

Governor's Advisory Council on HIV/AIDS

Implementation of the Medicare Modernization Act Findings and Recommendations

Background

As a follow-up to its May 2004 public forum on the potential impacts of the Medicare Modernization Act, the Governor's Advisory Council on HIV/AIDS (GACHA,) convened a panel to discuss the effects of the Act's implementation, specifically the new drug benefit, Medicare Part D. This discussion took place March 14, 2006, 10 weeks into the new benefit. GACHA heard comments from HIV case managers, medical providers, pharmacists, and consumers. The Washington State Health Insurance Pool (WSHIP,) the Evergreen Health Insurance Plan (EHIP,) the Department of Health and representatives from the Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA) also took part in the discussion. (A meeting agenda with a list of participants is attached.)

Summary of Key Findings

State and federal officials face an enormous task with Medicare Part D. The challenge is to enroll thousands of patients with individual needs in one of several dozen prescription drug plans (PDPs) which best meet their unique circumstances. In many cases, this new benefit must be coordinated with existing insurance and drug assistance programs. For the sake of the patient's health, all this must be accomplished without an interruption in the availability of prescription drugs. **For the most part, while there has been confusion, anxiety and frustration, transition to the new benefit seems to be progressing smoother in Washington State than elsewhere.**

There have been exceptions. **There have been significant delays of documentation of coverage to pharmacies, with some patients given inaccurate co-pay requirements and inaccurate information about covered drugs. The result has been some patients being refused drugs, either because of the lack of coverage documentation or an inability to make larger than expected co-payments.** The refusals came despite efforts by the governor (by way of written assurances) to pharmacists that where glitches in the system were the likely cause, patients should be granted an emergency 30-day supply of their medications.

Some pharmacies, including rural and mail-order are not processing secondary, or in the case of dual eligibles, third-party billing (to WSHIP or Medicaid as examples,) which may be causing an unknown number of patients to forgo drugs because of an inability to make the required co-payment, or deductible.

Pre-authorizations, particularly for medications used to treat AIDS wasting syndrome are a major problem. And once granted it is not known whether the authorization is for 30-

days or long term. Pharmacists and providers also noted it would be helpful if there were one uniform pre-authorization form. While CMS has introduced a uniform pre-authorization form, it is not being utilized.

The governor's decision in mid-February to use state Medicaid dollars to cover the co-pays for dual eligible patients (an earlier GACHA recommendation) is of great assistance **but this commitment from the state is only assured until June 30, 2007. If not extended, co-pays may again be problematic for some patients.**

Some EIP patients with spend-down requirements are worried they will not be able to meet those requirements now that medication costs, previously counted towards spend-down (even though the costs were paid by EIP,) are no longer being counted against the spend-down requirement. Consequently some may lose their low-income subsidy and EIP coverage.

There is significant concern about the gap in coverage for those who do not qualify for SSA's low-income subsidy. **State AIDS Drug Assistance Program (ADAP) costs could rise as these patients turn to it for assistance and patients would also be restricted to only those medications on the EIP formulary.**

Patients are concerned that plans may drop drugs from their formularies, leaving them in a plan which no longer works for them; and, patients worry that new drugs won't be added to their plans.

While the majority of the Department of Health's EIP clients have been enrolled in the new benefit, **any who fail to enroll may lose all drug coverage after May 15th and may not be eligible again until January 1, 2007, thus eliminating the state's safety net for HIV patients.**

WSHIP was able to become a CMS-approved state pharmaceutical assistance program (SPAP). **This enables WSHIP to pay client's out of pocket costs, including the infamous "donut hole" in the middle of the coverage period, and these payments are counted towards the patient's true-out-of-pocket costs (TrOOP).** Thus, clients qualify for Medicare Part D's catastrophic coverage, resulting in significant cost savings to both WSHIP and the client. The main requirement for an SPAP is that the funds are non-federal funds.

Recommendations

On the State Level:

- 1. The Department of Health should investigate the feasibility of establishing a state-funded State Pharmaceutical Assistance Program (perhaps through EHIP) to both contain and perhaps reduce ADAP costs, while ensuring that a safety net remains in place for state residents with HIV.**
- 2. EIP accounting systems should be changed to fully segregate federal and matching state dollars from non-matching state funds, thus allowing EIP to be a payer of last resort (and a safety net) for those unable to access other forms of coverage.**
- 3. EIP should send letters to case managers of clients who have yet to enroll in Medicare Part D, reminding them of the impending deadline. EIP should also verify through a legal opinion that its interpretation of required drug assistance cut-off (absent Part D enrollment) is correct.**
- 4. The Department of Health should not force clients into Medicare Part D plans, where other viable options exist.**
- 5. The state should continue making the co-payments for dual eligible patients, who otherwise may go without their prescription drugs.**

On the Federal level:

- 1. Medicare's Part D Prescription Drug Providers (PDP's) should be reminded of their responsibility to bill secondary insurers, so that patients don't have to front what to many are unaffordable (yet reimbursable) deductibles or co-payments.**
- 2. CMS should require the use of one uniform pre-authorization form.**
- 3. Once a pre-authorization is granted, it should remain in force for the remainder of the coverage year.**
- 4. If a PDP drops a drug from its formulary, consumers should be allowed to immediately change PDP's.**
- 5. ADAPs should be allowed to have their contributions count towards a patient's true-out-of-pocket costs.**
- 6. The legislative bar on states being able to use federal Medicaid dollars to cover co-pays for dual eligibles should be repealed.**

Complete Findings

Medicare's new prescription drug benefit (Medicare Part D) began January 1, 2006. For many (those on Medicaid and other drug assistance programs) the new benefit required a transition to a new system, new providers, new co-pays and coordination with their existing benefit programs. Particularly for those with HIV, a seamless transition was the goal given the health dangers an interruption of drug coverage would pose.

Washington State began its planning for the conversion in early 2004, with GACHA convening one of the first public forums in the state on the topic. This preparedness seems to have paid off, with the transition in the state going smoother than in other states. This isn't to say, however, that there hasn't been confusion, anxiety and frustration.

There have been significant delays of documentation of coverage to pharmacies, with some patients given inaccurate co-pay requirements and inaccurate information about covered drugs. The result has been some patients being refused drugs, either because of the lack of coverage documentation or an inability to make larger than expected co-payments. The refusals came despite efforts by the governor (by way of written assurances) to pharmacists that where glitches in the system were the likely cause, patients should be granted an emergency 30-day supply of their medications. CMS is addressing this issue by use of a "crisis" intake form. This form was supplied to GACHA and distributed by the Department of Health to case managers and other interested parties.

Some pharmacies, including mail-order are not processing secondary billing (to WSHIP as an example,) which may be causing an unknown number of patients to forgo drugs because of an inability to make the required payment, be it a co-payment or a deductible.

Pre-authorizations, particularly for medications used to treat AIDS wasting syndrome are a major problem. And once granted it is not known whether the authorization is for 30-days or long term. Providers report having to re-file the pre-authorization request at 30-day intervals, an extremely time-consuming and unnecessary step.

Pharmacists and providers also noted it would be helpful if there were one uniform pre-authorization form. CMS noted it was aware of the problem and is planning to encourage that PDP's use a uniform pre-authorization form.

The governor's decision in mid-February to use state Medicaid dollars to cover the co-pays for dual eligible patients (an earlier GACHA recommendation) is of great assistance but this commitment from the state is only good until funds run out then co-pays may again be problematic for some patients. It's estimated the funds will last through 2006. What happens in 2007 is uncertain. GACHA noted in its May 2004 report that numerous studies have concluded that even small co-pays can be a barrier to accessing prescription drugs for some patients.

Some EIP patients with spend-down requirements are worried they will not be able to meet those requirements. Previously, a patient was allowed to count his or her medication costs in the spend-down equation, even though those costs were reimbursed by EIP. Under Medicare Part D,

medication costs are eliminated or significantly reduced, thus making reaching spend-down problematic for some. Consequently, these patients (on the cusp of low-income requirements) may lose their low-income subsidy and EIP coverage in 2007, when their “grandfather” status expires.

There is significant concern about the gap in coverage for those who do not qualify for SSA’s low-income subsidy. Once the gap is reached these patients could turn to the State AIDS Drug Assistance Program (ADAP) for assistance. That would cause ADAP costs to rise. Additionally, patients would be restricted to only those medications on the EIP formulary.

Under Medicare Part D, PDP’s are allowed to drop covered drugs from their formularies once notice is provided. But consumers are only allowed to switch PDP’s during the once-yearly enrollment period. Patients are worried that plans may drop drugs from their formularies, leaving them in a plan which no longer works for them. Although PDP’s are required to have standing committees to promptly evaluate new drugs, patients are concerned that new drugs won’t be added to their plans.

The Department of Health has enrolled all but 45 of its EIP clients in the new benefit. EIP reports that its funding requirements mandate that if a Medicare-eligible patient fails to enroll in a PDP by May 15th, EIP will not be able to provide drug coverage to those patients. Those clients would not be eligible for coverage again until January 1, 2007. For them there is no state safety net, which was one of the prime goals of the two-decade old AIDS-omnibus legislation.

WSHIP was able to become a CMS-approved state pharmaceutical assistance program (SPAP). This enables WSHIP to pay client’s out of pocket costs, including the infamous “donut hole” in the middle of the coverage period, and these payments are counted towards the patient’s true-out-of-pocket costs (TrOOP). Thus, clients qualify for Medicare Part D’s catastrophic coverage, resulting in significant cost savings to both WSHIP and the client. The main requirement for an SPAP is that the funds are non-federal funds.

If the DOH supported the creation of an SPAP for HIV patients, perhaps through the Evergreen Health Insurance Program, there could be similar cost savings to both the state and patients.

Cost savings to the state would also be realized if the federal regulations allowed state ADAPs to count their contributions towards a client’s true-out-of-pocket costs, which would allow catastrophic drug coverage to take effect.