifer O'Sullivan.

[2] See CRS Report RS21837, *Implications of the Medicare Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs*, by Karen Tritz.

There are a number of differences among available plans. Key differences are drugs included in plan formularies and pharmacies participating in the plan as network pharmacies. Some dual eligibles may find that they have been auto-enrolled in a plan which may not best meet their needs. For this reason, they are able to change enrollment at any time with coverage under the new plan effective the following month. This is the only population group that has this option. It should be noted that if an enrollee selects a plan with a premium above the low-income benchmark, he or she is required to pay the difference.

Other Persons Qualifying for Extra Help. Other low-income persons in a second group automatically qualify for assistance in meeting Part D Medicare premium and cost-sharing requirements. These are individuals who do not meet the criteria for full benefit dual eligibles but who are currently enrolled in Medicare Savings programs [i.e., the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, and the Qualified Individual (QI-1) program],[3] or the Supplemental Security Income program. In the spring of 2005, CMS mailed letters to these persons informing them that they would automatically qualify for low-income subsidies.

Other low-income persons may qualify, but they will need to submit an application. In 2005, the Social Security Administration (SSA) sent application forms to low-income persons who the agency identified as possibly qualifying for extra help. SSA makes eligibility determinations for those who fill out the applications.[4]

Federal efforts are not expected to identify all persons potentially entitled to low-income assistance. Persons who think they might qualify need to file an application with SSA or their state Medicaid office.

CMS will facilitate enrollment in Part D plans for persons identified as qualifying for extra help (exclusive of dual eligibles). Low-income individuals who have not selected a plan by the close of the initial enrollment period (May 15, 2006) will be randomly enrolled in a plan with coverage effective June 1, 2006. The facilitated enrollment process will be similar to that for auto-enrollment for dual eligibles. Namely, persons will be randomly enrolled in plans with premiums at or below the low-income benchmark. However, they will only be able to switch plans once during 2006, with the new coverage effective the following month. Subsequently, they will only be able to change during the annual open enrollment period, with the coverage effective the following January.

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[3] The QMB program pays Medicare Parts A and B cost-sharing charges and Medicare Part B premiums for persons at or below 100% of the federal poverty level. The SLMB program pays Medicare Part B premiums for persons with incomes over the QMB limit up to 120% of poverty. The QI-1 program pays the Part B premiums for persons above the SLMB limit up to 135% of poverty.

[4] The Social Security Administration has reported significant challenges in meeting the additional workload requirements of the Medicare drug benefit. For additional information, see Los Angeles Times article, R. Alonso-Zaldivar, *Drug-Plan Woes Spread Past Medicare*, Feb. 4, 2006.

Low-income persons who have not been identified as qualifying for low-income assistance will not have facilitated enrollment. They will be subject to a late enrollment penalty if they delay enrollment after their initial enrollment period.

Enrollment Data

On January 17, 2006, the Department of Health and Human Services (HHS) issued a press release on drug coverage.[5] It estimated that nearly 24 million persons had drug coverage as of that date. The statistics include both those covered under Part D as well as those persons who continued to have drug coverage through retiree plans. The following are the numbers as reported by HHS:

- 3.6 million newly enrolled in stand-alone PDPs (including 2.6 million who have signed up since December 13, 2005);
- 6.2 million dual eligibles (including 600,000 enrolled in MA plans);
- 4.5 million in MA plans (plus 600,000 dual eligibles);
- 6.4 million persons in retiree plans receiving a subsidy (with about 1 million retirees in employer coverage that incorporates or supplements Medicare's coverage and another 500,000 continuing in plans with coverage at least as good as Medicare's); and
- 3.1 million in TRICARE and the Federal Employees Health Benefits program (FEHB).

Early Days of Program Implementation

Despite considerable efforts by CMS to establish a smooth implementation to the new Part D benefit, the program experienced a number of problems during the initial days of operation. The major problems appeared to be related to the transfer of the dual eligibles from Medicaid to Medicare drug coverage on January 1, 2006. The following highlights some of the problems that have been reported in the press and elsewhere:

- Many dual eligibles were leaving pharmacies without needed medications because their eligibility could not be verified or transition policies were not applied.
- Low-income persons had difficulty getting information on Medicare toll-free lines or had difficulty getting information targeted to dual eligibles or other low-income persons.
- Pharmacists had long waits on phone lines when trying to verify information.
- Pharmacists were unable to make eligibility determinations with the E-1 query (see the discussion of this query system, below).
- CMS and state eligibility data did not always match, with the result that not all dual eligibles were identified.

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[5] HHS, *Nearly 24 Million Medicare Beneficiaries Now Have Prescription Drug Coverage*, press release, at [http://www.hhs.gov/news/press/2006pres/20060117.html].

- Individuals who were auto-enrolled in a plan, but changed their enrollment were showing up as not enrolled or enrolled with two plans.
- Pharmacies did not know that an individual was a low-income subsidy individual and therefore subject to reduced copayments.
- Individuals were unable to contact PDPs on a timely basis.

CMS Actions to Address Enrollment Issues

Auto-Enrollment

Prior to implementation of Part D, the Centers for Medicare and Medicaid Services (CMS) took a number of actions designed to assure that dual eligibles did not face a coverage gap. In May 2005, CMS mailed a letter to all full benefit dual eligibles informing them that they automatically qualified for the low-income subsidy and did not need to apply. In November 2005, CMS mailed notices to dual eligibles informing them about the upcoming transition, the enrollment process, information on the plan they would be enrolled in if they failed to make another choice before January 1, 2006, and how to obtain information on other plans available in the area. CMS reported that the November letters were mailed first class so that undelivered letters would be returned to CMS for follow-up action. Plans were also expected to mail enrollment materials to dual eligibles assigned to their plans.

Facilitated Enrollment; Point of Sale (POS) for Dual Eligibles

Overview of Process. CMS established a back-up process for any dual eligible arriving at a pharmacy without the necessary documentation. Three contractors may be involved. First, an eligibility inquiry (described in greater detail below) is submitted to Per-Se Technologies (formerly NDC Health)[6] to determine whether the individual is enrolled in a PDP and what plan the individual is enrolled in. If the eligibility inquiry (commonly referred to as an E1 inquiry) does not identify a plan, Wellpoint (Anthem), a national PDP (the POS Contractor), is to provide point-of sale access to these persons, provided they have evidence of *both* Medicare and Medicaid eligibility. The POS process assures that beneficiaries do not leave the pharmacy without their medications. The process applies only to full benefit dual eligibles. Z-Tech (the Enrollment Contractor) is to expedite validation of dual eligibility and return independently verified information on the individual's eligibility for enrollment.

CMS has outlined the POS process as follows:

- Beneficiary presents at pharmacy with Medicaid card or recent history of Medicaid billing in the pharmacy's patient profile system.

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[6] CMS has also contracted with Per-Se Technologies to serve as the Part D program's TROOP Facilitator for plans. TROOP stands for true out-of-pocket drug costs.

- Pharmacist obtains photo ID or other supporting documentation and submits an eligibility inquiry (E1 query) to Per-Se Technologies (see discussion below).
- If E1 query returns Part D enrollment information, the pharmacist bills the appropriate plan. Otherwise the process continues only if the pharmacist cannot identify the appropriate plan and the pharmacist is able to verify both Medicaid and Medicare eligibility.
- The pharmacist enters the claim in the automated pharmacy system; the pharmacist submits the claim to the single pre-established service account indicated on the POS Contractor (Wellpoint) payer sheet and the drug is provided at the $1/$3 cost-sharing level.
- The POS Contractor (Wellpoint) processes the claim as paid.
- The POS Contractor (Wellpoint) sends a daily file to the enrollment contractor on the beneficiary data submitted with the claim.
- The Enrollment Contractor (Z-Tech) uses the information to validate dual eligibility and returns a validation of eligibility or ineligibility to the POS contractor.
- If the individual is dually eligible and not enrolled in a Part D plan, the POS Contractor (Wellpoint) enrolls him/her in a POS Contractor (Wellpoint) plan (with the individual having the option to choose another plan).
- If the beneficiary is already enrolled in a plan, the POS Contractor (Wellpoint) will contact the pharmacy to reverse the claim, and the pharmacy will bill the appropriate plan.
- If the beneficiary is Medicaid only (and not Medicare eligible), the POS Contractor (Wellpoint) will contact the pharmacy to reverse the claim, and the pharmacy will bill the appropriate state agency.
- If the person is Medicare-eligible only, the Enrollment Contractor (Z-Tech) notifies the individual that he/she is ineligible for facilitated enrollment, but may enroll in a Part D plan under normal rules.

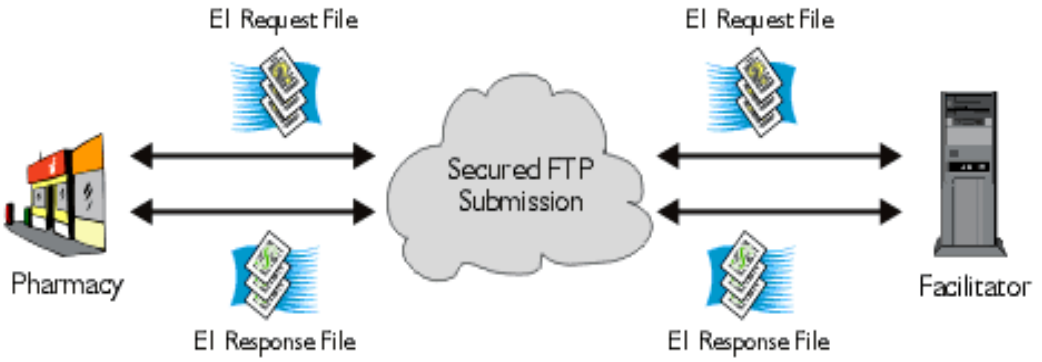
CMS reported that Wellpoint had provided details of this process on its industry "payer sheet" — the mechanism used by the pharmacy industry to communicate billing processes among pharmacies and payers. CMS also produced a media file presentation on the process.

E1 Eligibility Verification System

Overview. As discussed above, the E1 Eligibility Verification system is a new electronic inquiry system that allows pharmacies to access real-time Part D coverage information if a beneficiary arrives at a pharmacy without an enrollment card from a Part D plan. (The E-1 process can be used for all enrollees, not just dual eligibles). To conduct an E1 request, the pharmacy enters basic information about an individual (e.g., date of birth, first name, last name, Zip Code). The beneficiary information is transmitted electronically through the pharmacy's normal billing mechanism (referred to as the "switch"), which is in turn sent to the CMS contractor, Per-Se Technologies (formerly NDCHealth). Per-Se Technologies, in real-time, queries its

eligibility file (which is provided by CMS and updated nightly),[7] and returns information back to the pharmacy (through the switch) about a beneficiary's Part D coverage. The information will also show the billing order if the beneficiary has multiple insurance coverage. (See **Figure 1**.)

Figure 1. Eligibility Verification Process



Source: This diagram was excerpted from information posted on the Facilitator's website [http://medifacd.ndchealth.com/Pharmacies/MediFacD_Pharmacies_Overview_PartD.htm]; © Copyright 1999-2005 Per-Se Technologies, Inc., 1145 Sanctuary Parkway, Alpharetta, GA 30004 USA. All Rights Reserved.

Note: In some cases, the pharmacy may have a direct contractual relationship with the Facilitator in which case the E1 request does not go through the switch.

In submitting an E1 request, a pharmacy does not need to enter all beneficiary information, but including information in key fields increases the likelihood of a match to a particular beneficiary. The E1 request will be unable to identify a beneficiary when (1) the information provided was not accurate, (2) not enough information was provided for Per-Se Technologies to identify a match, or (3) the beneficiary is not included in the eligibility file that Per-Se Technologies has received from CMS.

If an individual is not enrolled in a Part D plan, a pharmacy can also use the E1 Eligibility Verification System to determine whether an individual is eligible for Medicare Part A and Part B, and therefore is eligible for Medicare Part D. If the pharmacy determines that the person is also eligible for Medicaid, the pharmacy can bill a drug plan known as the "Point of Sale Facilitator" for these claims, as described earlier. (For additional information, see **Appendix A**, which provides an overview of how the E1 Eligibility Verification System fits into the overall process used by pharmacies.)

The E1 Eligibility Verification System became active a few months prior to the start of the Part D benefit. Pharmacists and pharmacy system vendors were able to access the Part D component of the system in mid-October 2005 to test its operations.

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[7] [http://medifacd.ndchealth.com/Vendors/MediFacD_Vendors_Overview_PartAB.htm]

The Medicare Part A and B eligibility component became available on December 19, 2005.

Operational Issues with System Performance. Prior to implementation of the Part D benefit, the testing phase revealed several issues with the E1 Eligibility Verification System. A full discussion of pre-implementation issues is outside the scope of this report; however, Per-Se Technologies made several changes to the E1 system to correct early-identified problems.

After the implementation of the Medicare Part D drug benefit on January 1, 2006, the primary issues identified with the operations of the E1 Eligibility Verification System were the slow response time to queries submitted by pharmacies and/or transactions being stopped due to the length of the processing time. As of January 18, 2006, Per-Se Technologies reports that the system has been modified, that this issue is resolved, and that "response times are in the one to two second range and timeouts are at zero."[8]

Issues with Beneficiary Data. In addition to the system performance issues, it has also been reported that the E1 query is providing incomplete or inaccurate information about which plan an individual is enrolled in and how much an individual is required to pay for cost-sharing. These issues are somewhat more difficult to address because of the quality of the underlying data that feeds into the E1 Eligibility Verification System. On February 1, 2006, HHS reported that it has taken steps to improve the quality of data on dual eligible beneficiaries, and to improve data transmission between Medicare, health plans, and states.[9]

Transition Policies: First-Fill of Prescriptions

For some beneficiaries, drugs that were previously covered under Medicaid are no longer covered by the individual's Part D plan. An analysis by the HHS Office of Inspector General (OIG) found that 18% of dual eligibles were assigned to PDPs that included all of the 178 most commonly used Part D drugs by dual eligibles.[10] However, almost one-third of the dual eligibles are assigned to PDPs that include less than 85% of these drugs (151 or fewer).[11]

The federal regulations implementing Medicare Part D require each Part D plan to establish an appropriate transition process for all new enrollees whose current drug

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[8] [http://medifacd.ndchealth.com/Stakeholder/DocsDisp/Files/CurrentlyKnownIssuesandStatus.doc]

[9] M. Leavitt, Secretary's One Month Progress Report on the Medicare Prescription Drug Benefit, U.S. Department of Health and Human Services, Feb. 1, 2006.

[10] The HHS OIG reports that 22 of the top 200 drugs most commonly used by dual eligibles are excluded by law from coverage under Part D. State Medicaid programs may, at their option, continue to cover such drugs.

[11] U.S. HHS Office of Inspector General, *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090, Jan. 2006.

therapies may not be included in the plan's formulary [42 CFR 423.120(b)(3)]. The regulations also require that the transition plan meet any additional guidance or requirements outlined by CMS. The transition plan proposed by each PDP was reviewed by CMS as part of the formulary and benefit structure review process.

CMS guidance on the transition policy requirements for PDPs has changed. CMS released initial guidance in March 2005. Based on that initial guidance, PDPs developed various transition policies (described in **Table 1** below) and submitted them for CMS review. Generally, a 30-day minimum period was established. Following the implementation of the drug benefit, in February 2006, the Secretary of HHS extended the transition period for an additional 60 days, establishing a 90-day transition period.

The initial guidance released on March 16, 2005 stated that plans should "address situations where an individual first presents at a participating pharmacy with a prescription for a drug that is not on the formulary." In this guidance, CMS gave plan sponsors "discretion in deciding the appropriate time frame for a one-time transition supply"; policies could vary by drug or differ for those residing in a long-term care facility. CMS outlined that a temporary "first fill" supply of 30 days for individuals who were not long-term care residents seemed reasonable for new enrollees who first present at a pharmacy with a prescription for a drug not on the formulary. For residents of long-term care facilities, CMS recommended a transition period of 90 to180 days. If the drug plan does not use a temporary "first fill" supply method, CMS required the plan to have a process that ensures that new enrollees who are stabilized on non-formulary drugs that may carry risks associated with changing a drug regimen will continue to have access to medically necessary drugs without adverse health consequences. Finally, CMS required the drug plan to make transition policy information available to beneficiaries similar to information sharing about the formulary and benefit design of a particular plan.[12,13]

Based on PDP data from November 13, 2005, of the 88 organizations providing stand-alone Part D plans, 63% offered a first fill supply of 30 days for those new enrollees not residing in a long-term care facility, and 59% offered a first fill supply of 90 days for enrollees who reside in long-term care facilities. With a few exceptions, most of the 88 organizations sponsor between one and three different plans, and may offer these plans in various regions of the country or nationwide. Most organizations offer the same transition policies across the plans sponsored. (See **Table 1**.)

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[12] [http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/TransitionProcess_031605.pdf]

[13] K. King, *Medicare: Contingency Plans to Address Potential Problems with the Transition of Dual-Eligible Beneficiaries from Medicaid to Medicare Drug Coverage*, Letter to the Honorable Max Baucus, Government Accountability Office, GAO-06-278R, Dec. 16, 2005.

Table 1. Based on *Initial* CMS Guidance, the Number of Organizations Sponsoring Stand-Alone Part D Plans by Type of Transition Policy for First-Fill Prescriptions, and Type of Enrollee (as of November 13, 2005)

Description of transition period for first-fill prescriptions	New enrollee, not a long-term care resident	New enrollee, long-term care resident
15 days initially, may be extended up to 60 days	2	
Up to 30 days	2	
Up to 30-day supply for all Part D medications and, for select drugs, one plan year	1	
30-60 days	3	
30 days	55	
30 days initially, but may be extended up to 90 days if stabilized on multiple non-formulary medications		1
30 days initially — based on exceptions process outcome, may extend up to 90-180 days		1
30-90 days	2	
31 days	1	
34 days	1	
30 days, then up to 90 days if situation warrants		1
34 days initially, may be extended up to 60 days		2
60 days	7	4
60-180 days		1
90-day supply		1
90 days	13	52
90-180 days		13
90-180 days for all Part D medications or one plan year coverage		1
91 days		1
Open benefit	1	1
Open formulary (covers all Part D meds)	1	1
Up to 180 days		1
Up to 90 days		8
180 days		1
Utilization management clinical edits lifted during the 30-day transition period	1	
Utilization management clinical edits lifted during the 90-day transition period		1
Total number of organizations	**88**	**88**

Note: The sum of each column exceeds the total number of organizations because certain organizations offer more than one type of transition policy, as described below. Generally, organizations sponsoring multiple plans used the same transition policies across all the plans offered. There were a couple of exceptions. For general enrollees, two organizations offered different transition policies within the plans they sponsored: Instil Health Insurance Company had both a 30 day and a 30- to 90-day transition policy, and FOX Insurance company offered both a 30-day and a 60-day transition policy. For long-term care residents, three organizations offered different transition policies across the plans sponsored. Coventry AdvantraX provided both a 30-day (with up to 90 days

if the situation was warranted) transition policy and a transition policy providing up to 90 days of coverage. Highmark Senior Resources Inc., also offered two transition policies for various plans, a 90-day period, and a 90- to 180-day period. Finally, SilverScript offered a 90-day transition period and a 91-day period for a drug plan in Alabama.

Source: CRS analysis of PDP Transition Policies. The source file can be accessed at [http://www.healthassistancepartnership.org/assets/xls/PDPTransitionPolicySummary_12-27-05.xls.].

Following implementation of Medicare Part D on January 1, 2006, CMS began receiving reports that (1) the PDP plan's customer service representatives were unaware of the transition policies for their organization, (2) pharmacies within a PDP's network were unaware of how to implement the transition policy through an override to the billing system, (3) individuals were being asked to go through prior authorization or step-edit requirements before filling a prescription; and (4) there was "confusion over transition issues involving long term care (LTC) residents."[14]

On January 6, 2006, CMS issued guidance to all Part D plans to remind them of their transition plan requirements, which emphasize that customer service representatives and network pharmacies needed training and information on the transition policies. The letter also stated that delays or denials in the filling of initial prescriptions for new enrollees at the pharmacy because of prior authorization/step edit requirements "was not consistent with the intent of CMS' transition policy." In transitioning LTC residents, CMS reiterated that it was critical that the transition process address access to medications at the filling of the first prescription for enrollees who are LTC residents, and that plans take into account polypharmacy (multiple-prescription) circumstances of these enrollees.[15]

On January 13, 2006, CMS issued additional guidance to all Part D plans reiterating its earlier guidance from the January 6 letter, but also requiring that Part D plans strengthen their transition policies through ensuring an expedited process to implement the transition policies when a beneficiary first fills a prescription. Specifically, the PDP was required to establish an expedited process for a pharmacist to obtain authorization and to ensure that the customer service representatives had the authority to make or obtain quick decisions on transition policies and carry out these decisions in real time.[16]

On February 1, 2006, HHS Secretary Leavitt released a progress report on the implementation of the Part D benefit. In this report, Secretary Leavitt states that Medicare will be notifying plans that the 30-day transitional coverage period in effect will continue for 60 additional days, establishing a 90-day transition period.[17]

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[14] [http://www.ascp.com/medicarerx/docs/TransitionPolicyReminder.pdf]

[15] Ibid.

[16] [http://www.ascp.com/medicarerx/docs/CMSLetterPartners.pdf].

[17] [http://www.hhs.gov/medicare.pdf].

State and Federal Transition Funding

As of January 24, 2006, 25 states and the District of Columbia had decided to step in temporarily and pay for drugs for dual eligibles who would otherwise have a gap in coverage due to transition policy problems. Some of these states were only expecting to provide assistance through January.[18] In most cases, these costs should ultimately be recovered from the Part D plan to which the beneficiary has been assigned or through the POS system. However, states expressed concern about their ability to recover all of their expenditures.

On January 24, 2006, CMS announced that it was establishing a state reimbursement plan under the Section 402 demonstration authority.[19] Under the demonstration, Medicare will be able to make payments to states for amounts they have paid for a dual eligible's Part D covered drugs, to the extent those costs are not otherwise recoverable under Part D. The demonstration will also provide payments for administrative costs incurred in the coordination of the drug benefit by state Medicaid programs. CMS stated that it would expedite review of applications of states applying for the demonstration. CMS outlined the following key features of the demonstration:

- States meeting demonstration criteria will have their full drug costs reimbursed through CMS assurance of payment reconciliation with PDPs and Medicare payment of any net drug cost differential after reconciliation. Further, CMS will provide funding for administrative costs.
- States will use payment approaches that promote pharmacists' efforts to primarily bill the Part D plan and promote the use of POS billing before relying on state payment. States will provide input to CMS and plans on ways to enhance plans' and Part D program performance.
- States will provide timely summary information on claims to facilitate reconciliation and beneficiary transition to Part D plans. States will also work with CMS to provide valid data on any beneficiaries who may not have been included in the states' previous dual eligible files.
- States will separate transition claims from claims states would otherwise have paid through state programs.
- The demonstration authority has an anticipated end date of February 15, 2006, with states expected to discontinue payments through their Medicaid systems on or before that date. The Secretary could provide a short-term extension of the program.
- The demonstration is retroactive to the first date the state paid claims.

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[18] Avalere Health LLC, communication, Jan. 24, 2006.

[19] Section 402 of the Social Security Amendments of 1967 (P.L. 90-248), as amended.

On February 2, 2006, CMS provided state Medicaid directors and state pharmacy assistance program directors with a template they could use when applying to participate in the demonstration.