Dually Eligible Hit Hardest

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viewing the Medicare and drug plan Web sites, Dr. Wright said he still has unanswered questions about how to help his low-income Medicare patients apply for the "extra help" subsidy.

That low-income subsidy is especially important for his Medicare patients who do not qualify for Medicaid, he said. But without information about how to enroll, they can't choose a drug plan because they don't know how much it will cost. In some cases, these problems with logistics are delaying treatment.

Dr. Wright also described the challenges facing patients who are dually eligible for Medicare and Medicaid. These patients were automatically enrolled in a Part D drug plan before the beginning of the year. But technical glitches in the transmission of that enrollment information from Medicare to the drug plans have left many patients with the choice of covering the costs themselves or leaving the pharmacy without their medications (see sidebar).

Automatic enrollment of dually eligible beneficiaries has been far from hassle free. For example, many patients were signed up for plans that don't cover their medications. Individuals are allowed to switch plans, but doing so means facing the difficulties that automatic enrollment should have enabled them to circumvent, such as analyzing the formulary lists for all the various plans, Dr. Wright said.

As of Jan. 13, the Department of Health and Human Services reported that 14.3 million Medicare beneficiaries had enrolled in a Part D drug plan. Nearly half of those enrolled—6.2 million—are beneficiaries who are dually eligible for Medicare and Medicaid and were assigned to Part D plans. In addition, 4.5 million have enrolled in Medicare Advantage plans, which include drug coverage, and 3.6 million have signed up for stand-alone drug plans under Medicare.

AARP—which sponsors a Part D prescription drug plan for AARP members—reports that overall the benefit implementation is going well. George Keleman, campaign manager for the AARP Medicare Rx Outreach Campaign, said the bulk of reported problems relate to communication system failures between Medicare, the drug plans, and the pharmacies that have mainly affected dual-eligible beneficiaries.

Dr. Donna E. Sweet, an internist in Wichita, Kan., and chair of the board of regents for the American College of Physicians, has seen those problems firsthand in her practice. Dual-eligible patients with AIDS are hit the hardest because they are on three- or four-drug regimens that must be taken to prevent the development of drug resistance. "They are leaving the pharmacy without medications," she said.

In most cases, she said, the issue isn't that the drugs aren't covered by the participating drug plans but that the patient is either not in the system or is listed incorrectly and thus asked to pay a high copay or deductible.

Among her other patients, she's observed that the very elderly—those aged 90 and older—are opting out of the process entirely. For those patients who have selected a Medicare drug plan, Dr. Sweet has spent a lot of time reviewing formularies to determine the best plan based on each individual's needs. "It's a tremendous amount of staff and physician time," she said.

But Dr. Sweet said that in the long run, the program will be an asset for most seniors.

Dr. James G. Cunnar, a family physician in Naperville, Ill., said that most of his Medicare patients are waiting to see how the implementation progresses before deciding whether to join a plan. For his part, he has been trying to get patients as much information as possible about the program and has even reviewed the Medicare Web site (www.medicare.gov) with some individuals to help them narrow down their drug plan choices.

Dr. Cunnar added that he has no problems using the Medicare Web site and finds it to be intuitive and helpful. But he noted that some patients will need extra help navigating the site, and he advises them to enlist a family member—even if it's a computer-savvy grandchild. "We need to empower not just patients, but families," he said.

While more formularies will likely mean more work for physicians and their staff members, Dr. Cunnar predicts that over the long run, the prescription benefit will improve medication compliance and outcomes. ■

CMS Promises to Repay States for Expenses of Stopgap Drug Coverage

The federal government and private drug plan sponsors will reimburse states that have provided drug coverage to Medicare beneficiaries since the Medicare Part D prescription drug benefit went into effect on Jan. 1.

Twenty-five states and the District of Columbia have been paying for prescription drugs on an emergency basis for beneficiaries who are dually eligible for Medicare and Medicaid but have had difficulty getting their medications. Starting on Jan. 1, people who were eligible for both Medicare and Medicaid had their drug coverage transferred from the states to a Medicare prescription drug plan.

At the end of January, officials at the Centers for Medicare and Medicaid Services announced that they would begin a demonstration project that will allow them to ensure that states are fully reimbursed for their costs from the first date the state paid claims until Feb. 15.

The states will be reimbursed by the prescription drug plan sponsors for contracted costs, and Medicare will pay any remaining drug costs. CMS will reimburse states for their administrative costs.

The move came just days after a group of senators introduced legislation—the Medicare State Reimbursement Act (S. 2181)—that would require the federal government to reimburse states for all of their costs plus interest.

Sen. Frank R. Lautenberg (D-N.J.), the chief sponsor of the legislation, said the CMS plan does not change the need for legislation. "This is no solution," he said in a statement. "It is simply more red tape from the Bush Administration."

Sen. Lautenberg said the CMS plan will put a greater burden on the states by forcing them to act as bill collectors.

CMS Cites Drug Discount Card Program's Woes as Clues for Planning

BY JOYCE FRIEDEN
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The experience of the drug discount card program that Medicare beneficiaries participated in prior to the launch of the Medicare drug benefit offers some lessons for the Centers for Medicare and Medicaid Services, the Government Accountability Office said in two reports.

In its first report, the GAO said that although the Centers for Medicare and Medicaid Services (CMS) had identified and corrected some problems with the entities that sponsored the drug cards, it also "had some limitations with respect to the timeliness of oversight activities and the guidance provided to sponsors."

'We have learned many valuable lessons that will inform our future efforts as we plan for the drug benefit in 2006,' said CMS chief Dr. Mark McClellan.

For instance, the report noted, "CMS finalized guidance on how drug card sponsors should report data on price concessions from manufacturers and pharmacies in November 2004, about 5 months after the program began.

According to CMS, as of August 2005, the overall quality of that data remained questionable, with problems such as outliers and missing data."

The report also noted that a CMS contractor requested two preenrollment information packets from six drug card sponsors.

"All the packets were noncompliant with program requirements," the report said. "Most packets were missing materials required by CMS and some materials had not been previously approved for distribution by the CMS contractor. The contractor never received several requested packets." CMS told the GAO that it had worked with the sponsors to resolve the problems.

For its part, CMS said in a letter to the GAO that the report "did not paint a full picture of the depth and breadth of the actual monitoring and oversight activities." Dr. Mark B. McClellan, CMS administrator, acknowledged that with the discount card program, "We have learned many valuable lessons that will inform our future efforts as we plan for the drug benefit in 2006."

The second report looked at CMS's beneficiary and outreach education efforts for the discount card program. In general, the GAO found that "CMS's efforts did not consistently provide information that was clear, accurate, and accessible, and they collectively fell short of conveying program features." The report did add, however, that the GAO got this impression by looking at assessments that CMS has done on its own programs, and "these assessments acknowledge the actions taken by CMS to address some of these problems."

Beneficiary confusion about the discount card program was a particular problem, the report said. In spite of CMS's outreach efforts, "Beneficiaries confused the drug card with the 2006 prescription drug benefit, and some beneficiaries did not enroll because they were under the impression that Medicare would be sending them a card. Furthermore, the concept of a private drug card sponsor was difficult for many beneficiaries to understand."

Beneficiaries also were confused about eligibility, the report said. CMS's own research found that some beneficiaries might not have enrolled because they thought they were not eligible for the discount cards.

"Specifically, many beneficiaries incorrectly thought that the drug card was only for low-income people, and those who likely qualified for the $600 in transitional assistance did not believe they qualified for it, even after having the income criteria explained to them," the report noted.

In response to the second report, Dr. McClellan said that it, like the first report, did not address the "full picture of the depth and breadth of the actual activities undertaken." Dr. McClellan said that the number of education and outreach activities was "unprecedented for a program of limited duration."

As he did in responding to the first report, Dr. McClellan said that the lessons learned from this portion of the discount card program would be applied to the drug benefit. But he also added, "From a public service perspective, the most important question about the drug discount card is whether the program provided discounts and access to prescription drugs for any beneficiary who wanted help. The answer is yes, immediately." ■

The reports are available at www.gao.gov.