Approved: March 8, 2006
Date

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE

The meeting was called to order by Chairman Dwayne Umbarger at 10:40 A.M. on January 26, 2006, in Room 123-S of the Capitol.

All members were present except:
Senator Chris Steineger- excused

Committee staff present:
Jill Wolters, Revisor of Statutes Office
Michael Corrigan, Revisor of Statutes Office
J. G. Scott, Kansas Legislative Research Department
Michelle Alishahi, Kansas Legislative Research Department
Reagan Cussimanio, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Audrey Dunkel, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Judy Bromich, Chief of Staff
Mary Shaw, Committee Secretary

Conferees appearing before the committee:
Scott Brunner, Director of Medicaid, Kansas Division of Health Policy and Finance
Tammy Twait, Kansas City Regional Office Pharmacist, Centers for Medicare and Medicaid Services
John L. Kiefhaber, Executive Director, Kansas Pharmacists Association
Brian Caswell, R.Ph., Baxter Springs, Kansas
Bob Haneke, R.Ph., Wichita, Kansas
Alan DeFever, R.Ph., Overland Park, Kansas
Terry Bradstreet, R.Ph., Hutchinson, Kansas

Others attending:
See attached list.

Bill Introduction

Senator McGinn moved, with a second by Senator Schodorf, to introduce a bill concerning economic development; relating to the economic development initiative fund; creating the state affordable airfare fund to support certain programs (5rs1630). Motion carried on a voice vote.

Chairman Umbarger announced that the overview and discussion on Medicare Part D - Prescription Drug Coverage continued. The Chairman welcomed Scott Brunner, State Medicaid Director, Division of Health Policy and Finance, Kansas Department of Administration, who addressed the transition of Medicaid beneficiaries into the Medicare prescription drug benefit (Attachment 1). Mr. Brunner explained preparations that have been made regarding the transition to Part D and his participation in a workgroup consisting of senior program directors within the Kansas Department of Social and Rehabilitation Services, the Department on Aging, the Kansas Department of Health and Environment, the Kansas Insurance Department and Division of Health Policy and Finance which is described in detail within his written testimony. Mr. Brunner addressed the dual eligibles, emergency actions after January 1, 2006, and future Part D activities, all of which are detailed in his written testimony.

Mr. Brunner provided a detailed table of expenditures and prescriptions filled by date that had been updated from the table that was listed in his written testimony (Attachment 2).

The Chairman welcomed Tammy Twait, Pharmacy Officer for the Kansas City Regional Office of the Centers for Medicare and Medicaid Services (Attachment 3). Nancy Schmidt, Health Insurance Specialist, Kansas City Regional Office of CMS, was present at the meeting with Ms. Twait. Ms. Twait explained that there are still "plenty of bumps" and clearly specific problems that they have identified and are diligently working to remedy. She noted that some of these areas are the E1, or eligibility transactions, and the data translation

which are detailed in her written testimony. Ms. Twait explained that the Medicare Part D prescription drug benefit is the biggest, most dramatic change to Medicare in its history and it is happening all at once. In closing, she explained that the Kansas City Regional CMS office will continue to work diligently with their partners and central office staff to identify and correct problems or issues that may arise.

The Chairman welcomed John Kiefhaber, Executive Director, Kansas Pharmacists Association, who spoke before the Committee regarding the implementation of Medicare Part D in Kansas (Attachment 4). Mr. Kiefhaber explained that while the federal Centers for Medicare and Medicaid Services began disseminating information on the implementation of Medicare Part D soon after the final regulations were released early in 2005, and while the Kansas Pharmacists Association and others traveled the state all summer and fall of last year to explain the state all summer and fall of last year to explain the provisions of the program to pharmacists and beneficiary groups, no one was clearly ready for the deluge of patients and the complicated questions that would hit all of them on January 2, 2006, a Monday.

Mr. Kiefhaber introduced Brian Caswell, a Pharmacist from Baxter Springs, Kansas, and Chairman Umbarger welcomed Mr. Caswell and the following Pharmacists. The Pharmacists addressed the work they have done and the problems they have encountered in the implementation of the federal government's new Medicare Prescription Drug Program.

Brian Caswell, R.Ph., Baxter Springs, Kansas, explained the major areas for pharmacist concerns regarding patient eligibility including full benefit dual eligibles, nursing home patients and Medicare Part A/B eligibles. He also addressed the tools used to wade through process, the pharmacists role during transition phase, concerns as a health care provider and his concerns as an informed taxpayer (Attachment 5).

Bob Haneke, R. Ph., Wichita, Kansas, addressed issues concerning the long term care area, nursing homes, and in the hospital arena which involves long term acute care in both rural and larger metropolitan hospitals. He noted that the health care professionals in Kansas have stepped up to the plate in light of what is happening and have take care of their patients. Mr. Haneke noted that he knows of no instances outside of Kansas where services have been denied because payment had not been received. He emphasized in long term care that a lot of the plans are on a 30-day fill cycle and what happens when the month runs into 31 days and patients receive no medications until the following month and it needs to be addressed immediately in a long term care situation. (No written testimony was submitted).

Alan F, DeFever, R. Ph., Overland Park, Kansas, explained that planning ahead of time for the Medicare Part D program did not appear to take into consideration the front-line pharmacist(Attachment 6). Mr. DeFever addressed the short time frame to move all of the dual eligibles and all of the other Medicare patients into the system in 45 days and suggested that the dual eligible start dates should have been separated from the other start dates. Detailed information is contained in Mr. DeFever's written testimony.

Terry Bradstreet, R. Ph., Director of Pharmacy Operations for the Dillon's Stores, Hutchinson, Kansas, mentioned that he was very proud of his pharmacists and colleagues for the job that they are doing to supply the pharmacy needs of the people of Kansas during this trying time. Mr. Bradstreet noted information regarding dual eligibles that are not enrolled in any PDP and the use of the Wellpoint/Anthem point of sale process that is supposed to pay for the prescription but additionally triggers a sales person to contact the patient to get them signed up with a Medicare PDP. He expressed concern regarding the future and those individuals who have not signed up for a plan yet and the May 15 deadline approaching the same issues may hit the pharmacists again (Attachment 7).

Kevin Siek, Independent Living Resource Center, expressed concern regarding those that are dually eligible in that many vitamins, mineral supplements and over-the-counter medications that were previously covered by Medicaid will still be covered under Part D. Mr. Siek also noted certain prescription medications that Medicare will not cover, but for dual eligibles, Medicaid will continue to cover many of the medications. He explained that the problem is that not many people know this information (Attachment 8).

The meeting adjourned at 12:00 p.m. The next meeting was scheduled for January 30, 2006.

SENATE WAYS AND MEANS
GUEST LIST

Date January 26, 2006

NAME	REPRESENTING
Dusti Hardison	Senator Hensley
[signature]	DOB
Robert Day	DHPF
Bill Roy	"press"
Nancy Schmidt	CMS
TAMMY TWAIT	CMS
Kathy Sievers	KS Dpt on Aging
Barb Conrad	KDOA
Sharon Joseph	KS ADAPT
Mark Bozanyak	Capitol Strategies
[signature]	DEMHCA
[signature]	CGR
Tom Bruno	EDS
[signature]	Kearney + associates
Mike Hutfles	Hutfles Govt. Relations
Beth Innes	Hutfles Govt Relations
Chad Austin	KS Hosp Assoc
PAUL D HURLEY	PATRICK J. HURLEY & CO.
PETER STERN	KS. IND. PHARMACY SERVICE CORP.
Terry Bradstreet	KPhA / Dillon Stores
Robert Hanske	KPhA
ALAN DEFEVER	KPhA - Independent Pharmacist
John Kiefhaber	KS. Pharmacists Assoc.

SENATE WAYS AND MEANS
GUEST LIST

Date January 26, 2006

NAME	REPRESENTING
Kevin Sick	TILRC

KANSAS
DIVISION OF HEALTH POLICY AND FINANCE
ROBERT M. DAY, DIRECTOR
KATHLEEN SEBELIUS, GOVERNOR

Testimony on:
Medicare Part D and Dual Eligibles

presented to:
Senate Committee on Ways and Means

by:
Scott Brunner
Division of Health Policy and Finance

January 25, 2006

For additional information contact:
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Kansas Division of Health Policy and Finance

Robert M. Day, Director

Senate Committee on Ways and Means
January 25, 2006

Medicare Part D and Dual Eligibles

Mr. Chairman and members of the committee, my name is Scott Brunner and I am the State Medicaid Director with the Division of Health Policy and Finance (DHPF). I am providing testimony on the transition of Medicaid beneficiaries into the Medicare prescription drug benefit.

The Medicare Modernization Act

The Medicare Modernization Act of 2003 (MMA) made a prescription drug benefit available to every Medicare beneficiary beginning on January 1, 2006. This benefit, known as Medicare Part D, also pays for prescription drugs for low-income seniors and persons with disabilities who are eligible for both Medicare and Medicaid. These individuals are referred to as dual eligibles and there are approximately 40,000 dual eligibles enrolled in Kansas Medicaid. Before Medicare Part D, the Kansas Medicaid program paid for prescription drugs for these beneficiaries.

The federal government created regions across the country and contracted with private insurers to provide prescription-drug coverage to Medicare beneficiaries, either through a drug-only plan or a comprehensive health plan (i.e., prescription drugs and regular medical care).

On January 1, 2006, Kansas blocked dual eligibles from receiving Medicaid coverage for any prescription drugs covered by Medicare Part D. They had to choose a Part D plan or lose prescription drug coverage. There have been concerns about which drugs Part D plans will cover and whether dual eligibles will be able to receive the specific drugs they need. This population is often sicker and in need of more medications than the rest of either the Medicare or Medicaid populations. Part D plans are required to cover at least two drugs in every therapeutic class and must provide all or substantially all drugs in specific classes, but the plans have flexibility in the determination of drug classes and they can establish closed formularies.

The Center for Medicare and Medicaid Services (CMS) reviewed the formularies developed by the Part D plans and contracted with the U.S. Pharmacopoeia Convention to develop model guidelines for classifying drugs and drug categories. However, dual eligibles with HIV/AIDS, epilepsy, or mental illness may be vulnerable if Part D plans cover only a limited number of newer, more effective drugs. States have the option to cover specific drugs that are not covered by Part D plans, but no federal match will be available.

CMS automatically enrolled dual eligibles in Part D plans in November. Dual eligibles were randomly assigned to Part D plans that met benchmark benefit and cost levels. These auto-

assignments were shared with the states in November through an electronic file exchange. Kansas Medicaid was able to validate that dual eligibles were enrolled in a plan; however we were not able to check that the auto-assigned plan was the best fit for each beneficiary. Dual eligbles were allowed to change plans before December 31, 2005 and can change plans each month. Other Medicare beneficiaries have until May 15, 2006 to enroll in a Part D plan to avoid a financial penalty in their cost sharing. Companies began marketing their Part D plans on October 1 of last year.

Other low-income people (with incomes up to 150% of the Federal Poverty Level (FPL)) are potentially eligible for assistance with premiums and co-payments. Others, who have higher income and asset levels, and who have greater than $2,250, but less than $5,100, in total annual drug costs will have a gap in coverage. This gap is commonly referred to as the "doughnut hole." CMS has issued guidance to states on how to treat the costs Medicare beneficiaries will have in this doughnut hole. Some people may become eligible for Medicaid through the medically needy population category, which allows people to spend down their resources on medical services to achieve income eligibility. We do not anticipate significant increases in the medically needy population, if CMS does allow this out-of-pocket spending for drug costs in the doughnut hole. More likely, we will see a reduction in the number of medically needy who use their monthly drug costs to achieve their spenddown and be eligible for Medicaid.

Preparing for the Transition to Part D

State agencies have been working for almost two years to prepare for the implementation of Medicare Part D. I led an interagency workgroup, made up of senior program directors within the Department of Social and Rehabilitation Services (SRS), the Department on Aging, the Kansas Department of Health and Environment, the Kansas Insurance Department, and the Division of Health Policy and Finance. The groups charge was to coordinate the activities of state agencies to identify all populations affected by Part D, to make consistent policy decisions across agencies, and to identify resources in each agency that could be used for outreach activities. The group also was used to share information coming from CMS and the Social Security Administration.

An early decision of this group was to divide responsibilities for the populations affected by Part D. The Department on Aging was primarily responsible for conducting general outreach to Medicare eligible beneficiaries and specific insurance counseling through the Senior Health Insurance Counseling Program of Kansas (SHICK). DHPF and SRS were responsible for notification and outreach for Medicare and Medicaid dual eligibles and preparing to receive applications for the Low Income Subsidy. The Department of Health and Environment and the Insurance Department had a role in providing information to individuals and community organizations through existing publications, call centers, and networks. Other specific workteams were established for issues such as training and publications, which involved staff from each agency.

Within DHPF and SRS, transitioning the duals involved mailing notices to beneficiaries to raise awareness of Part D and the impact on Medicaid benefits. CMS provided a schedule of mailings for the dual eligibles and all Medicare beneficiaries soon after the final regulations were

complete last January. DHPF planned additional notices that would match and hopefully explain what was in the CMS letters to reduce confusion among Medicaid beneficiaries. The hope was to raise awareness of the change in benefit without creating panic. These notices were sent to beneficiaries and their responsible parties if a family member or guardian helped make decisions.

At the same time, SRS developed training for regional office staff on Medicare Part D. The first round of training provided an overview of Medicare and how the new benefit was structured to interact with Medicaid. Since most of the policy details had not been developed when this training was developed, it was used to raise awareness of the coming changes. A second round of training occurred during November and December after the detailed transition policy was developed and changes in the eligibility system were completed. Current training efforts are focusing on working with eligibility staff to help beneficiaries use the Part D plan finder tool to evaluate the costs and formulary offerings of different plans.

Transition Issues for Dual Eligibles

Auto enrollment created the first issue for Medicaid. The initial auto enrollment process occurred in October 2005 for all full benefit dual eligibles beneficiaries enrolled from April 1, 2005 through October 15, 2005. A monthly auto enrollment process will occur thereafter to ensure prescription drug coverage is available for new Medicaid beneficiaries. All individuals identified as a full dual eligible since May 2005 were automatically enrolled into a Medicare prescription drug plan. In Kansas, about 38,000 people were auto enrolled. This includes individuals who received Medicaid during this time period, but are no longer eligible. CMS specifically designed the process to include a broad group of individuals, and some ineligible individuals were included in the auto enrollment process. All dual eligibles were deemed eligible for the Low Income Subsidy and that eligibility lasts until December 2006.

CMS auto enrolled individuals by their current Medicare address. This could be different than the address reflected in the Medicaid file. If both files indicated a Kansas address, there was little impact on the process of auto enrollment. However, persons who lived in another state, or who recently moved to Kansas from another state, may be auto enrolled into an out of state plan. This occurred in approximately 250 cases, and another 1,000 beneficiaries were enrolled in a plan that operates in Kansas but with that plan in another state. CMS provided lists of the auto enrollment results that were shared with SRS caseworkers, Home and Community Based Service waiver case managers, and state institution reimbursement officers. This information was provided to help case workers and case managers assist beneficiaries that had questions about auto enrollment or assist in clarifying the impact of Part D on their Medicaid benefit.

DHPF and SRS issued specific guidance to eligibility staff to ensure that questions about the impact of Part D on Medicaid beneficiaries would be answered without referring the question to SHICK or another agency. Eligibility determination staff were not supposed to provide direct assistance on choosing among Part D plans. Instead, questions about plan choice and coverage decisions were referred to Medicare, Community Mental Health Center and Community Developmental Disability Organization case managers, the individual's pharmacist or medical provider, Working Health Benefit Specialists, or specific staff designated by each Regional Office.

DHPF and SRS are continuing to work with beneficiaries to trouble shoot issues with enrollment. We are receiving calls from community partners and CMS to work on specific eligibility cases and resolve them through CMS and the Part D plans.

Emergency Actions after January 1, 2006

As the Part D benefit started, we received many calls from pharmacists about difficulties in identifying dual eligibles in Medicare system. CMS created a central electronic point of sale system that contained all Part D enrollees, their plan assignment, and benefit coverage for each plan. This system was not responsive or correct for much of the first week of Part D. There were a variety of issues including not being able to find beneficiaries in the system, confusion over which Part D plan dual eligibles were enrolled in, and incorrect cost sharing amounts. To make matters worse, pharmacists were unable to contact the Part D plans through customer service lines and the emergency mechanisms CMS had put in place to ensure that beneficiaries would not leave the pharmacy without needed medications was unable to handle the volume of requests.

Governor Sebelius directed DHPF to take emergency action to ensure that dual eligible beneficiaries would not leave a pharmacy without medically necessary prescription drugs. On January 13, we turned off the block in the Medicaid Management Information System that prevented pharmacy payments for Medicare eligible beneficiaries. We provided direction to pharmacies that Medicaid could be billed for prescription drugs for Medicaid eligible beneficiaries if the Part D eligibility information in the point of sale system was incorrect or unavailable, if the cost sharing amounts that were indicated were incorrect, or if the temporary mechanism for payment created by CMS failed. The Medicaid payment was not intended to supplement a Medicare payment. As of January 24, 23,327 prescriptions have been paid for by Kansas Medicaid for 8,347 individual beneficiaries. We have expended $1,640,078. Below is a detailed table of expenditures and prescriptions filled by date.

Date	Unique Beneficiaries	Claims	Paid Amount
1/13/2006	695	1330	87,393.15
1/14/2006	729	1651	103,618.48
1/15/2006	205	455	29,536.33
1/16/2006	1755	3730	261,401.50
1/17/2006	1571	3395	251,018.51
1/18/2006	1464	3019	226,202.35
1/19/2006	1428	2887	201,934.41
1/20/2006	1289	2713	188,632.34
1/21/2006	585	1254	87,900.50
1/22/2006	198	403	34,160.35
1/23/2006	1102	2490	168,280.57
Total	**11021**	**23327**	**1,640,078.49**

This temporary measure was only offered until February 1, 2006. We will be evaluating this decision next week to determine if it should be extended. We were also notified yesterday that CMS is working on a mechanism to provide full federal reimbursement for costs incurred by states providing transitional coverage for dual eligibles. There are 26 states that have taken similar actions to protect dual eligible beneficiaries.

Future Part D Activities

Governor Sebelius has asked DHPF to begin planning on a method to provide copayment assistance for dual eligibles. Under Part D, full benefit dual eligibles are charged a $1 or $3 co payment per prescription. For some dual eligibles, especially individuals on the Home and Community Based Service Waiver programs, Medicaid did not charge a copayment for prescriptions. We are developing a mechanism to pay these costs for dual eligibles that were not subject to copays before Part D and gathering information on the number of people that could be affected and the total costs.

Another impact that has not been assessed is the ability of beneficiaries to get the prescription drugs they need through the Part D plans. The plans are required to cover two drugs in each therapeutic class, but evaluating whether each plan covers the drugs that auto assigned beneficiaries' need has to be done on a case by case basis. The plans were required to provide a transitional supply of the medications each beneficiary was taking for the first 30 days of the Part D benefit. After that supply runs out, beneficiaries will have to determine if their plan covers that drug, if a therapeutic substitution to a formulary drug is appropriate, or if they need to work with their physician to change prescriptions. Each plan also has an exception process to appeal coverage decisions, but these have not been evaluated. Medicaid covered most, if not all, prescription drugs for dual eligibles prior to January 1. The next round of Part D impacts will surface for beneficiaries that were on established drug regimens that will not be sustained by the Part D plan formularies.

That concludes my testimony. I am happy to stand for questions.

Date	Unique Beneficiaries	Claims	Paid Amount	Unique Benes Across All Dates
1/13/2006	688	1301	$86,013.37	
1/14/2006	725	1621	$101,291.92	
1/15/2006	203	447	$29,032.03	
1/16/2006	1725	3656	$256,447.17	
1/17/2006	1552	3319	$246,755.06	
1/18/2006	1446	2953	$222,097.75	
1/19/2006	1407	2727	$194,669.85	
1/20/2006	1276	2558	$177,629.46	
1/21/2006	570	1103	$80,666.45	
1/22/2006	179	340	$27,250.09	
1/23/2006	1624	3482	$247,782.24	
1/24/2006	1336	2648	$198,143.76	9247
1/25/2006	1914		$130,627.40	
	14645	26155	$1,998,406.55	

Senate Ways and Means
1-26-06
Attachment 2

CMS Testimony
Kansas Senate Ways & Means Committee
January 26, 2006

Thank you Chairman Umbarger and Vice Chairman Emler for the invitation to come before your committee today. My name is Tammy Twait and I am the Pharmacy Officer for the Kansas City Regional office of the Centers for Medicare & Medicaid Services. I'm accompanied here today by Nancy Schmidt, Health Insurance Specialist, also from the Kansas City Regional office of CMS. I've worked at CMS since December of 2005. I'm a graduate of the University Of Kansas School Of Pharmacy and currently hold licenses to practice pharmacy in the States of Kansas and Oklahoma. Prior to working at CMS, I have 20+ years of experience as a pharmacist in the Chain Drug Industry, holding many different positions from Prescription filling pharmacist to Regional Total Store Operations Manager.

As many of you know, Secretary Leavitt has been traveling around the country the past 9 days, if fact I think he is scheduled to be here in Topeka later today. He's been meeting with governors, state officials, pharmacists, drug plans, and beneficiaries. The Secretary indicated at his January 24 press conference that these visits have given him a very good understanding of the issues and what needs to be done. He also indicated he had received feedback from a pharmacist in Alabama emailing, and I quote "if it improves as much in the next seven days as it has the past seven days, we will be close to getting some significant relief. Still plenty of bumps, but it is much better" end of quote. I can report to you similar feedback from pharmacists I have spoken to in the State of Kansas.

There are still "plenty of bumps." And there are clearly specific problems that we have identified and are diligently working to remedy. There are clearly areas that still need improving. One of these areas is the E1, or eligibility transactions. The E1 response times are now generally less than one second with no time-outs. Due to data translation problems, the E1 system may not have been providing pharmacies with all the information they need to fill prescriptions every time. We are working with the drug plans, for them to staff in a way that will help remedy that problem.

A second problem we've identified is data translation. When data is transmitted between a state and CMS, and then from CMS to plans, sometimes the handoff of data isn't perfect. We have sent the drug plans a file of all of their dual-eligibles that we have on record a well as those beneficiaries eligible for the Low-income subsidy in the drug plan. The Part D plans have already been cross-checking this information with their own files and working with CMS to make sure that the information they have is correct, and they've been acting on the changes. As this is occurring, we are seeing fewer beneficiaries experiencing problems, and fewer pharmacists experiencing "bumps" at the pharmacy counter.

In addition to these steps related to our systems and data, our expectation is that no one, whether it's a pharmacist or a beneficiary or doctor should have to wait a long time on the phone to get help seeking information on their coverage. We improved our dedicated pharmacy Medicare line, 1 866 835 7595, from 150 Customer Service Representatives, or CSR's, to 4500.

Senate Ways and Means
1-26-06
Attachment 3

We also changed the availability of the line from 8am to 8pm Monday thru Friday to 24 hour, 7 days a week. I personally routinely check the wait times at this phone number and since we increased the number of CSR's I've never waited longer than four minutes. We're also tracking how plan customer service lines are working, and while many plans have already taken important steps to reduce the wait time for pharmacists, we expect all of them to get their wait times down. And we expect as we keep working intensively to improve our systems and data, plans will be able to achieve even better performance. In addition, we've been very clear about the importance of plans following the transition polices they have in place, and we will take further actions against plans that do not.

To build on these steps we plan to conduct an extensive outreach campaign to pharmacies in the coming days. I have a scheduled tele-conference today with Larry Kocot, senior pharmacy advisor to the Secretary, and the eight other regional pharmacy officers from across the country to discuss and set agendas for pharmacist training opportunities we've tentatively planned. The Kansas City Regional office has worked and will continue to work with pharmacists in the State of Kansas to provide information and training they need. In the past year I have made many presentations with the Kansas Pharmacist Association, or KPhA, including an MMA/ Part D overview at their 125th annual convention in September. I also attended and provided MMA/Part D training at KPhA events for District 5 in Wichita, and District 9 in Kansas City. Other members of the provider relations team have worked with KPhA as well, making presentations in other areas of the state. Actually, my first ever event as the CMS Regional Pharmacy Officer was in February 2005 at the Long Term Care workshop held by KPhA and I believe John Kiefhaber has invited us to attend again this year in February. I also have trained pharmacists for Kmart, and Hy-Vee as well as pharmacy students at the American Pharmacy Association's Academy of Student Pharmacists Mid- year meeting. I participated in two Town Hall events with our National Pharmacy Partners, the National Community Pharmacy Association, NCPA.

The Kansas City Regional office held it's first ever All States Pharmacy Associations meeting in March of 2005. We now meet with the Executives from all four of the states in the CMS Kansas City regional office face-face quarterly, via teleconference quarterly and when needed. These exchanges provide valuable feedback for both CMS and our valued pharmacy partners. Our next scheduled meeting with this group is February 16.

Additionally, the Kansas City regional office held a pharmacy symposium in May of 2005 to help educate our non- pharmacy partners about the business of pharmacy. Many of our partner organizations that assist Medicare beneficiaries, such as the Area Agencies on Aging (AAA's) and State Health Insurance Programs (SHIP's) have not worked with pharmacies or pharmacists in any significant way prior to Part D and we wanted to provide them an opportunity to learn about the pharmacy business. This day long event included an overview of the Drug Benefit presented by CMS Health Insurance Specialist Natalie Myers, an overview of the pharmacy industry by Jack Fincham, A. W. Jowdy Professor of Pharmacy Care at the University of Georgia and former Dean of the University of Kansas School of Pharmacy, a discussion of State Regulatory Issues by Sandy Praeger, Kansas Insurance Commissioner, the History of Pharmacy by Bob Piepho, Dean of Pharmacy at UMKC, and an informative light hearted look at a day in

the life of practicing pharmacist presented by pharmacy speaker and trainer Wendal Gaston of Sidney, NE.

The Medicare Part D prescription drug benefit is the biggest, most dramatic change to Medicare in its 40-year history and it's happening all at once. This is an important new benefit for many people who have never had coverage for their medicines before, and we're confident that it will be a success for millions of Americans who will save money, stay healthy, and gain new peace of mind. Pharmacists are working hard to meet the demands of the millions of new enrollees in this new Medicare system. We realize and acknowledge these efforts that have been described as "heroic" by many in the press. We at the Kansas City Regional CMS office will continue to work diligently with our partners and central office staff to identify and correct problems or issues as they may arise.

Thank you Mr. Chairman, I am happy to answer your questions.

Kansas Pharmacists Association
Kansas Society of Health-System Pharmacists
Kansas New Practitioners Network
1020 SW Fairlawn Road
Topeka KS 66604-2275
Phone 785-228-2327 ✢ Fax 785-228-9147 ✢ www.kansaspharmacy.org

TESTIMONY

Before the SENATE COMMITTEE ON WAYS AND MEANS

Concerning the Implementation of Medicare Part D in Kansas
By John L. Kiefhaber, Executive Director
January 26, 2006

Chairperson Umbarger and members of the Committee:

The 1,300 members of the Kansas Pharmacists Association (KPhA) would like to thank you for the opportunity to report on the work they have done and the problems they have encountered in the implementation of the federal government's new Medicare Prescription Drug Program, commonly known as Medicare Part D. Joining me today to deliver expert testimony on how this new and complex program has been introduced is Brian Caswell, RPh of Baxter Springs, Kansas. Brian is Immediate Past President of the Kansas Pharmacists Association and one of the most knowledgeable and involved pharmacists in the State. He also chairs our Government Affairs Committee and reports to the Association on the experiences of many pharmacists around the state. Also with me today are pharmacists Alan DeFever of Overland Park, Terry Bradstreet, Director of Pharmacy Operations for Dillon's stores and Bob Haneke, PharmD, national director of pharmacy services for Omnicare, member of the PDL Committee for Kansas and also a Past President of KPhA.

While the federal Centers for Medicare & Medicaid Services began disseminating information on the implemention of Medicare Part D soon after the final regulations were released early in 2005, and while KPhA and others traveled the state all summer and fall of last year to explain the provisions of the program to pharmacists and beneficiary groups, no one was clearly ready for the deluge of patients and the complicated questions that would hit us all on January 2, a Monday. In fact, many pharmacies in Kansas were open on Sunday, January 1, and found out ahead of time what was coming. Two basic problems emerged right away, one we knew was coming and one we did not expect. We knew that dual eligibles who had to move from Medicaid to Medicare all on one day could be left behind in the enrollment process or could be enrolled in the wrong PDP plan. And some of them were. But the second major problem came when the pharmacist, the health care professional most relied upon by Medicare patients throughout the state, called the PDP to find the patient's record of enrollment and whether their prescription could be covered, they got a busy signal. Not just a busy signal – A BUSY SIGNAL FOR HOURS! This meant that patients would have to wait for hours, or go home without their prescriptions. I will ask Brian to explain this process in a moment.

Over

KPhA would like to thank the Governor's office, which checked with us several times a week for an update on the problems, for stepping forward to fund those cases where Medicare patients could not get enrollments or payments through the system. In many case our pharmacists, concerned for their patients first, were actually funding prescriptions out of their own pockets not knowing if they would ever be repaid. We would also like to lend our support to the Insurance Commissioner after her announcement that the PDPs operating in Kansas should now be registered or licensed. These national companies are the plan providers serving our most vulnerable Kansas citizens, and we need to know who they are.

I would like to ask Brian Caswell to report to you on what this experience was like at the pharmacy.

Medicare Part D Summation Points
Prepared for Testimony before Senate Ways and Means Committee.
By Brian Caswell R.Ph.

January 26, 2006

Kansas State Capitol
Topeka, KS 66612

1. Major Areas for Pharmacist Concerns regarding patient eligibility

   A. Full Benefit Dual Eligibles (FBDE)
      1. Auto-enroll process – Patients were enrolled into plans not available in their area.
      2. FBDE's thought the "best" plan was chosen for them.
      3. Many pharmacists complain to CMS and SRS about certain Prescription Drug plans being favored over others in the lottery process of FBDE's. So far CMS has not answered the question for transparency on the issue.

   B. Nursing Home patients
      1. Many families unaware of the Medicare plans and assignment into plans.
      2. Families unwilling to help in locating plan information
      3. Assigned plans not the best for patient- Difficult to change

   C. Medicare Part A/B eligibles
      1. Eligibles very confused about plan choices
      2. Most eligibles are unable of making an "informed" choice due to marketing variables by PDP's. – e.g. Premiums, deductibles, copays, formulary choices, quantity limits, prior authorizations, etc.
      3. Eligibles begging for pharmacist input or selection of plans – Pharmacists are prohibited from plan selection by CMS.
      4. Marketing information very misleading
      5. Marketing and plan selection done by "Insurance Agent"

2. Tools to wade through the process
   A. E1 queries
      1. Very late start by CMS – Lessened time for trial run
      2. NDC contracted by CMS for electronic eligibility and plan enrollment- Did not have information downloaded by Jan. 1. System could not be tested as late as Dec. 30 th.
      3. TROOP information – availability?

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B. CMS Support
   1. Initially allotted 150 operators for entire nation
   2. Second week of January number of operators increased to 4,500
   3. Performed a number of conference calls. (I participated in 2)
   4. First call did not allow for questions on the call. It did allow for questions to be e-mailed. My e-mail question was answered by why I e-mailed and very little understanding of a very basic question.
   5. Second call allowed for a handful of calls. Each question was answered by having pharmacist call local CMS office. Answers were not shared to the other 715 pharmacists.
   6. Information very limited vs E1 query
   7. To obtain patient plan one needs to answer up to 10 or more questions in order to just obtain name of plan. **No** I.D. numbers given by CMS.

C. PDP Support
   1. Very long on hold waiting time. Many waited for over 5 hours!
   2. Most of the time you are answered by an automatic answering service that either asks you to call back at another time or simply hangs up.
   3. PDP support was inadequate with improper copays or deductible requirements with FBDE's

3. Pharmacists Role during Transition Phase
   A. Forward of meds to allow time for information gathering
   B. Became "Insurance Experts" – Help people select plans that may include Health insurance or Supplemental benefits.
   C. Patients giving up –"Just select a plan that is best for me"
   D. Pharmacists becoming "lending institution"
   E. Countless hours of patient help without "commission"
   F. Decreased time for all other patients
   G. Mental and Physical effects on pharmacist

4. Concerns as a Health Care Provider
   A. PBM control – No checks and Balance. Sued by many states
   B. Limited access and choice to drug selection
   C. PDP registration by Insurance Commissioner – Enough?
   D. Possible registration of all PBM's

5. Concerns as an Informed Taxpayer
   A. Cost of Medicaid as a whole
   B. Impact on state Medicaid plan with reduced rebates
   C. How does MMA affect overall prescription price inflation

TESTIMONY

Before the SENATE COMMITTEE ON WAYS AND MEANS

Concerning the Implementation of Medicare Part D in Kansas
By Alan F. DeFever
January 26, 2006

My name is Alan DeFever. I live in Leawood, KS but own a pharmacy in Coffeyville. I thank you for the opportunity to address this committee and hopefully bring more clarity to the issues that surround the Medicare Prescription Drug Plan that began on January 1, 2006.

I have listed many issues that have been either very important or at least note worthy, but I will limit my comments to a few of them.

- **Planning & Communication Lacking - Planning ahead of time for this program didn't seem to take in to account the front-line pharmacist. I am at least above average at my pharmacy current events and I can assure you that we were not getting good information and instructions about this program. We had questions of our own regarding implementation and processes and our patients had questions regarding their enrollment or auto-enrollment. Needless to say, the communication was not adequate. What information I did get was simply because I sought it out at a deeper level than most pharmacists would (esp. non-owners). Some of the information that was given also didn't seem to really bear true after the ball got rolling.**

- **Short Time Frame – It seems obvious to me that the plan to move all of the dual eligibles and all of the other Medicare patients in to this system in 45 days was a bit ridiculous in it's self. To plan for this new benefit for 1 & ½ years and then only give 45 days is silly. I doubt very much that those in power at Medicare honestly went to bed on New Years Eve believing they were ready for this program. I think the blame should be given to whoever felt that 45 days from initial signup to program beginning was adequate and then whoever decided to push forward when all signs were showing major problems in the system being ready. Furthermore, we should have separated the dual eligible start dates from the others.**

- **Pharmacist Will do it for FREE – Our profession has a long history of performing services for free. In the past, prescription reimbursement was more reasonable and we could financially justify our services. Today, as everyone from our state to private insurance cuts reimbursement, this is not true anymore. I very much resent that my government took advantage of my deep commitment to my patients. They new that I would not leave them hanging. They new that I would step up and assist them in trying to figure out this ridiculous maze of a drug benefit that is hard for even me to understand. So basically, my organization in Coffeyville has spent in excess of 300 hours and somewhere between $7,000 and $10,000 to help implement a program that probably will financially be a negative for my business. Why should I bear this financial burden? Heck, at least give me a tax credit.**

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- **Eligibility Verifications (E1 Transmission)** - **While this concept is obviously great and I am sure in the long run it will work fine, it left much to be desired in the first month. Having it completely down the 1st couple of days and then part of the next several was a huge problem. This has been corrected, but the bigger problem for us has been its accuracy. We have found that this system is not very up-to-date. We have countless examples of patients that signed up for a plan on Nov 15th or 16th in our store and they don't show up on the system as having coverage. Furthermore, some of these patients were dual eligibles that show up on the system as having coverage from their Auto-Enrolled plan and not the patient selected plan. Most of the time, the patient was enrolled in the plan they had desired, but the E1 transmission was not updated. Basically, if the system is not updated often enough, it is somewhat worthless on the front line.**

- **PDP Help Desk – It is true that our staff and/or the patient was on hold for at least 3 hours with these plans the 10 days of this program. It has improved some, but still is lengthy. While I am frustrated with this, if the E1 transmissions had worked properly, the PDP's would not have been in this situation at all.**

- **Help our patients OR Send them packing – each of us sitting here today had to make tough choices regarding our patients and their medication needs. The fact was that despite all efforts, there were often times we couldn't guarantee that we would get paid in a reasonable amount of time or at all. We often went ahead and gave medications to these patients to keep them healthy. I want to say "Thank You" to the state and SRS for being responsive to this mess and switching coverage for the dual eligibles back on during this storm. It was a HUGE help and we appreciate it.**

- **Cash Flow – Yes, this is going to be a very real issue for many of the pharmacies in this state. There are 3 reasons for this.**

    - **When we provide medication to patients without proper billing taking place at all or delaying it until the plan info is provided, this will cause cash flow problems.**
    - **When we do have proper plan info, but the copays are coming back at 100% of the allowable charge, but the patient is a dual eligible, we know this not to be correct. If we dispense the medications to the patient without getting this corrected for sometime. While the KS Medicaid solution has been very helpful, it still was delayed and will create cash flow issues.**
    - **Regardless of these problems, cash flow problems are inevitable. We are taking large portions of our patients and moving them from one payment model to a new one. For example, dual eligibles fell under the Medicaid payment model of payments coming in every 2 weeks. Our cash paying customers often paid when they picked up their medications. For all of these patients, we now will be getting payments in 4 to 8 weeks. This is the standard time frame for these PDP's. So, cash flow issues will exist in spite of the other problems.**

Medicare Part D Testimony
Prepared for Senate Ways and Means Committee

By Terry Bradstreet

January 26, 2006

Kansas State Capitol
Topeka, KS 66612

Mr. Chairman and distinguished members of the Committee, I would like to thank you for the opportunity to speak to you today about Medicare Part D. My name is Terry Bradstreet and I am the Director of Pharmacy Operations for Dillon Stores. I have responsibility for 60 Community pharmacies that operate with in Dillon Supermarkets from Liberal, to Colby, to Leavenworth, to Pittsburg, Ks and points in between.

First, I would like to let you know that I am very proud of my pharmacists and my colleagues for the job that they are doing supplying the pharmacy needs to the people of Kansas during this trying time. We are taking care of their pharmacy needs.

I would like to start with a story to illustrate what is happening in our pharmacies. We received a call from a lady in Wellington, Ks., distraught over how difficult it has been to get here prescriptions filled. She has been a longtime customer of Dillons Pharmacy but when she signed up here insurance company told her she would have to go to another Pharmacy. Knowing no difference she went to the other pharmacy and had a horrible experience obtaining her medication. The copays were incorrect, she had to wait hours and finally got frustrated enough she came back to our pharmacy to complain. We told her that she could use Dillons pharmacy as she always had and she was happy but she had been give wrong information. She had that trust of her pharmacist that is so important in pharmacy but her insurance company told her she needed to change. We have worked through here issues and she has the correct medication with the correct copay and is very happy. She is still frustrated with the insurance company however. My point is we have uniformed people (insurance companies) giving information to consumers that is incorrect.

The second issue is with dual eligibles that are not enrolled in any PDP and the use of the Wellpoint/Anthem point of sale process that is supposed to pay for the prescription but additionally trigger a Sales person to contact the patient to get them signed up with a Medicare PDP. So once again we have the insurance company trying to enroll patients in plans and who knows if the plan is the appropriate plan. Meanwhile there is no guarantee of payment on the initial transaction.

The third issue that is of concern is that of the future and those individuals who haven't signed up for a plan yet and with the May 15th deadline approaching I can see the

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same issues hitting us hard again come deadline date. The data problems and misinformation issues cannot continue as May 15th approaches.

Topeka Independent Living Resource Center

785-233-4572 V/TTY • FAX 785-233-1561 • TOLL FREE 1-800-443-2207
501 SW Jackson Street • Suite 100 • Topeka, KS 66603-3300

DATE: January 26, 2006

TO: Senator Ruth Teichman, Chair, Senate Financial Institutions and Insurance Committee

FROM: Kevin Siek

RE: Medicare Part D Coverage of Non-Prescription Medications and Prescription Medications not covered by Medicare.

In yesterday's meeting of the Senate Financial Institutions and Insurance Committee, Senator Wysong raised the question of why people should included vitamins, mineral supplements and over-the-counter medications in the list of medications they share with people assisting them in selecting a Part D plan.

One very important reason for people who are dually eligible (i.e., people who receive both Medicaid and Medicare) it that many vitamins, mineral supplements and over-the-counter medications that were previously covered by Medicaid will still by covered under Part D.

Another important issue that I have not heard any one mention yet concerns prescription medications that are not covered by Medicare. There are certain prescription medications that Medicare will not cover, but for dual eligibles, Medicaid will continue to cover many of these medications. The problem is that not many people know this. Also, some of the high deductible drug plans have included some of these medications in their formularies.

That means that when an advocate is assisting a consumer in selecting a plan, if they don't know that a medication will be covered by Medicaid and include it in the list of medications, the system shows one of the high deductible plans as the most cost effective when actually there is at least one zero premium plan that would cover all there medications.

I have included the latest information I have on what medications will be covered by Medicaid in Kansas.

Also, of concern is what will happen in February to people who have not gotten prior approval for drugs not in their plans formulary. This is likely to be the next big problem with implementation of Medicare Part D. I have enclosed a copy of an update from the Center for Medicare Advocacy that discusses this issue in greater detail.

Please let me know if you have any questions regarding these issues.

Advocacy and services provided by and for people with disabilities.

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Medicaid Outpatient Drug Coverage
Excluded Drug Coverage Information By State
January 1, 2006

KANSAS
(Pending State Plan Amendment Approval)

DESCRIPTION

This chart provides information excluded drug coverage for this State. If additional information is required, please see the address for the State Medicaid's website.

MEDICAID ELIGIBILITY

This State provides coverage for the Categorically Needy and Medically Needy.

EXCLUDED DRUG COVERAGE

Drugs when used for anorexia, weight loss, weight gain
Some
Weight loss: Xenical, Meridia, Phentermine

Drugs when used to promote fertility
None

Drugs when used for cosmetic purposes or hair growth
None

Drugs when used for the symptomatic relief of cough and colds
None

Prescription vitamins and mineral products
Some
Select drugs

Nonprescription drugs (Over-the-Counter)
Select drugs in the following categories: Antipyretics, Analgesics, NSAID's, Heartburn Medications, Hydrocortisone Cream, Antihistamines, Antifungal Creams, Vaginal Creams, Antidiarrheals, Ocular lubricant gels and tears, Antibiotic creams and ointments, Topical anitparasitics, Nicotine patches

Barbiturates
Some
Phenobarbital

Benzodiazepines
Some
Clorazepate, Temazepam, Lorazepam, Alprazolam, Diazepam

Smoking Cessation (except dual eligibles as Part D will cover)
Some
Nicotine Patches

Center for Medicare Advocacy, Inc.

www.medicareadvocacy.org

CMA Weekly Alert – January 19, 2006

THE PART D PERFECT STORM: WHAT TO DO IF YOU CAN'T GET MEDICATIONS YOU NEED FROM YOUR MEDICARE PRESCRIPTION DRUG PLAN

Introduction

The media, and advocates for people with Medicare, are focusing on the problems of dual eligibles who cannot get access to medically necessary drugs because drug plans are not honoring their obligation to provide a transition supply of prescribed medications. Despite statements by the Centers for Medicare & Medicaid Services (CMS), these issues will not go away even as drug plans get their computer and customer service systems up and running. As more people enroll and use their drug plans, problems will persist. They may change, but they will not go away.

Medicare's "Transition" policy only requires a drug plan to fill a prescription for a non-formulary drug or for a drug that requires prior authorization or other plan approval *one time* when the person first enrolls in a drug plan. After receiving the transitional *first-fill*, the beneficiary is expected to either go through the process to get the drug paid for by the plan or get a prescription for a different drug that is on the plan's formulary from the treating physician. Unfortunately, advocates report that many people are leaving pharmacies without their medications. Even when beneficiaries are able to secure a transitional supply of medications, they are not being told that they must take further action to get their medications next month.

As a result, in February, we can expect people to be told once again by their pharmacy that their Part D plan will not pay for their medications. But next month, the plans will not be required to supply the medications, and most states will not fill in the gaps.

This *Weekly Alert* is designed to provide Medicare beneficiaries with information about the steps they need to take when they are told their drug plan will not pay for their medications.

What to Do When Your Drug Plan Won't Pay for Your Medicine

> ***ANY TIME you can't get your prescription filled, for ANY reason, you (or someone you authorize to act for you) must contact your Part D Prescription Drug Plan and ask for an official "coverage determination" to explain why you can't get your prescription filled. You need this official explanation before you can take steps to get the drug you need, and it will tell you what to do next.***

What happens at the drug store?

When your drug plan does not cover your medicine, your pharmacy should either give you a piece of paper telling you to contact your drug plan or have a sign posted that explains how to get more information. Even if your pharmacy tells you why the drug isn't covered, you still must contact your drug plan.

Your drug insurance card will have the drug plan's phone number. If you don't have a drug card, look in the *Medicare & You* Handbook you received in October or call 1-800-Medicare. (NOTE: Some plan phone numbers were listed incorrectly in the *Medicare & You* Handbook.)

How long do I have to call my drug plan?

You have up to 60 days to contact the drug plan for an explanation as to why it will not cover your medicine, but the longer you wait, the longer it may take for you to get your prescription. You can also send a written request to the drug plan. There is no special form to use, but you should say you want a "Coverage Determination" when making your request. (Some Coverage Determinations are called "Exceptions". See below for details.)

What happens when I call my drug plan?

Ask why coverage has been denied for your medication and state that you want a *written explanation.* The drug plan must issue a written "Coverage Determination" that gives the reasons for the plan's denial of payment for your prescription, and tells you what you need to do next to challenge the drug plan's decision. If at all possible, get a letter from your doctor explaining why you need the medication. Submit it to the plan and keep a copy for your records.

The drug plan must issue the written Coverage Determination, within 72 hours of your request. It may have to issue the decision within 24 hours if you ask for, and are granted, "expedited" review. If an expedited decision is important, get a statement from your physician explaining that this is necessary, and why. The plan may have to issue the decision even sooner if your health condition requires a more immediate answer. If you have already paid for the drug yourself, the plan will issue a decision in 72 hours. If the drug plan doesn't issue a decision in time, it is required to send your claim to an outside, independent reviewer.

What can I do if the drug plan denies my request to pay for the drug?

You have 60 days to ask the plan for a "Redetermination" of its original decision. Your drug plan may require you to make a request for a "redetermination" in writing. The unfavorable coverage determination will tell you how to request a redetermination.

If you request a Redetermination, your drug plan must issue a written decision within 7 days or within 72 hours if you are entitled to expedited review. The drug plan may have to make a decision more quickly if your health condition requires a more immediate answer. The plan will issue a decision in 7 days if you have already paid for your drug. If the drug plan doesn't issue a decision in time, it is required to send your claim to an outside, independent reviewer.

The written decision will explain the reasons for the drug plan's decision and tell you what to do next.

What happens if the drug plan continues to say it won't pay for the drug?

You have 60 days to file a written request for reconsideration with the Independent Review Entity (IRE). The request must be in writing; there is no option to call the IRE to request a redetermination.

The IRE is an independent company that contracts with Medicare to review prescription drug claims. Maximus is currently the company that has been hired by Medicare to perform this job.

The IRE will review the evidence and may contact you or your doctor. It will then issue a written decision that tells you the reasons for the decision and what you need to do next. The decision should be issued within 7 days or within 72 hours if you are entitled to expedited review.

What happens if the IRE denies my claim?

If the value of your claim is large enough, you may request a hearing before an Administrative Law Judge (ALJ). The hearing process for denied drug claims is the same as the process for appeals from denied hospital, nursing home, doctor, and other Medicare claims.

In 2006, your claim must be at least $110 to get an ALJ hearing. This amount may change each year. In determining this amount, Medicare will consider the cost of your drug over the course of the year. For example, if your drug costs $30, and you have 4 refills left, the value of your claim will be $120.

Can I appeal if the ALJ denies my claims?

Yes. You can ask for review by the Medicare Appeals Council (MAC) and even by federal court if the claim is large enough. Your claim must be worth $1090 to file an appeal in federal court in 2006. The written decision from the ALJ and then from the MAC will tell you how to proceed.

Involving Your Doctor in Your Appeal

> ***Your prescribing doctor plays a critical role if your drug claim is denied. In some cases, you cannot get the drug plan to pay for your drug without your doctor's help.***

When is help from my doctor required?

You must have a doctor's statement when you are requesting a *special type of Coverage Determination called an "Exception."* A plan will not grant your Exception request without a statement from your doctor.

When would I ask for an *Exception*?

You would ask for an Exception:

- When the drug you need is not on your drug plan's list of covered drugs (formulary),
- When your drug plan requires you to get its approval (prior authorization) before it will pay for your drug,
- When the drug plan wants you to try a less expensive drug before paying for the prescribed drug (step therapy or fail first),

- When the drug plan limits the number of pills you may have (quantity limits), or
- To reduce the co-payment you have to pay to a lower, less expensive tier of co-payments.

How do I ask for an Exception?

You ask for an Exception the same way you would ask for any Coverage Determination. It is important to note that ***your doctor can ask for an Exception for you***. Some drug plans may require your doctor to use a special form when asking for prior authorization or making a different exceptions request. Each drug plan may have its own form or forms.

Even if the plan allows the doctor to request an Exception by telephone, the doctor should follow the telephone request with a written statement.

What does the doctor's statement have to say?

Each drug plan sets its own requirements for the doctor's statement. You or your doctor should check with the Evidence of Coverage from your drug plan, or directly with the plan itself, to find out its requirements. At a minimum, the doctor's statement would have to show that you need to take the prescribed drug because taking any of the similar drugs on the plan's formulary would cause adverse health consequences, would not be as effective, or both.

What happens if the exception request is denied?

As described above, you can ask your drug plan for a redetermination, just as you would if you got any other unfavorable coverage determination. The rest of the appeals process is also the same as that described above.

Are there other times when I should seek help from my doctor?

A drug plan and the Independent Review Entity must grant a request to expedite a coverage determination (including an Exception), a Redetermination, or a Reconsideration if a doctor asks for expedited review. They do not have to grant such a request if you make it yourself.

You should ask your doctor to request expedited consideration when making an Exceptions request. The doctor should indicate that waiting for a decision during the standard time period could seriously jeopardize your health or life or your ability to regain maximum function.

Conclusion

CMS has stated publicly that Medicare beneficiaries will have access to a wide array of drugs, though they may have to use the exceptions and appeals processes to get some of them. Only time will tell whether beneficiaries and doctors find these processes easier to use than the transition and other processes CMS said would help all beneficiaries get their medicine when the new Part D drug benefit went into effect.

For more information, please contact attorney Vicki Gottlich (vgottlich@medicareadvocacy.org) in the Center for Medicare Advocacy's Washington, DC office at (202) 216-0028.