kaiser commission on medicaid and the uninsured

PERSPECTIVES ON MEDICARE PART D AND DUAL ELIGIBLES: KEY INFORMANTS' VIEWS FROM THREE STATES

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THE CENTER FOR MEDICARE ADVOCACY, INC.

FLORIDA LEGAL SERVICES, INC.

MAY 2007

THE HENRY J. KAISER FAMILY FOUNDATION

kaiser commission medicaid and the uninsured

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EXECUTIVE SUMMARY

In 2006, low-income individuals receiving health coverage through both the Medicaid and Medicare programs – "dual eligibles" – experienced a change in their prescription drug benefit when their Medicaid prescription coverage was replaced by the Medicare prescription drug program known as Medicare Part D. Beneficiaries now must select from a wide array of Part D drug plans instead of dealing with one state program (Medicaid) for their health and prescription drug needs. Each of the Part D plans has a different formulary, utilization management practices, and pharmacy network. And, while dual eligibles qualify for certain protections in Part D, they still face other costs and restrictions that they may not have had under Medicaid, including prescription drug co-payments.

This study was designed to gather information on the ongoing successes and challenges that dual eligibles faced in the first eight months of Part D, and how different state approaches may affect dual eligibles' ability to access prescription medications. The study was conducted in August and September, 2006, when the well-documented initial Part D implementation difficulties were presumed to have subsided. It was conducted in three states: Connecticut, Washington, and Florida, which adopted different approaches to helping dual eligibles with their Part D expenses. Connecticut offers substantial assistance, paying co-payments and providing a "wraparound" to Part D that covers prescription drugs that are not on a dual eligible's Part D plan formulary. Washington pays dual eligibles' co-payments but does not cover non-formulary medications. Florida offers neither type of assistance to dual eligibles. In addition, all three states cover certain drugs excluded from Medicare Part D through their Medicaid programs.

Seventy-one key informants were interviewed for the study (19 in Connecticut, and 26 each in Washington and Florida) representing individuals in seven categories of professions or facilities serving dual eligibles: physicians; independent and chain pharmacies; nursing homes; assisted living facilities; state agencies; community clinics; and advocates and social service providers. The majority of key informants had worked in their professions for over five years, and close to half had more than ten years' experience. We asked all key informants to focus on their experiences with Part D during the summer of 2006, rather than their experiences during the initial few months of the program when problems might have been related to the rapid implementation of Part D, as opposed to ongoing areas of concern.

Respondents' Overall Experiences with Medicare Part D on Behalf of Dual Eligibles

A small proportion of respondents reported positive experiences with Part D, with the remainder either neutral or negative. Many reported that there were fewer problems with the program than there had been in early 2006 and that most beneficiaries were getting their medications. Several observed that Part D works best for those duals who have simple drug regimens. Washington and Connecticut respondents commented positively about the assistance their states are providing for dual eligibles. Over a third of respondents reported overall negative experiences with Part D, citing program complexity. In particular, they reported problems with formularies, utilization management, enrollment, spend-down issues for Medically Needy dual eligibles, communication with Part D plans and payment issues.

The majority of respondents reported neutral to negative experiences dealing with Part D plans (both stand-alone plans and Medicare Advantage plans). Their biggest complaint was the difficulty in communicating with plans. In addition, almost all those familiar with the Part D plans' utilization controls described them in negative terms, and many, but not all, considered Part D controls more stringent than those used by other prescription drug insurance plans.

Affordability of Medicare Part D

When asked whether Medicare Part D was affordable to dual eligibles, respondents' answers differed dramatically depending on whether their state offered co-payment assistance. In Florida, most respondents said co-payments affect access to care, whereas in both Connecticut and Washington, fewer considered co-payments a problem for dual eligible enrollees. Many respondents in Connecticut and Washington voiced concern about what would happen if their state dropped co-payment assistance, and a number of respondents in all three states said that Medicare Part D could be improved by ceasing to require co-payments from dual eligibles.

Many of the respondents – and all who see at least 500 dual eligibles per month - were aware of duals not taking needed medications because of co-payments. Others knew of dual eligibles not taking medications as prescribed, not paying other bills, and going without food or other necessities because of the cost of their medications. The most severe situations were described by Florida respondents.

In addition, some respondents reported that pharmacies continued to charge dual eligibles co-payments that were too high. This appeared to be caused by a lag in Low-Income Subsidy eligibility data being made available to pharmacies through CMS and Part D plans.

Enrollment of Dual Eligibles in Medicare Part D

Dual eligibles are randomly assigned to Part D plans; individual medication needs are not factored into the assignment process. Dual eligibles are permitted to switch plans at any time. Most respondents reported that duals assigned to plans that don't fit their needs change plans, and that the primary reason they do so is that the drugs they need are not on the plans' formularies. This was reported by more Florida and Washington respondents than Connecticut respondents, a difference that may be attributed to Connecticut's policy of paying for non-formulary drugs. Other reasons for switching plans included the inconvenient locations of plan pharmacies (especially in Washington), plan utilization management policies, and the frequency with which beneficiaries must fill prescriptions. Respondents noted that many duals require assistance to switch plans and that this process is time consuming.

Respondents were evenly split on the question of whether random assignment to Part D is the best way to enroll dual eligibles in Part D. While it means that people may be assigned to plans that don't meet their needs and therefore may switch plans more often, at least it gets people enrolled. When asked how enrollment could be improved, respondents had a number of suggestions to assist duals in getting into an appropriate plan initially, rather than having to switch, including providing direct personal counseling to dual eligibles and providing more accurate and updated information on websites (Part D plans' and formulary finders).

When Medicaid beneficiaries become eligible for Medicare, and thus for Part D, respondents believed that many may not be receiving notice of this change. For those who do receive notices, respondents believed that many do not understand them, due to the way in which the notices are written, the language used, and the complexity of Part D.

Formulary and Utilization Management Issues

About two-thirds of respondents were aware of dual eligibles who were being denied drugs by their Part D plans, particularly newer, more expensive drugs. More than half of respondents

said they had seen Part D plans deny prescribed drugs, requiring duals to use formulary drugs that they had previously tried and failed, often without determining whether the dual eligible had already failed on the drug. In addition, over half of respondents said that dual eligibles were experiencing delays in getting needed drugs. When asked how dual eligibles respond to denials or delays, the most common answers were that they go without needed medications, they switch Part D plans, or they try new medications. Respondents also reported that duals are paying out-of-pocket for drugs, sometimes borrowing money to do so. Some reported serious health consequences faced by duals as a result of denials and delays.

Certain classes of drugs are excluded from Medicare Part D, some of which continue to be covered by state Medicaid programs in all three study states. Nevertheless, respondents in Florida reported that duals are having trouble accessing these drugs, and some are paying out-of-pocket for them. This was less of a concern in Connecticut and Washington.

Exceptions and Appeals

Respondents were asked how well the exception and appeals processes – the processes used to request that one's plan cover medications not on the formulary were working. Although respondents expressed familiarity with the processes, their responses did not reflect deep understanding. Respondents felt that most beneficiaries were not receiving notice of their right to request an exception or appeal, and almost all respondents believed that enrollees do not understand the exceptions and appeals process. Few requests for exceptions and appeals were being filed, but those that were filed with the help of respondents appeared to succeed more frequently.

Administrative Complexity

Most respondents felt that getting prescription drugs through Part D was "difficult" or "very difficult," for dual eligibles, while a minority considered it "easy" or "very easy" (primarily respondents working in nursing homes and State agencies). Many reported that Part D is confusing, and that most dual eligibles are not able to select Part D plans without assistance, especially given their often debilitating health conditions and cognitive issues. The number of plans available in each state, with different and changing formularies, makes Part D very challenging, particularly when a patient needs a drug that is not on the plan's formulary. Advocates and social service providers reported that Part D greatly strains the resources of organizations that assist beneficiaries in navigating the program.

About a third of respondents were aware of problems faced by dual eligibles with drug coverage other than Part D, such as retirement plans and Veteran's Administration benefits. According to Part D rules, Medicare beneficiaries cannot be enrolled in a Part D plan and another plan such as the VA or an employer plan that provides creditable prescription drug coverage. Because dual eligibles qualify for the Low-Income Subsidy, Part D is often less costly to the beneficiary than other sources of coverage. In order to enroll in Part D, however, they must drop their other coverage, and, in the process, forego other potentially valuable benefits.

Some dual eligibles are reportedly being asked to pay premiums and co-payments they do not owe. One cause of this problem is a lag in data exchange between CMS and Part D plans and pharmacies. Another cause is that some duals inadvertently select Part D plans that are not "standard," and they are billed for the difference between the "standard" and non-standard premiums and co-payments.

State Assistance

Respondents had varying degrees of knowledge of their states' policies to help dual eligibles get the drugs they need. All Connecticut respondents, most Washington respondents, and a few Florida respondents said their state was doing something to help dual eligibles. About half of Connecticut respondents correctly described their state's co-payment assistance policy, but fewer were aware of the state's wrap-around policy of paying for duals' non-formulary drugs. Most Washington respondents correctly described their state's co-payment assistance policy. In all three states, few respondents were aware that the state pays (through Medicaid) for some classes of drugs excluded by Medicare Part D.

Connecticut and Washington respondents were very positive about the impact their states' co-payment policies were having on dual eligibles. They reported that duals were getting the medications they needed as a result of the policies, which was not the case before the policies were put in place. Connecticut respondents were also very positive about the impact of their state's wrap-around policy. Nearly two-thirds of Connecticut respondents said that this policy helps enrollees receive drugs subjected to prior authorization by the plans. However, less than a quarter of Connecticut respondents said the wrap-around works when a plan imposes quantity limits on drugs or when a plan requires a person to try and fail a series of medications before being allowed the requested one.

Many respondents said they had encountered dual eligibles who qualify for Medicaid as medically needy who lost their Medicaid eligibility after going on Part D, because they did not meet their "spend down" or "share of cost." When asked if these individuals continue to receive the drugs they need, most said yes. However, respondents in all states reported that these beneficiaries often do not receive other needed medical services, such as physician and lab services, and that many go to emergency rooms for care.

Lessons Learned

Although many of the difficulties involved in the initial transition of a large number of dual eligibles from Medicaid to Part D had been resolved at the time of the study, some ongoing challenges remained. More than three-quarters of respondents said they saw continuing problems with Medicare Part D that did not appear to be adequately resolved at the CMS or plan levels. Some beneficiaries who had been part of the initial transition from Medicaid to Part D drug coverage faced persistent problems getting their medications. People who were newly enrolled in Part D later in the year and those who changed their prescription drug plans could also face difficult transitions.

Respondents report that duals in all three states are experiencing denials and delays in getting needed drugs, especially newer, more expensive drugs. Obtaining drugs that are not on a Part D plan's formulary is particularly problematic and time consuming. As a result, dual eligibles are going without needed medications, switching Part D plans, or trying new medications. Few exceptions and appeal requests are being filed with plans.

Enrollment and plan switching remain problematic for dual eligibles who are assigned to plans with incompatible formularies or utilization restrictions. Study respondents, who assist duals in switching plans, would like to see improvements in the plan assignment process that would allow better matching of people with plans.

This study suggests that dual eligibles' ability to obtain needed drugs under Part D is affected by the type of state assistance provided to them. According to key informants, Connecticut's policies of covering co-payments and non-formulary drugs for duals made it easier for them to access needed medications. Washington's co-payment policy also made access easier for formulary drugs. In Florida, where neither type of assistance was provided, access appeared to be more problematic.

INTRODUCTION

When the Medicare Modernization Act (MMA) of 2003 established Medicare Part D, the new prescription drug benefit, it transformed drug benefits for those covered by both Medicaid and Medicare, commonly referred to as "dual eligibles" or "duals." For many dual eligible individuals, unlike others enrolled in Medicare, the transfer of their prescription benefit from Medicaid to Part D resulted in less generous coverage, either through more stringent formularies and utilization management, through increased cost sharing, or both. Duals are also the only Medicare enrollees for whom the MMA required enrollment in Part D.[1]

This study focuses on dual eligibles and the impact Medicare Part D has had on their access to prescription drugs in three states from the perspective of health care providers, advocates, and others who work with duals. In particular, the study looks at ongoing successes and challenges duals faced by duals after the well-documented difficulties of initial Part D implementation were expected to have passed. While the initial transfer of dual eligibles from Medicaid to Part D as of January 1, 2006 created many challenges, this study looks beyond those challenges to understand duals' experiences several months into the program and what, if any, persistent problems and issues they faced.

The "Dual Eligible" Population

Dual eligible individuals are the most vulnerable of all Medicare beneficiaries. Most have incomes at or below the Federal Poverty Level (FPL)[2] and they have disabilities or are over age 65. They qualify for Medicare based on age or disability, and qualify for Medicaid based on their low incomes and asset levels.[3] There are two categories of dual eligibles – "full duals" and "partial duals."[4] This study focuses on both categories. Because of their limited income and assets, duals generally have no alternative way of paying for prescription drugs.

All dual eligibles qualify for a Low Income Subsidy (LIS or "Extra Help") for Medicare Part D. This is a federal subsidy for individuals with incomes below 150% of the FPL and who have limited assets. For dual eligibles, this subsidy covers all premiums and deductibles for Part D plans deemed as "benchmark" by the federal government (those with standard benefits and premiums below a set limit). It also limits co-payments for drugs to between one and five dollars per drug, and covers drugs during the Part D doughnut hole[5] or coverage gap. LIS is also available for other low-income Medicare beneficiaries, although those with incomes between

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[1] It is possible for dual eligibles to disenroll from Medicare Part D, but many would have no other source of prescription drug coverage.

[2] In 2007,The FPL for an individual is $10,210 and for a couple, $13,690

[3] Income and asset levels for Medicaid are set by each state, within federal guidelines.

[4] Dual eligibles may qualify for any of a number of Medicaid programs. The lowest income duals receive "Categorically Needy" (CN) Medicaid based on their limited income and resources, for example, individuals whose Social Security benefit amount falls below the Medicaid level. Others qualify for "Medically Needy" (MN) Medicaid based on a combination of limited income and high medical expenses; they must also have limited resources. The CN and MN groups are designated "full dual eligibles." Another group, the partial dual eligibles, consists of those who qualify for "Medicare Savings Programs" (MSP) because their incomes are higher than full duals but still below 135% of the federal poverty level and twice the Supplemental Security Income (SSI) program asset limits.

[5] "Doughnut hole" is the term commonly used to describe the Medicare Part D benefit's gap in coverage when enrollees reach $2,250 in prescription expenses. They are responsible for paying the next $3,600 themselves before any additional Part D coverage is available.

135 and 150% of the FPL have responsibility for partial payment of premiums and an annual deductible, and they pay higher co-payments.

The transfer of dual eligibles to Part D was conceived as a shift of program responsibility from state Medicaid programs to the federal Medicare program, based in large part on the philosophy that all Medicare beneficiaries should have the same array of Medicare options from which to choose. However, the switch from Medicaid to Medicare drug coverage has resulted in a significant change in benefits for duals. These beneficiaries now face co-payments for their prescription drugs, which many did not incur in the past. They are also required to select from a wide array of Part D drug plans instead of dealing with one state program (Medicaid) for their health and prescription drug needs. Each of the Part D plans has a different formulary, utilization management practices, and pharmacy network. Some individuals who were previously on Medicaid as Medically Needy beneficiaries have lost their eligibility because their prescription drug expenses shifted to Part D, removing the primary means through which they spent down to qualify for Medicaid. Loss of Medicaid eligibility can cause them to lose coverage for other health services covered by Medicaid but not by Medicare.

How are Dual Eligibles Affected by Medicare Part D?

Full Duals. Full duals received prescription drug coverage through Medicaid until December 31, 2006. Part D drug coverage, which took effect for full duals on January 1, 2006, differs from the Medicaid drug benefit because it requires the individual to:

- Obtain most medications from a Medicare Part D Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug Plan (MAPD), both of which have greater discretion to limit drug formularies and limit the number of pharmacies with which they work than does Medicaid;
- Pay co-payments ranging from $1 to $5 per prescription drug (but not premiums, deductibles, or "doughnut hole" expenses);
- Be automatically enrolled by the Centers for Medicare and Medicaid Services (CMS) in a randomly-selected PDP or MAPD ("auto-assignment"), unless they take action to change plans;
- Pay additional charges for choosing an "enhanced" PDP with better benefits, whose premium exceeds a benchmark level determined each year by CMS.

Many dual eligibles qualified for Medicaid as medically needy beneficiaries in the past, based on their unreimbursed prescription drug expenses, known as "spending down[6]." Now that their drug expenses are covered by Part D, it is more difficult for them to qualify for Medicaid.

Partial Duals. Those covered by Medicaid through Medicare Savings Programs (MSPs) did not previously have their prescription drugs covered by Medicaid. Some may have had drug coverage through sources such as employer sponsored retiree health benefits; others may have used private programs, purchased drugs without insurance (paying full retail price), or not had any drug expenses. Partial duals are required, as of May 2006, to choose, or by default be enrolled by CMS (called "facilitated enrollment") in a randomly-selected PDP or MAPD; they are then permitted to switch or disenroll. Those who remain enrolled must:

- Obtain most medications from a Medicare Part D PDP or MAPD

[6] For more information, see "Part D Impact on Dual Eligibles Who Spend Down to Medicaid" Barbara Coulter Edwards, Sandy Kramer and Linda Elam. KCMU May 2007.

- Pay co-payments of $1 to $5 per drug per prescription fill (but not premiums, deductibles or "doughnut hole" expenses)
- Pay additional charges for choosing an "enhanced" Part D plan with better benefits, whose premium exceeds the benchmark level determined by CMS

State-level Policies to Assist Dual Eligibles' Transition to Medicare Part D

While the MMA partially relieved states of the obligation to pay for dual eligibles' medications, a few states recognized that these low-income enrollees would have difficulty affording co-payments and might need specific drugs not covered by Medicare Part D plans. States have adopted a variety of policies regarding whether, and how, to help duals with Part D. In this study, we sought information about the experiences of duals and their providers in three states: Connecticut, which offers a substantial Medicaid "wraparound" to Part D; Washington, which offers limited assistance; and Florida, which offers no assistance to duals. In particular, our goal was to examine the impacts of these varying levels of assistance, contrasting the three states to determine the effectiveness of the different state approaches.

> **Connecticut** covers Medicare Part D co-payments for all duals. It also covers medications that are not on a beneficiary's Medicare Part D plan formulary, provided that the beneficiary makes a good faith effort to utilize the Medicare Part D exceptions process to obtain drugs. This coverage took effect when the Part D program began in January 2006. (Connecticut also covers certain costs for low-income non-Medicaid eligible persons in a state-funded prescription access program called ConnPACE.)[7] There are approximately 63,000 dual eligibles in Connecticut.
>
> **Washington** began covering Part D co-payments for full duals in February 2006. It does not offer wraparound coverage for non-formulary drugs.[8] There are approximately 109,000 dual eligibles in Washington.
>
> **Florida** does not cover co-payments or offer wraparound coverage for non-formulary drugs. There are approximately 407,000 dual eligibles in Florida.

The Medicaid programs in all three states cover certain categories of drugs for duals that are not covered by Part D, including benzodiazepines.[9]

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[7] Co-payments are provided for in statute; wraparound is currently funded through December 2006.
[8] This co-payment assistance continues but will need to be re-authorized in 2007.
[9] The other drugs in this category include: drugs when used for anorexia, weight loss or weight gain; drugs when used to promote fertility; drugs when used for cosmetic purposes or hair growth; drugs when used for the symptomatic relief of coughs and colds; prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; nonprescription drugs; covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; and barbiturates. Additionally, drugs when used to promote smoking cessation may be excluded from Medicaid, but Part D plans are permitted to cover them.

METHODOLOGY

The questionnaire and interview protocol used in this study were designed to gather as much information as possible about dual eligibles' recent experiences with Medicare Part D from the perspective of health providers, advocates, social service providers, and state agency personnel who work with this population. One questionnaire was used for all provider interviews, with the understanding that not every key informant would necessarily be able answer all of the questions (for example, some questions are more applicable to pharmacists and others to advocates or social service providers). As a result, the questionnaire is lengthy and comprehensive. (See Appendix A.)

Seventy-one (71) key informants participated in the study, 19 in Connecticut, and 26 each in Washington and Florida. They represented seven provider categories: physicians (8); pharmacies - independent (10) and chain (2); nursing homes (10); assisted living facilities (2); state agencies (7); community clinics (7); and advocates and social service providers (19); and other (6), including a State Senator and a County Medical Director. The majority of key informants had worked in their professions for over five years, and close to half had more than ten years experience. Below is the breakout of providers by state.

Table 1
Number of Key Informants by Provider Type

	Connecticut	Washington	Florida
Physician	1	4	3
Pharmacy: Chain	0	1	1
Pharmacy: Independent	1	4	5
Nursing home	4	2	4
Assisted living facility	0	0	2
State Agency	2	2	3
Community clinics	0	3	4
Advocates / Social Service Provider	9	7	3
Other	2	3	1
Total Key Informants	**19**	**26**	**26**

The targeted key informants regularly work with dual eligibles and have experience with duals enrolling in and using Medicare Part D. Potential key informants were identified by the three organizations conducting the study, all of which have strong networks of contacts among health and social service providers in their various states.

Northwest Health Law Advocates (Washington): Northwest Health Law Advocates (NoHLA), founded in 1999, is a non-profit organization based in Seattle, Washington, that promotes increased access to health care and basic health care rights and protections for all individuals through legal and policy advocacy, education and support to community organizations in the Pacific Northwest.

Center for Medicare Advocacy, Inc. (Connecticut): The Center for Medicare Advocacy, founded in 1986, is a national non-partisan education and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare and quality health care.

Florida Legal Services, Inc. (Florida): Florida Legal Services (FLS) is the state support center for providers of legal assistance to low-income persons in the State of Florida. FLS engages in legislative and administrative advocacy on priority issues impacting low-income residents of Florida; provides representation to low-income clients in court and administrative proceedings; conducts substantive law and skills training; and provides field support to legal providers and the low-income community.

Building on these networks and additional referrals, potential key informants were contacted by phone and/or email requesting their participation in the study. They were provided with a letter of introduction from the Kaiser Family Foundation and a copy of the questionnaire, which they were urged to review before their scheduled interviews. Many key informants reported that previewing the questionnaire assisted them in providing more accurate answers.

Interviews were conducted between August 23, 2006 and October 12, 2006. Most took place over the telephone (68); three were conducted in person. Most of the interviews lasted 45 minutes to one hour, although some were significantly longer. A confidentiality clause was read to key informants at the beginning of each interview, and informants were reminded to limit their answers to recent experiences with the Medicare Part D, rather than focusing on the program's initial launch period.

To streamline data management and assure consistency among interviewers, responses were entered into SurveyMonkey.com, an on-line data collection program. The program allows multiple interviewers to enter data simultaneously. Its security features allow data to be protected, while still allowing access to review and analyze the data. Interview data were analyzed using SurveyMonkey.com, and exported to Microsoft Excel for permanent storage and additional analysis.

The study was designed to collected qualitative, rather than quantitative, data. Results are presented in terms of general proportions where this information helps provide context for the information, but given the relatively small number of key informants involved in the study, none of the findings can be considered statistically significant.

Efforts were made when recruiting key informants to assure geographic representation of providers in each state, as well as representation of both urban and rural communities. The maps in Appendix B show the geographic distribution of key informants. Across states, approximately 70% of key informants worked in urban locations and 30% in rural. In Connecticut, the percentage of urban key informants was higher (85%).

Approximately a quarter of the key informants reported seeing fewer than 10 dual eligibles per month, over a quarter reported seeing 11-50 duals per month, and over a quarter reported seeing 51-500 duals per month. Seven key informants reported seeing over 500 duals per month. Florida key informants saw larger numbers of duals, on average, than those in Connecticut or Washington.

Respondents' ideas for improvements to the Part D program were compiled and summarized, and suggestions that call for broad changes in the program are at the conclusion of this report, while suggestions that relate to the specific areas addressed by the survey have been included in the relevant sections. The practical perspectives of these key informants should be useful to policymakers at the state and federal levels as they evaluate Medicare Part D.

Not all of the views are consistent with each other; we have presented the full spectrum of suggestions provided by respondents, with the exception of funding recommendations that did not specifically deal with dual eligibles. Some proposed improvements could be addressed through administrative changes in Part D, while others would require changes in the law governing the Part D program.

FINDINGS

I. Overall Experiences with Medicare Part D

Respondents' Experiences with Part D Were Mixed

Respondents were split in their attitudes towards the program. Many expressed either neutral or negative experiences and a smaller proportion reported a positive attitude towards Part D. Many reported that there were fewer problems with the program than there had been in the beginning, and that most beneficiaries were getting their medications. Over a third of respondents reported overall negative experiences with Part D, describing their experiences as "confusion" or "chaos" and typically citing program complexity as a predominant issue. In particular, they reported problems with formularies, utilization management, enrollment, spend-down issues for Medically Needy dual eligibles, communication with Part D plans and payment issues.

All 71 respondents provided answers when asked what does not seem to be working well with Medicare Part D. Although their responses were varied, the most common responses included the following:

- Formularies - formulary limitations, changes in formularies, and the fact that all Part D plans have different formularies;
- Utilization management - prior authorizations and exceptions;
- Spend down (share of cost) for Medically Needy dual eligibles;
- Co-payments – many beneficiaries find them unaffordable;
- Administrative issues - duals who are enrolled in multiple plans, "mysterious terminations" of duals from Part D (reported in Connecticut); transition issues (duals who go without coverage for months); time it takes to deal with Part D problems; and problems with the CMS automated insurance information system;
- Communication - communicating with Part D plans regarding prior authorizations and exceptions; Part D plan notices that don't address state-specific issues; elderly beneficiaries who are not computer savvy and therefore have trouble gathering information about, and selecting Part D plans; Part D plans' websites that are not updated regularly;
- Payment - disconnect between states and Part D plans about who pays for medications during the first month after admission to a skilled nursing facility, resulting in the costs of drugs being borne by nursing homes; slow (35-40 day) payments to pharmacists, whereas Medicaid paid claims in 1-2 weeks; Point of Sale plans not covering the drugs that they should and/or back-billing pharmacists.

Many respondents in all three states reported that Part D is "confusing." A Connecticut respondent said it is "extremely difficult and confusing" and a Florida respondent reported being transferred to nine different offices only to end up where he started in trying to get a question answered. A Washington respondent noted that Part D has required much more work and paperwork on the part of pharmacists and that pharmacists receive less compensation under Part D than they did under Medicaid.

Many respondents said they were seeing fewer problems with Part D than in the initial implementation of the program and that the situation had improved. All respondents answered when asked what seems to be working well with Medicare Part D. The most common response was that beneficiaries were getting their medications. Several respondents commented that

auto-enrollment of dual eligibles worked fine, and several others commented that once beneficiaries got into Part D plans and understood the system things worked well. Washington and Connecticut respondents commented positively about the assistance their states provided to dual eligibles. Several respondents said that Part D works best for those duals who have simple drug regimens.

When respondents were asked about their experiences dealing with Part D plans (PDPs and MAPDs), the majority reported neutral or negative experiences. In general, the more experience individuals had dealing with plans, the less positive their responses. The general consensus was that plans are complex and their biggest complaint was a lack of communication or poor communication with plans. Respondents, particularly those in Connecticut and Washington, reported problems with paperwork, time needed to respond to inquiries, prior authorization requirements, formularies, and customer service representatives.

Many respondents reported long telephone wait times before reaching a customer service representative. When they finally got through to customer service, respondents often felt that plan representatives were insufficiently informed to address their Part D questions. According to a Connecticut respondent, "It was hopeless in getting through to plan representatives, and when you can speak to an actual person, knowledge of details is poor." A Washington respondent said, "Communication with the plans is poor regarding pre-authorizations and medication. Plans don't communicate back to physicians when they approve or deny drugs. It's not clear whether plan or physician is supposed to communicate drug changes to the patient."

The answers were mixed when respondents were asked what aspect of dealing with Part D plans worked well. About a quarter of those who answered the question said "nothing," but many responded that beneficiaries were getting their medications. Several respondents reported good experiences with the Part D Formulary Finder, and many Florida respondents complimented the service they received from plan representatives.

II. Affordability of Medicare Part D

Prior to the implementation of Medicare Part D, dual eligibles received medications under Medicaid and many had nominal co-payments, or none.[10] If a state implemented co-payments, pharmacists could not legally deny medications because the beneficiary could not afford to pay. However, under Medicare Part D, the pharmacy can refuse to dispense medications if co-payments are not paid at the time of service regardless of the beneficiary's income. Adding to this potential financial burden, lack of formulary coverage and prior authorization constraints may require beneficiaries to pay more for their medications.

Respondents' answers regarding the affordability of Medicare Part D differed dramatically depending on state laws designed to assist dual eligibles. Florida has no state assistance in place to assist dual eligibles with affordability issues under Medicare Part D. Both Connecticut and Washington currently pay co-payments for dual eligible individuals. Connecticut also provides for additional wraparound services for dual eligibles, paying for non-formulary drugs

[10] Before Part D replaced state Medicaid prescription drug coverage, 10 state Medicaid programs did not require co-payments for prescriptions, and 18 had lower co-payments than those required by Part D for dual eligibles. See Kaiser Family Foundation, Medicaid Benefits: Online Database, Benefits by Service: Prescription Drugs (October 2004), available at: http://www.kff.org/medicaid/benefits/service.jsp?gr=off&nt=on&so=0&tg=0&yr=2&cat=5&sv=32

where duals make an effort to obtain these drugs through their Part D plans' exceptions and appeals process.

Medicare Part D Co-payments Believed to Impact Access to Medications for Duals

Over half of respondents across states reported that Medicare Part D co-payments were having an impact on dual eligibles' access to drugs. Co-payments were reported to be less of a problem in Connecticut than in Florida and Washington. In Connecticut and Washington, those who believed there was an impact indicated that this was due either to pharmacies that were improperly charging co-payments, individuals who had difficulties due to their spend down, or duals trying to obtain non-formulary medications. Individuals in both states voiced concern about access if the states did not continue to pay for co-payments. In Florida, where there is no state assistance, a few respondents thought that the problem was getting better, but others saw this as a continuous stream of problems and stated that co-payments "absolutely" impacted access. Community clinics respondents were more likely than other providers to report that co-payments impacted access.

Respondents Felt That Medicare Part D Co-payments are Unaffordable for Dual Eligibles

Respondents were asked whether duals were having difficulty paying co-payments. Again, answers varied widely depending on state policies. Of those who answered the question, the vast majority of Florida respondents reported co-payment difficulties, with many fewer such difficulties reported in Washington and Connecticut.

Those who stated that paying co-payments was a problem for dual eligibles were then asked how duals were coping (they were permitted to select multiple responses). Responses included that beneficiaries were not taking needed medication, or they were not taking medication as prescribed (pill splitting, taking only when they feel sick, or taking less often than prescribed). Some respondents knew of duals who were not paying other essential bills, and some reported that they knew of duals going without food and other necessities in order to pay their co-payments.

Respondents from Florida described particularly worrisome situations that have arisen because of dual eligibles' inability to pay co-payments. One woman reportedly skipped her blood pressure medication so that she could afford her anti-psychotics. Florida respondents described individuals charging medications to a credit card that they could not afford to pay, and individuals giving up other necessities, such as their cars, to pay for co-payments. Some duals are able to rely on friends, family, neighbors and social service agencies to assist with co-payments, however, these additional costs can be difficult for organizations to cover. One facility reported that it paid co-payments for those who could not afford to do so and consequently had to cut back on its staff and food services.

Few Were Aware of Pharmacies that Waive or Delay Co-payments or Provide Emergency Supplies of Medications for Dual Eligibles

Respondents were asked whether pharmacies had put policies in place to assist dual eligibles with co-payments. Few respondents knew of pharmacies that would waive[11] or delay co-

[11] The Medicare Modernization Act created a new exception to the federal Anti-Kickback statute that allows, but does not require, pharmacies to waive or reduce Part D co-payments. For beneficiaries eligible for the Low Income Subsidy, pharmacies do not need to meet any criteria to waive or reduce co-

payments and few knew of pharmacies that dispense an emergency or limited supply of medications. Some reported that pharmacies would not dispense medications without payment, and some reported that co-payments were being billed to the state. There was concern about the viability of the pharmacies; one pharmacy that waived co-payments indicated that profits were down significantly, as co-payments are often the profit margin for pharmacies, and another voiced concern about pharmacies going under due to increased costs. Independent pharmacists were more likely than other respondents to know of policies in place to help duals with co-payments.

Improper Co-payment Charges Have Decreased, but Remain a Problem Due to Incorrect Identification of Dual Eligibles

Roughly a quarter of respondents reported that duals were being incorrectly charged co-payments above the $1-$5 allowed for beneficiaries receiving LIS, and a few indicated that this was common. Most of those who reported this as a continuing problem stated that the difficulty was caused by a time lag in entering data regarding LIS status in the CMS system.

Respondents' Views on How to Improve Affordability of Part D for Duals

Two prominent ideas on how to improve affordability emerged from respondents' comments:

1. **Eliminate cost-sharing (co-payments and other beneficiary costs) for dual eligibles.** Respondents were in agreement that cost sharing is a barrier to access to necessary drug therapy for many dual eligibles.

2. **Provide a Connecticut-type wraparound for duals in all states, paid for by CMS or the states, to ensure maintenance of necessary medications.** Alternatively, dual eligibles should be allowed to opt out of Part D and retain the ability to get prescription drugs through Medicaid.

III. State Assistance

The three states involved in the study provide varying levels of assistance to dual eligibles to help them cover Part D costs. Connecticut has the most comprehensive wrap-around policy, covering Part D co-payments as well as non-formulary drugs. Washington covers Part D co-payments but not non-formulary drugs, and Florida does not cover either.[12] All three states cover classes of drugs excluded by Part D (benzodiazepines, etc.) as long as the drugs are covered for other Medicaid beneficiaries in the state.

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payments. For other beneficiaries, the reductions or waivers must be unadvertised and non-routine, and pharmacies must determine in good faith that the beneficiary is financially needy or must fail to collect co-payments after reasonable efforts. See: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=7793.

[12] Florida did establish a limited state program in 2006 that covers a percentage of Medicare Part B premiums and co-payments for grandfathered individuals needing cancer and organ transplant drugs.

Understanding of State Assistance Varied

Respondents were asked whether their state was providing assistance to dual eligibles to get the drugs they need. Given that respondents were chosen for the study because of their work with the dual eligible population, a high level of state-specific knowledge could reasonably have been expected. However, responses indicated a wide variability of knowledge about state efforts.

All Connecticut respondents, a majority of Washington respondents, and a minority of Florida respondents said their state was doing something to assist dual eligibles with their Part D coverage. When asked to describe what their state was doing to help dual eligibles, most Connecticut respondents correctly stated that the state pays co-payments for duals and some correctly stated that the state covers non-formulary drugs. Most Washington respondents correctly reported that the state pays co-payments for dual eligibles. Some correctly reported that the State covers classes of drugs excluded from Part D. Many were not aware that the State covers over-the-counter drugs and other drugs excluded from Medicare Part D.

Among Florida respondents, very few were aware that the state covers benzodiazepines. A few were aware of a state program that covers a percentage of Medicare Part B premiums and co-payments for cancer and organ transplant drugs. A state agency respondent said this program was approved for 2006 to help medically needy beneficiaries who can't meet their share of cost due to Medicare Part D.

Co-payment Assistance Aids Dual Eligibles in Connecticut and Washington

Connecticut and Washington respondents were asked to assess their states' policies of paying dual eligibles' Part D co-payments. All Connecticut respondents who answered the question had positive things to report. Generally they felt that duals were getting the medications they need. An advocate/social service provider said "these poorest-of-the-poor cannot afford co-payments, no matter how small," and another said the assistance has "really protected access to medications. People would go without otherwise."

Washington respondents were overwhelmingly positive with regard to the state's assistance, with many crediting the state program for making drugs accessible to duals. However, one advocate/social service provider said that providers are confused about who pays what and who should be billed for drugs, and a pharmacist said the policy created extra work because the State requires a separate transaction for each co-payment it covers. Several advocates, physicians and pharmacists expressed concern that the policy might not be extended for future years.

Connecticut's Wrap-around Policy Benefits Duals

When asked about the impact on duals of Connecticut's policy of covering drugs that are not on their Part D formularies, Connecticut respondents were very positive: "Huge;" "It has allowed them to continue to receive medications;" "Very significant impact . . . and streamlined the process . . . [of] working with plans;" "It's the difference between people getting their meds or not." Very few respondents reported that things are not working well with the policy. One nursing home respondent said that the coverage was the same as when Medicaid covered prescription drugs for duals, but the administrative workload has increased. An advocate/social service provider said that the "State has not put enough money aside, and has not contracted to

do appeals and a State Senator pointed out that the State is covering the costs of the policy when Part D plans should be covering the costs.

Connecticut respondents were asked if the state wrap-around policy was working for drugs that are subject to utilization management policies. Over half said the wrap-around policy was working with drugs subject to prior authorization, while many fewer said it was working with drugs subject to step therapy or with drugs subject to quantity limits.

Those who said the policy was not working for drugs subject to utilization management were asked whether duals are having trouble accessing needed drugs. A state agency respondent said "sometimes," explaining that application of the policy is inconsistent depending on the Part D plan, pharmacy and drugs in question. Another state agency respondent said that dual eligibles have to follow step therapy required by their plans, and that quantity limits are not a problem, but duals need to fill their prescriptions every month instead of every six months. A long-term care pharmacy reported problems with certain drugs that plans are pushing but that are deemed by CMS to be inappropriate for the elderly, as well as problems with plans imposing quantity limits on sleeping aids. Advocates said that the prior authorization policy has just begun to work properly.

Medically Needy Duals Who Lose Medicaid Eligibility Continue to Receive Drugs, but May Not Get Other Medical Services

About half the respondents said they had encountered individuals on the Medically Needy (MN) program who lost Medicaid eligibility after going on Part D, because they didn't meet their "spend down" or "share of cost." Respondents in Washington reported these problems less frequently than those from Connecticut or Florida. A state agency respondent in Connecticut classified this as "a big problem," and a Connecticut advocate/social service provider said "This is a tremendous problem. Since the cost of drugs . . . cannot be applied against the client's spend down obligation, many have lost and will never regain Medicaid eligibility," especially those with higher spend down amounts." Many others had greater concern, making such comments as: "They suffer. They go without." "A terrible problem."

When asked what happens to duals who lose Medicaid eligibility because they don't meet their spend down, respondents identified many issues. Duals in Florida and Washington were reportedly not receiving physician and lab services or were going to the emergency room for these services. A Florida community clinic respondent said that beneficiaries had to change physicians and were facing increased medical bills and denial of service, and a Florida physician said that beneficiaries were "forgoing doctor's appointments" and "going to emergency rooms for lab work." One advocate/social service provider said that emergency rooms were being overwhelmed because of this and were turning people away.

Several Washington and Connecticut respondents gave similar reports, saying that patients had to pay out of pocket for care and that many beneficiaries were going without needed care, accumulating medical debt or going to hospital emergency rooms for care. Some respondents noted that medical transportation is no longer available, and that some physicians will no longer see dually eligible patients. Other respondents said that duals who lose Medicaid eligibility were not able to get mental health services, durable medical equipment and home care.

Florida respondents described several specific situations: a beneficiary who had end stage renal disease, diabetes and chronic pain disorder had to cut back on physician visits because

he couldn't afford them; he received $1,075 in disability and needed to incur $875 in medical costs in order to qualify for Medicaid, leaving him $200 per month for living expenses.

Over half of respondents said that the duals who lost Medicaid eligibility were continuing to receive the drugs they needed. A number commented, however, that they were not getting benzodiazepines because they were no longer Medicaid eligible. A Connecticut pharmacy described the Medically Needy program as a "revolving door," with beneficiaries cycling in and out of dual eligible status. A Florida community clinic respondent said that sometimes physicians wrote expensive prescriptions to help beneficiaries regain eligibility, and a Florida pharmacist said that beneficiaries continued to receive needed drugs because the pharmacy provided them.

A number of respondents expressed concern that in 2007 these formerly Medically Needy beneficiaries would not be deemed dually eligible because they would not have met their spend down in 2006. As a result they would lose LIS, and could lose their Part D coverage if they could not afford their Part D plan premiums.

IV. Enrollment of Dual Eligibles in Medicare Part D

Full dual eligible beneficiaries were assigned to benchmark Part D plans effective January 1, 2006; partial duals who had not selected a plan by May 15th, 2006 were also assigned to one. Both groups were assigned only to plans at or below a benchmark premium. Individual medication needs were not factored into the assignment process. For many beneficiaries, the choice of plan made little difference, but many other beneficiaries ended up in plans that did not adequately cover their prescription drug needs. Some also ended up being assigned to more than one plan, or to no plan at all. After January 1, 2006, dual eligibles newly entering Part D continued to be auto-assigned to Part D plans. Respondents reported that new duals were sometimes assigned to more than one plan, particularly in the summer of 2006, and that this was a difficult problem to resolve.

Many New Dual Eligibles May Not Receive or Understand Medicare Part D Notices

Many respondents do not believe that enrollees understand the notices they receive from CMS regarding their auto-enrollment into Part D. They attributed the lack of understanding to the way in which the notices are written, the fact that notices are usually provided only in English, and the belief that Part D is hard to describe due to its complexity. Respondents also mentioned the following:

- New dual eligibles often do not really understand how their benefits will change and the letters do not give them enough information to understand what they need to do
- Many of those who call Medicare's toll-free number to get an explanation seem more confused afterwards
- Notices are not reaching limited English speakers:
    - Most agency notices are available in English and Spanish, but speakers of other languages need translation.
    - Many are not literate in their native languages.
    - Particular problems exist for speakers of Somali, Vietnamese, Oromo, Cambodian and Amharic.
- New duals may not even open the notices

- Mental health clients may not have fixed addresses so notifications may not reach them. One Florida respondent had a client living in a tent in the woods and found it hard to imagine how he would receive notices.
- Duals in Connecticut receive a notice from the state saying that their Medicaid prescription coverage is ending. However, the information they receive from Medicare about their new Part D coverage is both overwhelming (the Medicare & You handbook) and incomplete.

Some Duals are Experiencing Gaps in Coverage when Switched from Medicaid to Part D

Several respondents indicated that some dual eligibles were experiencing gaps in prescription drug coverage when they switched from Medicaid to Part D. A gap in coverage typically happens because of delays in the Part D auto-assignment process; these delays can last one to three months. To address this problem, CMS developed a workaround: pharmacists could fill the prescriptions by temporarily enrolling a new dual in a "Point of Sale" (POS) plan on the spot, with this enrollment lasting until the new dual eligible individual is enrolled in a Part D plan. [13]

When asked what they saw happening to duals who were not auto-assigned to any plan, the majority of respondents were not sure. Washington and Connecticut respondents appeared more likely to know of the POS plan, than Florida respondents. According to respondents who were aware of the POS plan, the use of this workaround is inconsistent. A Connecticut respondent said that duals are not informed about the POS process unless they are in crisis and contact an advocacy agency. A state official said that they have instructed clients and pharmacists to use the POS plan, Wellpoint, but have seen problems when Wellpoint does not have the information needed to process the claims. Respondents frequently reported that many pharmacists are not using Wellpoint. One advocate/social service provider in Washington said that he had heard from more than one pharmacist that they cannot use the POS plan. One possible rationale was supplied by an urban Washington pharmacist who said, "Wellpoint regularly reverses claims, saying someone else is responsible. Pharmacists are getting large claims reversed." A Florida pharmacist agreed that pharmacies have lost money as a result of using the POS plan, saying he'd lost $3,000 of claims. He asked "How do I prove a person is on Medicaid?" when Wellpoint claims the person is not a dual eligible.

One other potential way to address the delay in coverage was suggested by a Washington pharmacist. Since it is obvious to the pharmacy that the person is a dual, the pharmacy should be permitted to fax a "screenshot" showing Medicaid eligibility to the plan.

Many Dual Eligibles Auto-enrolled in Unsuitable Plans Switch Plans

Respondents were asked what they had observed happening to dual eligibles who were auto-assigned to a Part D plan that did not fit their needs. Over half of respondents reported that the new duals in this situation changed plans, with more Florida respondents reporting that new duals changed plans than Washington or Connecticut respondents. A Connecticut respondent commented that it can take weeks or months for new duals to actually be enrolled in a plan, and in the meantime many go without needed drugs.

[13] After early problems with delays in Part D enrollment that caused people to have trouble obtaining their prescriptions, CMS contracted with one prescription drug plan (Wellpoint) to provide these enrollees with prescription coverage on a fee-for-service basis until their PDP enrollment takes effect.

Over Half of Respondents Helped Duals Enroll In or Switch Plans

Over half of respondents reported helping dual eligibles enroll in or switch plans. Almost all of those who work with assisted living facilities, independent pharmacies, nursing homes and community clinics have helped duals enroll in or switch plans. Physicians and those who worked with state agencies were much less likely to have provided these services.

One Washington respondent reported helping duals to enroll in or switch to plans of their choice, only to have auto-enrollment kick in and negate the beneficiary's choice, sometimes repeatedly. Another Washington respondent said that while actually enrolling someone in Part D takes only about 10 minutes, researching and selecting plans takes 20-30 minutes. Language was reported as a barrier to enrollment in Washington: "It takes 1.5 hours to explain the program through translation." A Connecticut pharmacist reported that the state had given beneficiaries vouchers that they could use to have pharmacists help enroll them in plans that fit their needs. The state then reimbursed pharmacists for their services.

Duals Switch Plans Largely Because the Medications They Need are Not on a Plan's Formulary

When asked if they knew of dual eligibles switching plans, most respondents said yes. One Connecticut respondent commented that because the State pays for non-formulary drugs, there is less need for duals to switch plans. One Washington respondent said she did not know that duals could switch plans at any time. All pharmacists, chain and independent, reported seeing duals switch plans. Among other providers, over half reported seeing duals switch plans, except for physicians who reported less switching activity.

When asked how often, on average, they are seeing duals switch plans, most respondents said that duals are switching plans because the drugs they need are not on their plan's formularies, particularly in Florida and Washington. Other reasons given for duals switching plans in Washington included convenience of pharmacies, quantity limits, and step therapy. In Florida, several respondents commented that cost and co-payment structure (some plans have no co-payments for generic drugs) were reasons for duals switching plans.

In Washington, respondents said that duals were switching into plans with more comprehensive formularies and fewer utilization management limitations. A Connecticut respondent reported duals switching out of Medicare Advantage prescription drug plans.

When respondents were asked if duals have difficulty with their LIS following them when they switch plans only a few were aware of this problem and only one said it happened frequently. There were no major differences across states. A Florida respondent stated that switching plans was risky because the LIS does not always follow a beneficiary who changes plans. One Washington respondent commented that duals usually have to prove that they are eligible again by completing the Social Security Administration form.

Respondents Have Mixed Feelings About Random Auto-Assignment as a Method of Enrolling Dual Eligibles in Part D

Respondents were almost evenly split on the question of whether auto-enrollment is the best way to enroll dual eligibles in Part D. Many commented that auto-enrollment may not be ideal but at least it gets duals enrolled. They felt that without auto-enrollment many duals would not have Part D coverage because the enrollment process is so complicated. One Washington respondent said it would be a better method if the plans were more uniform. A Florida respondent articulated three things that made auto-enrollment difficult: 1) no reconciliation (a state cannot tell in what plans duals have been auto-enrolled); 2) auto-enrollment information is sent to the representative payee's[14] state, which is sometimes different from enrollee's state; and (3) difficulty getting early information from CMS regarding contract IDs, Plan IDs, plan formularies and plan premiums and cost-sharing. In addition, a Washington respondent reported that the system did not recognize when duals are already enrolled in Medicare Advantage plans.

Respondents were asked what they would recommend as the best method for enrolling dual eligibles. Several pharmacists suggested that pharmacists should help enroll duals in Part D plans, since they are the most knowledgeable about the plan formularies. This would be expensive, but according to one pharmacist would be "better in the long run." One pharmacist said that duals should be notified in a timely manner about enrollment in Part D and allowed a longer grace period to choose plans. Another pharmacist suggested that auto-enrollment would be good if it were done by a "knowledgeable, plan-neutral person at the local level." Another suggested having a single Part D plan that covers all duals and the drugs they need.

Respondents' Views on How to Improve Enrollment in Part D for Duals

Respondents had a large number of ideas to improve enrollment, based on their perceptions that the enrollment process is difficult to navigate. What follows are the recommendations mentioned most frequently by respondents to address enrollment challenges.

- **Offer fewer Part D plans in order to simplify the plan selection process.** The sheer number of plans was seen by some respondents as a hindrance to plan enrollment. The number of variables that must be considered to make a good selection can make the process overwhelming to beneficiaries and providers.

- **Offer individualized assistance to beneficiaries to help them select and enroll in plans.** Respondents suggested providing funding to State agencies, social service agencies and/or pharmacists to assist beneficiaries. Respondents also suggested that open enrollment should not occur during holiday season if social service organizations are responsible for assisting beneficiaries with enrollment.

[14] A representative payee may be either a person or an organization selected by the Social Security Administration (SSA) to receive benefits on behalf of a beneficiary. A representative payee will be selected if SSA believes that the interest of a beneficiary will be served by representative payment rather than direct payment of benefits. Generally, SSA appoints a representative payee if SSA determines that the beneficiary is not able to manage or direct the management of benefit payments in his or her own interest. 20 C.F.R. 416.601.

- **Assure that complete information regarding formularies and utilization management is available to beneficiaries and providers during the plan selection process.** Even when a beneficiary has determined that his or her drugs are covered, the utilization management strategies employed by the plan can hinder access to the beneficiary's (or prescriber's) drug of choice.

- **Improve information sharing regarding eligibility and enrollment between States and CMS, and between CMS and plans, pharmacies and nursing facilities.** Respondents suggested continuous updating of eligibility and enrollment information (instead of monthly updating).

- **Better educate providers and beneficiaries about the Point of Sale option for obtaining drugs.** A good proportion of respondents indicated that they were not clear on this mechanism to provide coverage to beneficiaries who have not been enrolled in a Part D plan through the regular avenues.

- **Require nursing facilities to inform families about how to transition a patient into a Part D plan when discharged.** Because the drug coverage that a beneficiary has while institutionalized may be different from what is available once he or she is back in the community, this transition protocol is key.

- **Explore new enrollment procedures for dual eligibles, including: a) keeping new duals on Medicaid during the transition period; b) enrolling all duals in Point of Sale plans to start with, and then allowing them to choose their own plans; or c) considering facilitated enrollment for all dual eligibles.** The fact that some of the beneficiaries with the greatest need for prescription drugs are being somehow are being missed by the enrollment process suggests that a more streamlined, uniform approach may be of value.

V. Formulary and Utilization Management Issues

Part D Plans Denied Some Necessary Prescribed Drugs for Dual Eligibles

Many respondents reported denials of prescribed drugs but several Florida and Washington respondents reported that they saw fewer denials at the time of the study than they had in the past. Respondents in all three states reported that newer, higher tier, more expensive drugs were being denied. Benzodiazepines and proton pump inhibitors are frequently reported to be problematic, although benzodiazepines were covered by Medicaid for full duals (but not partial duals) in all three states. Some Connecticut respondents reported denials of psychiatric medications. Several respondents reported denials of drugs prescribed for off-label use. One Florida respondent who works with the HIV/AIDS population commented that Part D formularies were not staying current with HIV/AIDS treatment and that new drugs and combination drugs were not on formularies. A Connecticut pharmacist remarked that "plans are actually very discriminatory in what is covered" for the mentally ill.

Most respondents were aware of Part D plans denying requested drugs and instead requiring beneficiaries to use formulary drugs that they had already tried and found did not work for them. Many of these respondents reported that plans did not attempt to find out if the beneficiary had tried and failed the drug.

Dual Eligibles are Experiencing Delays in Getting Needed Drugs

Many respondents also reported delays in duals getting prescribed drugs. Washington and Florida respondents reported that duals commonly experienced delays in getting expensive drugs and mental health drugs (anti-psychotics and anti-depressants). Washington respondents specifically mentioned benzodiazepines and one mentioned injectable drugs that could also be covered by Medicare Part B, depending on their use. When respondents were asked what reasons are given for the delays, the most common response was that exceptions and appeals were necessary. A few respondents mentioned prior authorization, step therapy and enrollment problems.

Dual Eligibles are Experiencing Serious Consequences due to Denials and Delays

Respondents shared many stories about duals who had been denied needed drugs. A Connecticut advocate told of a dual who was denied an antipsychotic drug because it was not on formulary, had a psychotic episode and ended up in prison. Another reported a denial that led to abrupt withdrawal from a drug previously paid for by Medicaid that put the beneficiary's unborn child at risk of death. A Washington advocate told of a beneficiary with post-traumatic stress syndrome who was denied adequate dosages of a drug needed to keep him/her from hearing voices.

Most Florida respondents, but fewer than half of Connecticut or Washington respondents, said they were aware of specific consequences of duals not getting needed medications due to denials and delays. In all three states, duals are paying out-of-pocket for drugs, sometimes borrowing money to do so. A Florida respondent reported that people on dialysis were unable to get a drug needed to stimulate appetite, which has resulted in wasting syndrome for some patients. Another reported that some duals have had to change as much as 75% of their drug regimens, leading to more monitoring and increased costs. A Florida respondent said that a dual eligible she worked with was hospitalized two or three times, each time returning to the hospital due to delays in getting medications after being discharged. Finally, the hospital paid for her drugs after discharge, because it was cheaper than hospitalizing her again. Other Florida respondents reported problems with anti-psychotic medications, including schizophrenic beneficiaries who have had their illness under control for years, but have been forced by Part D plans to change medications and have ended up hospitalized and homeless. Several Washington respondents reported that duals have stopped taking medications, and some have ended up hospitalized as a result.

Providers Recommend a Variety of Strategies to Deal with Denials and Delays

Respondents were asked what they recommend duals do if drugs are denied or delayed. The most common recommendation was for duals to contact their prescribing physicians. The second most common recommendation was for duals to switch plans. Other recommendations to duals included contacting their Part D plan, Medicare, a community organization or an advocacy organiztion; filing an exception or appeal; trying a new medication; getting a sample medications from a provider; paying for a medication; or going without a medication.

Respondents were asked what other providers are doing to help dual eligibles get the drugs they need and if they had heard of any particularly creative solutions. Some Florida respondents knew of physicians who had hired additional staff to work on Part D and said that community providers were "banking unused drugs and even interagency banking and trading is

going on as a matter of survival." Washington respondents reported coordination between community mental health providers and a local hospital pharmacy to provide needed mental health drugs, and said that beneficiaries were going to Canada to get drugs. There was much frustration on the part of pharmacists. One pharmacist opined that pharmacies should not have to be playing such a great role in resolving problems. Another pharmacist felt that plans don't seem to know their own rules; they "make it up as they go along," communication is inefficient and CMS requirements for Part D plans are too vague and open-ended.

Duals in Florida Reportedly Had More Trouble Than Those in Connecticut or Washington Obtaining Drugs Excluded by Medicare Part D

Respondents were asked what they had seen happening to dual eligibles who need classes of drugs that are excluded from Medicare Part D: benzodiazepines, barbiturates, drugs for weight loss and weight gain, fertility drugs, cosmetic drugs, vitamins and over-the-counter drugs. Although all three states maintained their existing level of Medicaid coverage for these excluded drugs for dual eligibles (some are not covered, such as fertility and weight-loss drugs), respondents reported differences in access to these drugs in the three states.

Most Florida respondents reported that duals were having trouble accessing benzodiazepines, and many reported that duals have trouble accessing barbiturates, vitamins, weight loss/gain drugs, and over-the-counter drugs. By contrast, only a few Connecticut and Washington respondents reported that duals were having difficulty accessing any of the drugs excluded by Part D.

Plans are Changing Formularies, Leading to Confusions and Delays in Duals Getting Needed Drugs

About two-thirds of Florida respondents, but a minority of Connecticut respondents and Washington respondents said that they knew of Part D plans changing formularies. Several Florida respondents and a Connecticut respondent said that plans have added drugs to their formularies, although there was concern that this was a marketing tactic and that plans might remove the drugs from their formularies after beneficiaries had enrolled. Several Florida and Washington respondents mentioned that information about plan formularies is often unreliable and may not be up to date. Some respondents suggested that formulary changes result in confusion, delays in getting needed medications, not getting prescribed medications, and time-consuming efforts to resolve these issues.

Part D Utilization Controls Are Viewed Negatively by Respondents

Most of the respondents who commented on Part D plans' utilization controls spoke of them in negative terms: "unnecessarily burdensome," and "more restrictive" than other prescription drug insurance. One Washington respondent stated, "Clients have generally been angry because the Part D plans' utilization controls are far more stringent than anything they had faced previously. Most dual eligible clients complained that 'Everything was fine before; I never had any trouble getting my medications with my Medicaid coupon. Now nothing works and I'm stressed out worrying about getting my medications.'" A Florida respondent said "you have to go through hell with [Part] D." Five respondents found utilization controls used by Part D plans comparable to other prescription drug insurance coverage.

Respondents' Ideas for Improving Part D Formularies & Utilization Management

Respondents suggested several improvements to formularies and utilization management focused on requiring more open and stable formularies and limiting and clarifying utilization controls.

- **Require Part D plans to include on their formularies medications needed by specific populations.** Although Part D plans are prohibited from covering drugs such as benzodiazepines, some respondents felt that this was a shortcoming of Part D because of the importance of these drugs to certain populations.

- **Limit the types of utilization controls that can be used by Part D plans, such as quantity limits.** At a minimum, assure that beneficiaries know about utilization controls when they are selecting plans.

- **Improve the quality of plans' customer assistance lines and websites.** Respondents reported that customer assistance personnel are often poorly informed about the plans and that web sites are not kept up-to-date.

- **Restrict plans from changing formularies between Open Enrollment periods.** It can be confusing and difficult for beneficiaries to deal with changes in drug formularies even once a year, so changes during the plan year can prove to be overwhelming.

VI. Exceptions and Appeals

Dual eligible beneficiaries whose medication needs are not covered by their Part D plan may change plans at any time. However, a plan change does not take effect until the following month, so a beneficiary with immediate drug needs will have to take other action. Also, if no other plan provides the coverage that a beneficiary needs, then changing plans is not a viable option. It is sometimes necessary for beneficiaries to file an exception or appeal an adverse coverage determination in order to get their medications from the plan in which they are currently enrolled.

Respondents Have Some Understanding of the Exceptions and Appeals Process but Believe that Others Do Not

The majority of respondents described themselves as familiar with the exceptions and appeals process. However, many do not have deep understanding or knowledge about the process, as respondents repeatedly noted that they were "vaguely familiar" or "somewhat" familiar with the process or otherwise expressed uncertainty as to how much they actually knew.

To gauge how well the respondents understood the exceptions and appeals process, they were asked whether they understood the process well enough to help a beneficiary through it. More than half of respondents felt that they understood the process well enough to help a beneficiary through it. Across states, the most confident respondents in guiding a beneficiary through the process were the two respondents from chain pharmacies, respondents from community clinics, state agencies, and advocacy and social services providers. Respondents from nursing homes and assisted living facilities were more likely to say that they did not understand the process

well enough. Physicians were evenly divided when asked whether they understood the process. Only a third of independent pharmacy respondents felt confident that they could help a beneficiary through the process.

Respondents were also asked how well they thought other providers and beneficiaries understand the exceptions and appeals process. Of the 20 who responded, only one felt that other providers understand the process. None felt that beneficiaries understand the process, and many offered emphatic comments such as "definitely not."

Information about the Exceptions and Appeals Process Has Come from Many Sources

Chain pharmacy respondents reported learning about the process through pharmacy trainings, often sponsored by the corporate parent or a pharmacy association. In contrast, respondents of independent pharmacies reported relying more on trial and error. Comments from assisted living facilities indicated a high degree of reliance on trial and error. Community clinics cited a number of self-initiated trainings from pharmacies, plans or Internet sites. CMS outreach on the exceptions and appeals process appears to have best reached nursing homes and state agencies. Trainings by advocacy organizations appear to have best reached other advocacy organizations and social service agencies, state agencies, and nursing homes.

Respondents are Unsure if Dual Eligibles Are Receiving Notice of Their Right to File Exceptions and Appeals

Federal regulations require that beneficiaries receive notice of any denial, including the right to file an exception or appeal. Respondents were asked whether beneficiaries are getting this notice. Most respondents were unsure of whether beneficiaries were getting notice. About a third reported that beneficiaries "always" or "frequently" received notice. Respondents were also asked how beneficiaries received notice. Their answers reflected a variety of ways: by phone, by mail; orally at the pharmacy; through postings at the pharmacy; on plan websites. The wide variety of inexact comments suggests that most beneficiaries are not receiving notice of their right to request an exception or an appeal, and many beneficiaries may be told only that the plan won't pay for their prescribed medication, but not what steps they may take to have that decision reviewed.

Respondents Filed Few Exceptions and Appeals

Most respondents reported filing less five or fewer exceptions and appeals per month. A few respondents reported filing more than ten appeals per month. Respondents from Florida reported filing more exceptions and appeals than those in the other two states. The more dual eligibles a respondent actually sees each month, the more likely he or she is to file exceptions and appeals. However, even respondents who saw large numbers of dual eligibles tended to report filing five or fewer exceptions and appeals per month.

Respondents were asked if they had been personally involved in helping with exceptions and appeals, and if so, what role they had played. Below is the percentage of each type of respondent that reported personal involvement. Community clinics, physicians, independent pharmacies and assisted living facilities were most likely to help duals file exceptions and appeals.

In terms of the roles respondents played, physicians reported explaining the process to beneficiaries, completing forms, providing medical records, contacting Part D plans, and filing

exceptions and appeals on the beneficiary's behalf. Independent pharmacy respondents reported explaining the process to the beneficiary; filling out forms, contacting physicians and filing exception and appeal requests on behalf of the beneficiaries. Nursing home and assisted living facility respondents reported doing all of the work involved in filing exceptions and appeals, while community clinic respondents said that they completed forms and explained the process to beneficiaries. Advocacy and social service respondents and state agencies reported referring duals to other for help filing exceptions and appeals.

Respondents Report Success in Obtaining Exceptions and Appeals

While respondents may not have filed many exceptions and appeals, those they did file were most often successful. Twenty-five respondents provided some description of what happened with the exceptions and appeals they filed. The majority of these respondents reported having success with the exceptions and appeals processes. Only one respondent (from an assisted living facility) reported an unsuccessful appeal. Some respondents noted that they had not been informed whether their efforts were successful or not.

Respondents were asked about particular things that helped with or made more difficult the navigation of the process. Some respondents commented that seeking assistance from CMS, working together with providers and advocates or having good working relationships with pharmacies helped. Assistance from advocacy groups and advocacy groups' materials were also noted. Several respondents credited experience and persistence as beneficial to navigating the exceptions and appeals process. One independent pharmacy respondent started an independent pharmacy Web blog, grassrootsrx.org, to assist other independent pharmacists.

When respondents were asked why navigating the process was difficult, several respondents commented that the Part D plan representatives did not understand the exceptions and appeals processes for their plans, were poorly trained, and gave inconsistent answers. Many respondents described the process as "complex," "cumbersome," or "confusing." Social service agency respondents noted that plan staff often did not want to work with social service agencies. One respondent waited two and a half hours on the phone, only to be given another number to call, which turned out to be the telephone number of a towing company in another state. Respondents complained that plan website information was not up-to-date and had incorrect information about formularies. Some respondents also noted the high paperwork burden and the difficulty of assembling a beneficiary's medication history in order to substantiate the need for an exception to a plan formulary.

Respondents were largely unsure of whether their involvement made a greater difference than if the beneficiary had pursued the exception or appeal on his or her own. However, respondents from nursing homes and community clinics commented that their patients could not possibly get through the process on their own.

Respondents are Unsure about Plans' Compliance with Exceptions and Appeals Timeframes

Federal regulations require plans to respond to exceptions and appeals requests within certain timelines. These timelines are shortened when denial of a medication would result in serious harm to a beneficiary's health. Respondents' knowledge of these timelines was mixed. More than half knew the timelines existed, but two-thirds were not sure whether plans actually responded within the required times. One Connecticut respondent noted that an independent

review entity (IRE) took two weeks more than the time allowed. An IRE also did not solicit information from a beneficiary's physician as is required by law. A Florida respondent told of an exception that was supposed to take three days, but when the plan hadn't responded within six weeks, he contacted a Congressman for help. An advocate spoke of clients in tears after multiple failed appeals and described the situation of one person who must file an appeal with each prescription refill. An assisted living facility respondent told of a plan that took fourteen days to make a decision during which time the patient lost the ability to maintain normal or appropriate psychological functioning.

Respondents' Ideas to Improve the Exceptions and Appeals Process

Respondents' views on improving the appeals process focused on the need for a clear, uniform and publicized appeals process, with proper notices to enrollees.

- **Establish a single, uniform appeals process for all Part D plans, with instant, toll-free/web access.** Respondents also suggested an appeals clearinghouse that would forward requests instantly to plans.

- **Monitor plans to assure that they are sending beneficiaries notices regarding their right to file exceptions and appeals.** While dual eligible beneficiaries may often be hard to reach, some respondents felt that even those beneficiaries that did not necessarily fit into hard-to-reach categories were unaware of their rights.

- **Assure that plans share outcomes of prior authorizations, exceptions and appeals with the pharmacists and physicians who request them, as well as with beneficiaries.** A number of respondents who did attempt to get non-formulary drugs or drugs that needed prior authorization for beneficiaries were unaware of the outcomes of their efforts.

- **Better educate providers and beneficiaries about the exceptions and appeals process – both the availability of the process and procedures for filing exceptions and appeals.** Respondents suggested a marketing campaign to publicize the exceptions and appeals process.

VII. Administrative Complexity

Respondents Generally Agreed that Medicare Part D Is a Complex Program that Is Difficult To Navigate

Respondents were asked to rate the Part D program on ease of obtaining prescription drugs. More than half of respondents reported that obtaining prescription drugs through Part D was difficult or very difficult and less than a fifth found it easy. One respondent summed up the opinion of many, saying that Part D was "the most confusing process I've ever dealt with." A Florida pharmacist said, "Part D is a morass of complex choices."

Respondents reported that most individuals are not able to figure out how to select plans on their own. The factors cited by respondents as making it difficult to navigate include:

- The number of plans, and the distinct formulary and cost-sharing requirements within each plan. The formulary issue was cited repeatedly. While cost-sharing is less of an

issue for dual eligibles than for non-duals, it comes up when a dual selects a non-benchmark plan with more drug choices on its formulary.
- The Part D plans' ability to change formularies during the plan year and the change in plans from year to year.
- Conflicting information from different sources of assistance to beneficiaries
- Pharmacists often still require instruction about how to proceed with billing
- Internet access and proficiency is required to compare plans.
- Too much paper is sent from plans; much of it is for all states and not specific to the choices an enrollee has in a particular region.

Advocates and social service providers in all three states mentioned the strain that the program placed on the organizations that were most involved in assisting people in navigating Part D. Each individual requires significant time to counsel because the plan selection process has so many variables. Although the demands were particularly onerous at the beginning of the program when the volume of new enrollees was much higher and understanding of the program was lower, the problems continued, and well into 2006, these organizations were still experiencing the effects.

Respondents repeatedly reported that navigating Part D is most difficult when a patient needs a drug that is not on a plan's formulary – often an expensive drug. Once a plan is found that includes all of the individual's medications, and the person understands how it works, the program becomes easier to handle. One social service worker expressed the fear that at the end of the year, when plans changed again, things would again become difficult.

A number of respondents said it was easier to get coverage when duals were auto-assigned, as long as people are assigned to plans that work for them or had assistance transferring to plans that do. However, for those who found themselves in a plan whose formulary did not cover their drugs, it is "next to impossible," to get needed drugs, according to a Florida nursing home staff member.

Almost all of the survey participants agreed that individuals with cognitive difficulties such as Alzheimer's had a very difficult time with Part D, both getting coverage and selecting plans, due to the complexity of the process and the number of choices. However, having a conservator, guardian or other representative available made the process easier. One state agency staff member said, "Unless they have a representative, they are in trouble."

For those with cognitive difficulties, an established routine is critical to daily functioning, as one respondent pointed out. But for some dual eligibles, there was a drastic change from how Medicaid worked to how the Part D program functions. As one pharmacist pointed out, it is hard to make it clear to a person with cognitive difficulties what has happened when there is a change in a formulary and that "It becomes a stressful situation."

Providers Experience Administrative Hurdles when Duals Have Other Prescription Drug Coverage

When private health insurers receive federal subsidies to provide drug coverage, a beneficiary cannot simultaneously remain in the subsidized private insurance and enroll in a separate Part D plan. However, for dual eligibles and others eligible for LIS, the private coverage may cost more than Part D. This is because state Medicaid programs are no longer permitted to cover any costs related to drugs that are now available through Part D, and the Medicare LIS is only

applicable to Part D plans. Respondents noted that patients who qualify for LIS want the "LIS rate" if they choose to keep their private coverage, and it "requires a lot of explaining" that this is not possible. This probably inadvertent consequence of the MMA means that enrollees are faced with the choice of dropping their private coverage in order to qualify for the public subsidy – frequently resulting in a substitution of public dollars for private ones.

When asked whether they had seen problems when dual-eligible clients also had other drug coverage (such as Veterans' Administration benefits or private insurance), a third of respondents said yes. They described the enrollees' desire not to drop their existing coverage because it was preferable, but also wanting to take advantage of the lower cost-sharing for duals available through the Part D LIS. A couple of respondents mentioned problems with Tricare and the Veterans' Administration not wanting to cover Part D enrollees anymore. Similarly, some private insurers kept their enrollees out of their plans if they enrolled in Part D.

For some duals, the loss of private health coverage has other adverse consequences. It may mean that their previous health care options are limited, as in the case of one Florida clinic patient who found that going on Medicare limited the choices of where she could go for dialysis. Switching to Part D may also mean that one's dependents – spouses and children – lose coverage as well; in some cases not just drug coverage but all health benefits.

A Washington physician identified a problem with an HIV/AIDS drug assistance program. No one is sure who pays – that program or Part D. A number of others mentioned the confusion entailed in figuring out who pays for what when a client has overlapping insurance plans that include prescription coverage.

A Washington pharmacist specializing in filling prescriptions using "compliance packaging" designed for patients in assisted living facilities described how Part D has resulted in a more cumbersome process. It now requires more steps: the third party fills the prescription (not using compliance packaging), the patient sends the filled prescription to the pharmacy that does the packaging to meet compliance requirements, and the pharmacy then delivers it back to the patient. The pharmacist wondered why he is not able to fill the prescription directly and package it. It would be simpler and faster for the beneficiary to get the medication, and payment could be reconciled later.

Part D's Complexity Leads to Cost-Sharing Problems for Duals

Many respondents said they knew of Part D enrollees who were asked to pay premiums and co-payments they should not have incurred. Some said this problem had improved since the launch of the program. However, it still takes until mid-month for CMS to communicate to Part D plans that a beneficiary is eligible for LIS, and, in the meantime, he or she may be charged inappropriate co-payments. Another problem occurs when someone with LIS chooses non-standard plans for which CMS will not pay the full premiums and they don't understand that they will have to pay the difference between the plan's premium and the federal benchmark.

In Washington and Connecticut, co-payments are now paid by the state. This means pharmacists do not bill full dual eligibles for the co-payments. However, in both states, Medicare Savings Program beneficiaries still must pay co-payments even though they have full LIS. Some pharmacists reportedly have become better at identifying co-payments that are too large – for example, when a Part D plan doesn't have LIS status on a patient – and tell patients they don't need to pay it.

Some Respondents Report Problems in Assisting Beneficiaries with MAPDs

Several respondents encountered problems with Medicare Advantage plans when assisting enrollees. A chain pharmacist in Florida said that coverage of brand name drugs by an MA plan there was poor. Most of the problems identified with MA plans were not specifically about the prescription drugs, but rather about the plans themselves. There were reports in Connecticut and Florida of people who thought they were signing up for a PDP, not a full Medicare managed care plan and who had to be switched out with the help of advocates. In both Connecticut and Washington, respondents reported questionable marketing of these plans.

Respondents Used Many Resources in Dealing with Medicare Part D

Respondents were asked what resources they had used in answering questions about Part D. The following table indicates their responses.

Table 2
Resources Used by Respondents

	Connecticut (19 respondents)	Florida (26 respondents)	Washington (26 respondents)
Medicare.gov Website	74%	92%	96%
Plan Websites	68%	58%	81%
Medicare Phone Line	37%	65%	77%
Plans Phone Line	79%	69%	73%
State Medicaid Office	68%	58%	46%
State Health Insurance Assistance Plans (SHIBA (WA), SHINE (FL), CHOICES (CT))	58%	27%	73%
Local/State Advocacy Organizations	63%	58%	50%
Your Professional or Trade Organization	37%	54%	39%
Materials from State Medicaid Programs	84%	46%	62%
Materials from a Professional or Trade Group That You Belong To	58%	46%	42%
Beneficiary Advocates' Material	53%	42%	50%
Have Not Used Any Resources	0%	4%	0%

The Medicare.gov website was the most used resource. Long wait times were reported on the phone lines and respondents preferred not to use them. One Connecticut respondent said "Medicare.gov was good, plan sites were terrible. Hotlines were ice cold. At times I was telling them what they were supposed to be doing."

Respondents' Ideas on How to Reduce Complexity and Improve Equity

Many of the responses to questions about how to improve the Part D program involved ideas to simplify the program and make it more equitable for beneficiaries as well as providers. The suggestions also focused on education and individual assistance to help navigate the program.

- **Monitor Part D plans, and enforce with real consequences when plans do not perform.** Some respondents' experiences with and knowledge of plan practices led them to believe that plans were not performing up to expectations. In those instances, plans should be penalized.

- **Improve coordination between SSA, States and Part D plans to assure that LIS follows beneficiaries who switch plans.** The lag time of delivery of subsidy status information between entities responsible for the functioning of Part D remained a problem, one that neither beneficiaries nor those who assist them could address.

- **Allow coordination of benefits with LIS for duals who have other insurance.** Duals who may have other sources of coverage should not be disadvantaged by premiums or higher cost-sharing, or forced to drop other insurance.

- **Continue LIS eligibility for Medically Needy Medicaid beneficiaries who lost other health coverage in 2006 due to Part D.** Medically needy beneficiaries who spend down exclusively or in large part through their prescription drug expenses should not lose their eligibility for Medicaid (and its other vital coverage) now that Part D covers their drug costs.

- **Require Part D plans to streamline pharmacy compliance packaging for nursing home residents.** Because a large number of dual eligibles reside in nursing homes, drug delivery to them should be efficient and cost-effective.

IIX. Part D Projections

Most Respondents Report Continuing Problems with Part D

The majority of respondents in all three states said that they saw continuing problems with Part D that were not being fixed. Respondents identified co-payments, (re)enrollment, and different formularies as the biggest problems with Part D. Physicians saw pricing as a continuing problem that is not being fixed. Pharmacies found enrollment and co-payments to be ongoing, unresolved issues. Community clinic respondents noted the lack of education about Part D. Advocates and social service providers mentioned all of the above.

Upcoming Problems or Emerging Issues Expected with Medicare Part D

Most respondents believed there would be more problems with Part D in the future. Some of the same issues identified above as ongoing problems are also expected to be problems in the future. Fifty-four percent of respondents expressed doubt and skepticism about the future of Part D plans. Co-payments were one of the bigger worries.

General Views on Improving Part D for Dual-Eligible Beneficiaries

- **Change Part D to be like traditional Medicare.** Respondents suggested this approach based on a perception that Part D does not work as well for beneficiaries as Parts A and B due to the involvement of private drug plans. Also, the number of choices, and the fact that they are not standardized make navigating Part D difficult for many individuals.

- **Negotiate prices and benefits with drug companies.** Medicare is precluded from negotiating for the best price with drug companies by statute. Respondents felt that this might be a mechanism to reduce the costs of the Part D benefit.

- **Form an advisory council made up of Part D beneficiaries to advise CMS on modifying and improving the Part D program.** Ultimately, the input of those most directly affected by Part D is invaluable to improving the performance of the program, and the satisfaction of those citizens who depend upon it for access to vital drug therapies.

LESSONS LEARNED

Although many of the difficulties involved in the initial transition of the dually eligible population from Medicaid to Medicare Part D have subsided, some ongoing challenges remain. More than three-quarters of respondents in this study said they saw continuing problems with Part D that were not being fixed. Some previously enrolled beneficiaries faced persistent problems getting their medications. People newly enrolled in Part D or who changed their Part D plans can still face difficult transitions.

Respondents reported that duals in all three states experienced denials and delays getting needed drugs, especially newer, more expensive drugs. Obtaining drugs that are not on a Part D plan's formulary can be difficult and time consuming. As a result, dual eligibles were going without needed medications, switching plans, or switching to new medications for non-clinical reasons. Respondents knew of few exceptions and appeals being filed with plans, but when they assisted beneficiaries, they were typically successful.

Enrollment and changing plans remained problematic for dual eligibles assigned to plans with incompatible formularies or tight utilization restrictions. Study respondents, who assist duals in changing plans, would like to see improvements in the plan assignment process that allow better matching of people with plans.

This study suggests that dual eligibles' ability to access needed drugs under Part D is significantly affected by the type of state assistance provided to them. According to key informants, Connecticut's policies of covering co-payments and non-formulary drugs for duals made it easier for them to access needed medications. Washington's co-payment policy also made access easier for formulary drugs. In Florida, where neither type of assistance was provided, access appeared to be more restricted.

Respondents described a Medicare Part D program that has left some dual eligible beneficiaries with gaps in access to needed medications. Many of these gaps persist beyond the initial transition of duals to Part D, and they differ across states. Given the health care needs of this population and their reliance upon prescription drugs, these gaps are particularly troubling. Steps taken by states to bolster Part D appeared to provide significant help to duals and maintained their access to many drugs. In the absence of Federal remedies to persistent Part D inadequacies for this population, state efforts may be key. However, feedback from affected individuals should be useful as Part D is improved and strengthened administratively and/or legislatively.

Appendix A

QUESTIONNAIRE

PLEASE LIMIT ALL YOUR RESPONSES TO RECENT EXPERIENCES OF DUAL ELIGIBLES SITUATIONS
(Not experiences related to the start-up of the Part D in January 2006)

MEDICARE PART D STUDY

Introduction

As we discussed when we set up this interview, we are conducting a study on the implementation of the Medicare Prescription Drug Program (Medicare Part D) with dual eligible beneficiaries – those who receive both Medicare and Medicaid. As you are aware, these people received their prescription drugs through Medicaid prior to January 1, 2006. Now, they receive prescription drugs through Medicare Part D.

Your responses to this questionnaire will remain confidential; your name will not be mentioned in association with the study. The study report may refer to key informants by category and state (i.e. "a pharmacist in Florida"), but will not include any other identifying information. Similarly, direct quotes may appear in the study report but will not be attributed to any key informant by name.

Throughout this interview, please provide examples of the impact Medicare Part D has had on dual eligibles that you interact with, focusing on the current and ongoing effects of Part D (as opposed to the initial implementation of the program). Please share with us stories about your experiences with dual eligibles and their experiences with the program.

GENERAL QUESTIONS

1. My understanding is that you work with _____ and that you do _____. Am I correct? *(i.e., Doctor: My understanding is that you are a doctor at _____ and your specialty is _____. Am I correct?)*
   1.1. How long have you been in this position/profession?

2. Please briefly describe the nature of your interactions with people who are dually eligible for Medicaid and Medicare, the “dual eligibles” or “beneficiaries.”
   2.1. About how many dual eligibles do you see per month?

3. How would you rate your recent experiences with Medicare Part D?
   - ☐ Overall positive
   - ☐ Neutral
   - ☐ Overall negative
   - ☐ Not sure

4. What seems to be working well?

5. What does not seem to be working well?

FORMULARY & UTILIZATION MANAGEMENT

6. Are any dual eligibles you work with being denied drugs?
   6.1. Do you know why they are denied? Please explain.
   6.2. How many times per month do you see denials?
   6.3. Are certain drugs or certain classes of drugs problematic?
      6.3.1. If so, which ones?
   6.4. Have you encountered situations in which Prescription Drug Plans and/or Medicare Advantage Prescription Drug Plans (hereafter referred to as "Plans") deny a drug and require a beneficiary to use a formulary drug that he/she has already tried and failed?
      6.4.1. Did the Plans attempt to find out if the beneficiary has tried and failed that drug before requiring beneficiary to use it?
      6.4.2. Please share with me any stories and/or details about the situations you have encountered.

7. Are dual eligibles experiencing delays in getting needed drugs?
   7.1. How frequently are dual eligibles seeing delays in getting prescription drugs?
      ☐ Never
      ☐ Infrequently
      ☐ Frequently
      ☐ Always
      ☐ Not sure
   7.2. Are certain drugs problematic?
      7.2.1. If so, which ones?
   7.3. What reasons have been given for these delays?

8. Are you aware of specific consequences of dual eligibles not getting needed medications because of denials or delays? Please give specific examples.

9. In what ways have you seen beneficiaries respond to denials or delays?

10. What have you recommended dual eligibles do if drugs are denied or delayed?
    10.1 Have your suggestions been successful?
       10.1.1 Please explain.
    10.2 Do you know of things other providers are doing to assist beneficiaries in getting the drugs they need? Please tell me about any particularly creative solutions you have heard of.

11. Medicare Part D excludes certain drugs [*Benzodiazepines, Barbiturates, drugs used for weight loss or weight gain, fertility drugs (including drugs for sexual/erectile dysfunction), drugs used for cosmetic purposes, vitamins, and over-the-counter drugs*], although some are covered as injectables. What have you seen happening to dual eligibles who need these drugs?
    11.1 Have dual eligibles had particular difficulty accessing any of these drugs?
       ☐ Benzodiazepines
       ☐ Barbituates
       ☐ Drugs for weight loss or weight gain
       ☐ Fertility drugs (including drugs for sexual/erectile dysfunction)
       ☐ Drugs used for cosmetic purposes

- ☐ Vitamins
- ☐ Over-the-counter drugs
- ☐ Not sure
- ☐ Other: _____

12. Are any of the following being used to deal with problems in Medicare Part D?
    - ☐ Referring patients to specific pharmacie(s)
    - ☐ Prescribing certain drug(s) to be sure that they are covered
    - ☐ Advising beneficiaries to switch plan(s)
    - ☐ Referring patients back to their prescribing physician(s)
    - ☐ Advising patients of their right(s) to seek an exception to the formulary?
    - ☐ Referring beneficiaries to specific plan(s)
    - ☐ Seeking payment from the State to cover beneficiaries' drug(s)
    - ☐ Not sure
    - ☐ Other: _____

13. Have you observed Plans changing formularies?
    13.1 What impact have these changes had on beneficiaries?

14. Are there any other stories or anecdotes you would like to share with me related to formulary and/or utilization management?

EXCEPTIONS & APPEALS

15. Are you familiar with the Part D exceptions and appeals process?
    15.1 How did you learn about this process?
    15.2 Do you feel that you understand the process well enough to help a beneficiary through it?
    15.3 Do you feel that most other providers understand the process?
    15.4 Do you feel that most beneficiaries understand the process?

16. Are beneficiaries getting notice that they have a right to file an exception or appeal?
    - ☐ Never
    - ☐ Infrequently
    - ☐ Frequently
    - ☐ Always
    - ☐ Not sure

    16.1 How are beneficiaries getting notice of this right?

17. Approximately how many exceptions and appeals are being requested by you or your practice/organization monthly?

18. Have you personally been involved in helping beneficiaries file exceptions and/or appeals?
    18.1 What was your role?
        18.1.1 Can you explain what happened?
    18.2 Are there particular things that <u>helped</u> your navigation of the process? Please explain.
    18.3 Are there things that made your navigation of the process <u>difficult</u>? Please explain.
    18.4 Have you found a difference in how the process was handled when you were involved in comparison to when the beneficiary him/herself filed without your involvement?
        18.4.1 If yes, please explain.

19. To your knowledge, do plans have to respond to exceptions and appeals within specific timeframes?
    19.1 Are plans responding in the required timeframes?
        - ☐ Always
        - ☐ Frequently
        - ☐ Infrequently
        - ☐ Never
        - ☐ Not sure

20. Are there any other stories or anecdotes you would like to share with me related to exceptions and appeals?

AFFORDABILITY

21. Are you aware of any impacts Part D co-payments are having on dual eligibles' access to drugs?
    21.1 In your experience, are dual eligibles having difficulty paying co-payments?
        21.1.1 If yes, how are dual eligibles you work with dealing with the difficulty of paying co-payments?

22. What policies have pharmacies put in place to deal with co-payments for dual eligibles?

23. How often do you see plans charging incorrect co-payments?
        - ☐ Never
        - ☐ Infrequently
        - ☐ Frequently
        - ☐ Always
        - ☐ Not sure

    23.1 Do you see any patterns with particular Plans (PDPs/MA-PDs) or prescriptions?

24. How often do you see plans waiving co-payments?
        - ☐ Never
        - ☐ Infrequently
        - ☐ Frequently
        - ☐ Always
        - ☐ Not sure

25. Are you referring or seeing others refer dual eligibles to certain pharmacies?
    25.1 If yes, what makes these pharmacies more attractive to dual eligibles?

26. Are there any other stories or anecdotes you would like to share with me related to affordability?

STATE ASSISTANCE

27. Is your state doing anything to help dual eligibles get the drugs they need?
    27.1 If yes, can you describe what the State is doing?

    27.2 How do you think the State assistance is working?
        - ☐ Very well
        - ☐ Well

- ☐ Inconsistently
- ☐ Not well
- ☐ Not sure

28. *CT and WA ONLY*: What impact has your state's law/policy regarding co-payment assistance had on dual eligibles?
    28.1 What is working with the state law/policy?
    28.2 What is not working with the state law/policy?

29. *CT ONLY:* What impact has your state's wrap-around law/policy (covering drugs not covered by beneficiaries' Part D plans) had on dual eligibles?*)*
    29.1 What is working with the state law/policy?
    29.2 What is not working with the state law/policy?

30. *CT ONLY*: Is Connecticut's Part D law/policy being used more often for co-payments or because beneficiaries cannot get the drugs they need from their Plans?
    30.1 Is Connecticut's state wrap-around law/policy working for drugs that are subject to:
        30.1.1 Prior authorization?
        30.1.2 Step therapy?
        30.1.3 Quantity limits?
    30.2 If no, are dual eligibles having trouble accessing needed drugs?

31. Have you encountered individuals on the medically needy program (those with "spend down," "share of cost") who have lost this Medicaid eligibility since going on Part D?
    31.1 Are they continuing to receive the drugs they need? Please explain.
    31.2 Are they able to receive non-pharmacy services they need? Please explain.
    31.3 What happens to a dual eligible who has not yet spent down? Please explain.

32. *Pharmacists*: When do you find that you use the state assistance program the most?

33. Are there any other stories or anecdotes you would like to share with me related to your state's assistance program for dual eligibles?

ENROLLMENT

34. For new dual eligibles, what do you see happening to those auto-assigned to:
    34.1 A plan that does not fit their needs?
    34.2 No plan?
    34.3 More than one plan?

35. Have you helped anyone enroll in or switch plans?

36. Are you seeing dual eligibles switch plans?
    36.1 For what reasons are they switching?
    36.2 On average, how frequently are dual eligibles switching plans?
        - ☐ Frequently
        - ☐ Occasionally
        - ☐ Infrequently
        - ☐ Rarely
        - ☐ Never
        - ☐ Not sure

36.3 Are you seeing trends in the plans they are switching out of or into? Please explain.
36.4 When dual eligibles switch, do they have problems with their Low Income Subsidy following them into the new plan?
- ☐ Never
- ☐ Infrequently
- ☐ Frequently
- ☐ Always
- ☐ Not sure

36.4.1 Please explain.

37. Do you believe that auto-enrollment is the best way to enroll dual eligibles into Part D?
37.1 If not, what would you recommend as the best alternative method?

38. Are there any other stories or anecdotes you would like to share with me related to enrollment?

ADMINISTRATIVE COMPLEXITY & ITS IMPACT

39. How would you rate the Part D program for providing drugs?
- ☐ Very easy
- ☐ Easy
- ☐ Difficult
- ☐ Very difficult
- ☐ Not sure

39.1 Please explain.

40. Have you seen any problems associated with:
40.1 Beneficiaries who also have other drug coverage (e..g, V.A., A.D.A.P.)? Please explain.
40.2 Beneficiaries being asked to pay premiums or co-payments they do not owe? Please explain.
40.3 Beneficiaries in Medicare Advantage (Medicare HMO) plans? Please explain.
40.4 Other problems associated with administration of the Part D program?

41. How easy or difficult is it for dual eligibles <u>with cognitive difficulties</u> (e.g., Alzheimer's, dementia, etc.) to:
41.1 Select Plans?
- ☐ Very easy
- ☐ Easy
- ☐ Difficult
- ☐ Very difficult
- ☐ Not sure

41.2 Get Plans to cover their drugs?
- ☐ Very easy
- ☐ Easy
- ☐ Difficult
- ☐ Very difficult
- ☐ Not sure

42. How easy or difficult is it for dual eligible <u>mentally ill persons</u> to:
42.1 Select Plans?

- ☐ Very easy
- ☐ Easy
- ☐ Difficult
- ☐ Very difficult
- ☐ Not sure

42.2 Get Plans to cover their drugs?

- ☐ Very easy
- ☐ Easy
- ☐ Difficult
- ☐ Very difficult
- ☐ Not sure

NEW DUAL ELIGIBLES

43. In your experience, are new dual eligibles receiving notification about their shift from Medicaid to Part D?
    - ☐ Never
    - ☐ Infrequently
    - ☐ Frequently
    - ☐ Always
    - ☐ Not sure

    43.1 Who are they receiving notification from?
    - ☐ Medicare
    - ☐ State agency
    - ☐ Not sure
    - ☐ Other: _____

    43.1.1 Is this notification being provided in a timely manner?
    - ☐ Never
    - ☐ Infrequently
    - ☐ Frequently
    - ☐ Always
    - ☐ Not sure

    43.1.2 Do you feel that new dual eligibles understand the notification that they receive?

    43.1.3 Is this notice provided in a language that recipients can understand?

    43.2 Are there any common issues faced by dual eligibles in regard to notification?

    43.2.1 If yes, please explain.

44. Are you seeing a gap in coverage of prescription drugs when new dual eligibles switch to Part D? Please explain.

    44.1 Is Wellpoint[15] being used to cover this gap? Please explain.

WRAP-UP QUESTIONS

45. What have been your experiences dealing with Part D Plans (PDPs & MA-PDs)?

    45.1 What <u>has</u> worked well?

    45.2 What <u>has not</u> worked well?

[15] Point of Sale Facilitated Enrollment often referred to by advocates as "Wellpoint," "contingency," or "temporary." CVS calls it "condor codes" and Walgreens calls it "Plan ID codes" and Brooks calls it "MD5113" and has no code.

45.3 Have you found either PDPs or MA-PDs easier to work with? Why?

46. Have you found Part D Plans' utilization controls (e.g., prior authorizations, etc.) comparable to other prescription drug insurance coverage (e.g., private sector health insurance plans that cover drugs)?
    46.1 If not, how are they different?

47. Have you used any of the following resources to help you answer questions related to Part D?

- ☐ Medicare.gov website
- ☐ Plans website(s)
- ☐ Medicare phone line(s)
- ☐ Plans phone line(s)
- ☐ State Medicaid office
- ☐ SHIBA (*WA)*, SHINE (*FL)*, CHOICES (*CT)*
- ☐ Local or state advocacy organization(s)
- ☐ Your professional or trade organization
- ☐ Material(s) from your state Medicaid program
- ☐ Material(s) from a professional or trade group that you belong to
- ☐ Beneficiary advocates' material(s)
- ☐ Have not used any resource(s)
- ☐ Other resources: _____

47.1 Have you found them helpful?
47.1.1 Why or why not?

48. Do you see continuing problems with Part D that are not being fixed?
    48.1 What are they?
    48.2 Do you find certain providers or populations are more concerned about these problems than others? Please explain.

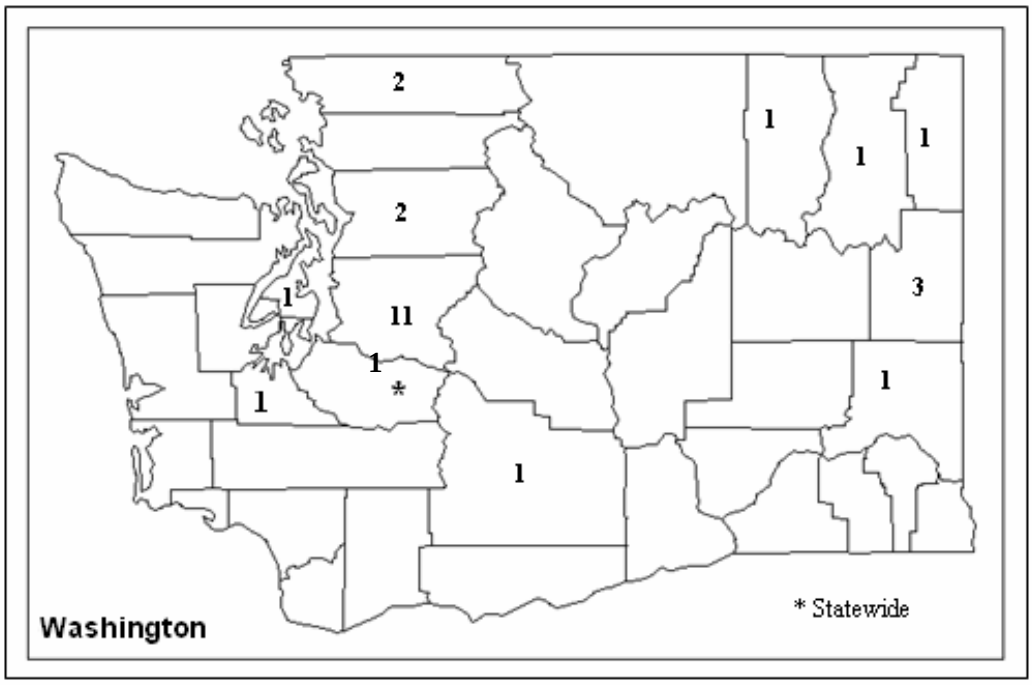
49. Do you foresee upcoming problems or emerging issues? Please explain.
    49.1 Do you have suggestions on how these problems may be avoided or ameliorated? Please explain.

Thank you for participating in this study. Your responses will be extremely helpful in understanding how Medicare Part D is working for dual eligibles.

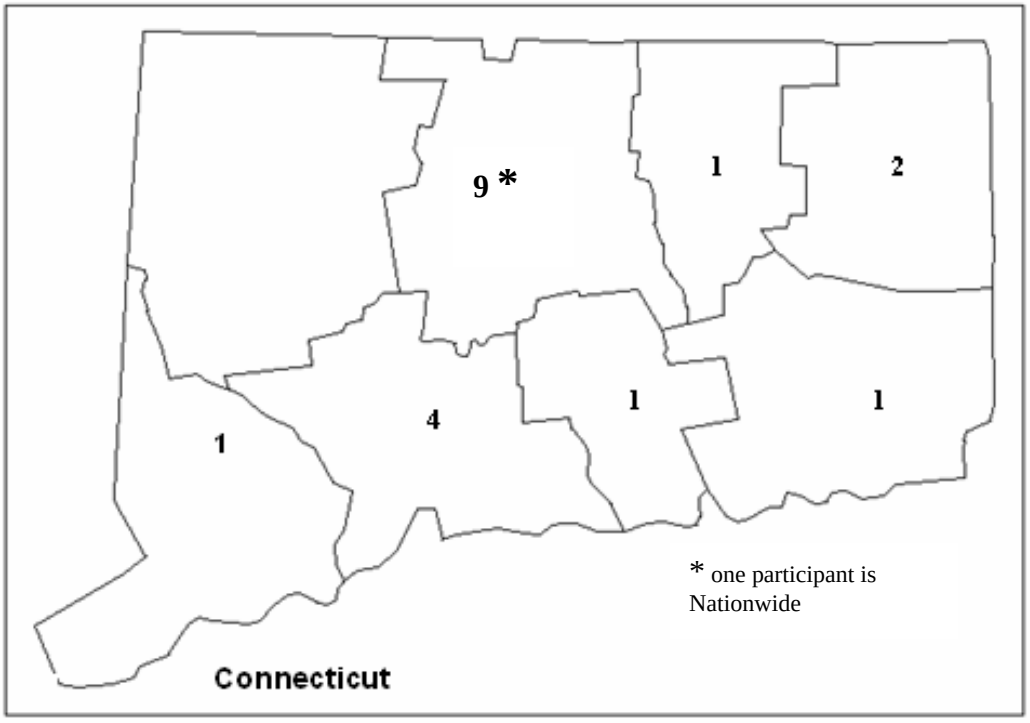
Appendix B

DISTRIBUTION OF KEY INFORMANTS BY COUNTY

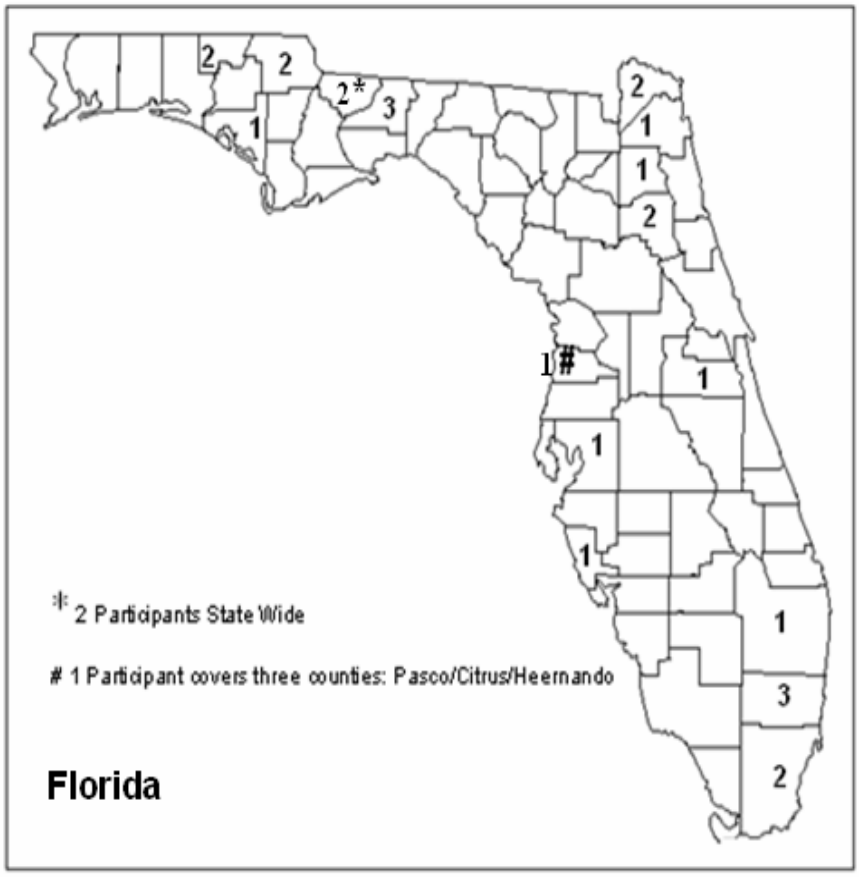
Distribution of Key Informants - Washington



Distribution of Key Informants - Connecticut



Distribution of Key Informants - Florida



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