

Meeting the Challenges of the Medicare Drug Benefit Implementation

Testimony of Susan Sutter, RPh before the U.S. Senate Special Committee on Aging

February 2, 2006, Washington, DC

Wisconsin pharmacist and PSW President-Elect Sue Sutter testified before the U.S. Senate Special Committee on Aging on February 2 in Washington, D.C. She was asked to address issues of concern to pharmacists regarding the implementation of the new Medicare Part D benefit.

Sutter was invited to testify by Wisconsin Sen. Herb Kohl, the ranking Democrat member of the committee. Sen. Feingold of Wisconsin is also a committee member.

Good morning, Chairman Smith, Senator Kohl and members of the committee, thank you for conducting this hearing and for providing me the opportunity to address you.

My name is Susan Sutter and I am a pharmacist from Wisconsin. My husband and I are both practicing pharmacists and we have owned two pharmacies in the rural communities of Horicon and Mayville, which are between Milwaukee and Madison, for nearly 25 years.

I am also the President-elect of the Pharmacy Society of Wisconsin—the state’s professional society for pharmacists.

ON THE SIDE OF PATIENTS

When it comes to Medicare Part D, I have been asked which side I am on. It is critical for your consideration of my comments today to understand that my husband and I, as well as our pharmacist colleagues, are on the side of our patients. Pharmacists and seniors have been frustrated together with the rocky start to this new program.

IMPLEMENTATION CHALLENGES

It is important to emphasize that the provision of a pharmacy benefit for Medicare recipients is a valuable addition to the health care of everyone enrolled in the program—especially those without any prior prescription drug insurance. However, implementation and use of the Part D benefit has been an enormous challenge

for everyone involved.

Calling these challenges merely glitches diminishes what tens of thousands of pharmacists and pharmacy technicians have had to do in our attempt to provide medications to our patients when the system has not worked the way it is supposed to work. CMS has worked diligently to address many of the Part D problems, and some have lessened, but significant problems still remain, and millions of seniors are yet to enroll in the program.



DEFINING THE PROBLEMS

I won’t waste your time today by pointing fingers. Rather, my appeal to you is to acknowledge that the problems exist and for you to demand that they be corrected immediately.

I’ll begin with the complexity of the program. It must be made easier to understand, easier to enroll and easier to use. I recognize that can not happen overnight, but steps to simplify and standardize the Part D program can and should begin in earnest.

As part of my written testimony, I have

provided, for your consideration, a list of 15 specific problems and 15 corresponding recommendations for resolving those problems. Time does not permit me to review this list but please consider it a pragmatic tool for making Part D work. Some of the solutions I have outlined must be implemented by the prescription drug plans, some may require changes by CMS, and others may require Congress to act, but each deserves serious consideration.

The health care needs of Medicare patients are as diverse as their last names. But because PDPs have built their programs on norms, many of those diverse needs are not being met. For example, discharges of some hospitalized patients are being delayed because their at-home medications can not be authorized. Thousands of seniors at home, in assisted living facilities

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— Susan Sutter, RPh

ties and mental health clinics have lost the special packaging of medications they are reliant upon to take their medications safely and correctly because a PDP won’t authorize the packaging. These examples are prevalent and they have significant cost and quality of care consequences.

HOLDING RESPONSIBLE PARTIES ACCOUNTABLE

I have been surprised to see CMS make requests, not mandates, to the PDPs to get the program right. I think that is unacceptable and perhaps so does CMS.

It appears that CMS does not have sufficient authority to regulate PDP policies and activities. They should be given that authority and they should use it. And, there should be significant financial penalties assessed to the PDPs when they fail to perform.

To illustrate this point, after learning of coverage problems the first week of January, CMS asked for a second time that all PDPs remove prior authorization requirements and allow a one month transitional supply of each medication for every Part D enrollee. Some plans have complied with this request but many have left various hoops and hurdles in place that make it extraordinarily difficult to provide essential medication therapies.

For example, I have a plan that has refused coverage and is still requiring an extensive prior authorization process because the quantity of medication prescribed for a particular patient is beyond what the plan would expect for a "normal" month supply of medication, even though that quantity is the amount that my patient needs and has been stabilized on for her condition.

Insurance plan rules have over-ruled patient needs and it should be the other way around. Further, I should not be the person required to serve as the policy administrator for the PDP in order for the patient to receive his or her medications. This burdensome process must change.

PROVIDING FAIR TREATMENT

Medicare Part D was created so that recipients would be properly treated. In closing, I must emphasize that the nation's pharmacy providers must also be fairly treated. It hasn't happened, and it won't, unless Congress steps in. We pharmacists simply want to care for our patients and be paid for the services we provide. Rather than recognizing the valiant effort and sustained contribution of the nation's pharmacists over the past weeks, the Part D benefit is undercutting the financial viability of the very pharmacy infrastructure that it depends upon.

I look forward to your questions and I ask for your leadership and resolve in ensuring fair treatment, for both the recipients and the providers of the Part D benefit. Thank you. ●

Part D Problems and Solutions List

As determined by pharmacy providers, 1/31/06

General Prescription Drug Plan (PDP)/Medicare-Advantage Prescription Drug Plan (MA-PD)

OPERATIONS

PROBLEM: Insufficient PDP/MA-PD support for pharmacy providers and prescribers. Problems range from insufficient technology support (telephone circuits are busy) to insufficient competent staffing (telephone calls often not answered; callers cut off after being on hold for hours; customer service representatives unable to answer questions regarding eligibility, co-pay and deductible amounts, transition supply procedures, prior authorization/step-therapy/formulary requirements).

SOLUTION: Mandate sufficient competent staffing and broad dissemination of plan requirements/procedures. Help-lines (with competent staff) must be available at least 15 hours a day, 7 days a week. Plans must disseminate transition policies and prior authorization/formulary/step-therapy procedures to pharmacy providers and prescribers, and post such information on their Web site. Plans should be required to follow uniform procedures for providing transition supplies and for communicating with pharmacies.

PROBLEM: Patients unable to access medication while their doctors and pharmacists navigate plan formulary requirements. Although plans purport to offer a transition supply, procedures to access the supply vary from plan to plan. In some situations, procedures are not available to pharmacists or physicians because customer service representatives are unavailable or ill-informed. The result of these inadequacies is that recipients are left without medications or pharmacies are dispensing medications with no guarantee of payment. Neither is acceptable.

SOLUTION: Extend transition supply requirement to at least 30 days for all prescribed medications unless disallowed by MMA; mandate standard process for authorizing transition supplies via the claims-processing system. Require PDPs/MA-PDs to phase-in their formulary compliance efforts.

PROBLEM: PDPs/MA-PDs provide wrong cost-sharing information for patients eligible

for both Medicare and Medicaid, as well as for patients residing in long-term care facilities.

SOLUTION: Designate dual-eligibles on prescription drug benefit cards, allowing pharmacists to help patients determine appropriate cost-sharing and work with PDPs/MA-PDs to correct cost-sharing information. Require PDPs/MA-PDs to comply with claims processing standards to determine whether a patient is residing in a long-term care facility.

PROBLEM: Patients confused by prescription drug benefit cards containing the logos of certain pharmacy providers. Many enrollees incorrectly assume that the card may only be used at those pharmacies listed on the card.

SOLUTION: Require removal of all pharmacy logos from prescription drug benefit cards.

STRUCTURAL FLAWS

PROBLEM: Some medications are covered under Part D or Part B depending on use of the particular product, creating administrative burdens for prescribers and pharmacists.

SOLUTION: Direct CMS to establish a method to administratively simplify this confusing situation.

PROBLEM: PDPs have generally not negotiated business terms with pharmacy providers. Instead, PDPs mailed pharmacy providers take-it or leave-it contracts with terms that do not adequately pay for the medication dispensing services required.

SOLUTION: Require PDPs to verify that the payment terms included in the plan's standard pharmacy provider contract meet the average pharmacy costs associated with acquiring and dispensing a medication in each region.

PROBLEM: Pharmacy providers have been unable to verify authorization of payment from a PDP for a medication needed by Part D enrollees and dual-eligible recipients during the implementation of the Part D program. Many pharmacies have dispensed prescriptions to beneficiaries to make sure the patient received the necessary medication. These actions have placed the pharmacy at financial risk in the event that a plan does not reimburse the pharmacy for the medication dispensed.

SOLUTION: Require prompt, efficient and adequate payment to pharmacy providers, by either a PDP or by CMS, for all medications dispensed by pharmacies, in good faith, to persons who were presumed eligible for the Part D program.

PROBLEM: Eligibility verification and enrollment systems cannot support the promise that a beneficiary who enrolls on the 31st of January will have coverage available in the pharmacy on February 1. When the eligibility information does become available and pharmacy staff can look up eligibility information via the claims processing system, pharmacies must pay to access the information.

SOLUTION: Change consumer communication to explain that while their coverage is effective the next month, they should refill their medications in their usual cycle, requesting the refill five to seven days before they will run out of medication. Change enrollment standards so that any enrollment form received by a plan by the 15th of the month will have coverage starting the first of the following month. Suspend charges to pharmacies for use of the eligibility verification system.

PROBLEM: Failure of PDPs/MA-PDs to compensate pharmacists for time spent determining eligibility, coordinating benefits, and participating in formulary compliance efforts.

SOLUTION: Mandate PDP/MA-PD payment to providers for these services, in addition to dispensing fees and compensation for medication therapy management services.

PROBLEM: Some dual-eligibles were auto-enrolled in PDP/MA-PD plans that are not accepted by their pharmacy provider. While the patient may change to a plan accepted by their pharmacy for coverage effective next month, their option for securing medications in the current month is to pay cash and await reimbursement from the plan or to move all of their prescriptions to another pharmacy for one month, if another pharmacy is even accessible.

SOLUTION: Require plans to pay out-of-network pharmacies (not beneficiaries) when beneficiaries' auto-assigned plan was not accepted at their pharmacy.

PROBLEM: PDP/MA-PD coverage of medication therapy management insufficient to improve medication use. There is no standard of MTM service expected by CMS.

SOLUTION: Mandate PDP/MA-PD coverage of baseline medication therapy management services and direct PDPs to contract with pharmacy providers for such services.

PROBLEM: PDPs/MA-PDs are not required to pay pharmacies in any specific time

frame. With many eligibility problems still unresolved, many practices will be required to pay for medications dispensed to Medicare beneficiaries, but without payment or assurance of payment from PDPs/MA-PDs.

SOLUTION: Require PDPs/MA-PDs to pay pharmacies at least twice monthly.

Problems for Patients in Long-Term Care Facilities, Assisted Living Facilities, or Using Home Infusion Services

PROBLEM: Patients in long-term care facilities may receive medications via unit-dose packaging for a calendar month (up to 31 days supply.) PDPs/MA-PDs are limiting medication supplies to 30 days.

SOLUTION: Require PDPs/MA-PDs to pay for one-month supplies if that is what is dispensed, not merely 30-day supplies.

PROBLEM: State law may require special medication packaging for patients who reside in assisted living facilities or other environments, but PDPs/MA-PDs refuse to pay for the safety packaging.

SOLUTION: Require PDPs/MA-PDs to pay for the medication packaging services needed by any given Medicare recipient.

PROBLEM: Patients are staying in the hospital longer than clinically necessary while their doctors secure approval from PDPs/MA-PDs for home infusion medications and supplies, medications requiring approval by the PDP, and for some medications needed in the long-term care facility. In some situations, PDPs/MA-PDs refuse to pay for supplies and services necessary for proper administration of the medication.

SOLUTION: Mandate 24-hour response time by each PDP for all medication approval processes, and mandate coverage of all necessary home infusion supplies and services. ●

Regional HHS Director Visits Wisconsin Pharmacy

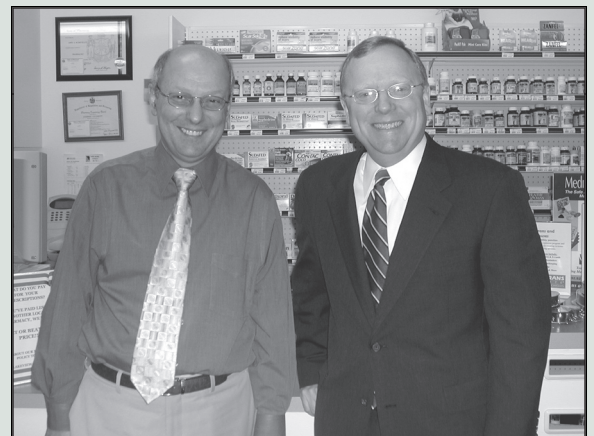
On Thursday, Jan. 26, 2006, Douglas O'Brien, Regional V Director of the U.S. Department of Health and Human Services (HHS), visited Lakeview Pharmacy in Racine. In true Racine fashion, Pete Ciaramita, RPh, owner of Lakeview Pharmacy, greeted O'Brien with Kringle and coffee.

O'Brien visited Lakeview Pharmacy in southeastern Wisconsin to get a sense of the issues occurring with Part D implementation in pharmacy settings. Lakeview Pharmacy provided him with a comprehensive look at both the retail and LTC-related challenges associated with the new Medicare program.

"At one point, I thought his eyes would pop out of his head," Ciaramita said of O'Brien's reaction.

Despite O'Brien's surprise at the extent of many of the Medicare Part D start up issues – from eligibility line problems with PDPs to 30-day supply caps on 31-day prescriptions – the meeting was pleasant and positive. The discussion centered not only on the many problems encountered by pharmacists during the program's launch, but also on the efforts being made by HHS and Medicare to help eliminate the problems and hold accountable those responsible.

Both Ciaramita and O'Brien expressed confidence that the challenges currently faced by pharmacy would eventually be resolved. ●



Pete Ciaramita, RPh (l) and HHS's Douglas O'Brien (r)