

Office of External Affairs

MEDICARE FACT SHEET

FOR IMMEDIATE RELEASE
March 31, 2006

CONTACT: CMS Media Affairs
(202) 690-6145

Transition Fact Sheet

Medicare's highest priority is making sure that Part D beneficiaries have access to the drugs they need. Millions of prescriptions are being filled every day, with Medicare drug plans generally covering a broader range of drugs than many public and private health insurance plans.

Just like any other insurance plan, Medicare drug plans have preferred drugs and prior authorization requirements to promote safe and effective drug use and to avoid unnecessary costs. To help ensure smooth transitions to drugs that are covered, and to allow beneficiaries time to obtain exceptions to these requirements when clinically appropriate, Medicare called on plans to implement a three-month initial transitional period for Medicare prescription drug coverage.

While that transition period is ending, Medicare's requirement that prescription drug plans have an effective transition process is permanent. This requirement continues to apply for beneficiaries who did not complete the transition process during the 90-day transition period.

First and foremost, at all times, Part D plans have an important role in communicating with their enrollees and informing them about what they need to do to make a successful transition. They also need to make timely decisions on enrollees' requests for exceptions and appeals.

Medicare Part D enrollees should not have to learn at the pharmacy counter about their need to obtain prior authorization for a drug or transition to a different drug, nor should they face delays at the pharmacy counter because exceptions requests have not been resolved.

Throughout the transition period, CMS has repeatedly corresponded with plans outlining their role in assisting beneficiaries in this transition. These communications include:

- **Transition Policy Reminder** (January 6). CMS informed prescription drug plans that delaying or denying initial prescriptions for new enrollees at the pharmacy counter with prior authorization or step edit requirements is not consistent with CMS's transition policy.
- **Further Transition Policy Reminder** (January 13). CMS clarified our guidance and told plans that they need to have a process that ensures that "first fill" prescriptions are filled promptly.

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- **Collaborative Next Steps** (January 18). CMS asked plans to provide beneficiaries with a temporary supply of medically necessary, non-formulary medication in order to smooth the transition process. We also pointed out that plans should use sound judgment to extend coverage in special situations where a longer transition may be required for medical reasons.
- **Transition Extension** (February 2). CMS called for an across-the-board extension of this temporary supply until March 31 for individuals enrolled during the first three months of the program.
- **Transition Next Steps** (March 17). CMS reminded plans that the purpose of the required transition process is not simply to provide a temporary supply of non-formulary drugs, but to provide enrollees with sufficient time and guidance to work with their health care providers to switch to a therapeutically appropriate formulary alternative, or to request a formulary exception if medically necessary.
- **Critical Next Steps as Transition Period Ends** (March 29). CMS reiterated that plans should provide enrollees who have used a transition benefit with the appropriate assistance to help them successfully transition to a formulary drug or take the necessary action to maintain their current medication.

CMS made it clear that it is holding plans accountable for meeting their contractual requirements for resolving exceptions and appeals. CMS is monitoring plan performance and expects them to provide a temporary prescription drug supply when they are unable to meet established timeframes. In addition, CMS will impose corrective action, and where necessary employ stronger sanctions—including civil monetary penalties—when enrollees are unable to obtain the drugs they need on a timely basis.

Approaches plans can take to help enrollees understand what they need to do to successfully transition to Part D coverage include:

- Analyzing claims data to determine which enrollees needed additional information;
- Contacting enrollees to ensure they have the information they need to enable them to switch to an on-formulary drug, or whether they need to get a prior authorization from their doctor or file a formulary exception request;
- Increasing staff, call center, and pharmacy line capacity to respond to an anticipated increase in the volume of exceptions requests; and,
- Extending the transition period, on a case-by-case basis, if the enrollee's exception request or appeal has not been processed by the end of the transition period.

CMS has also taken additional steps to assist physicians, pharmacists and other health care professionals assure a smooth transition.

For physicians and other health care providers:

- CMS has an extensive outreach program to health care providers to inform them of the resources available to them to help their patients through this transition period.
- CMS offered a formulary finder on its website to enable providers to find plans in their states matching the patient's required drug list. In addition we worked with Epocrates, the medical software company, to make formulary and other coverage information available to providers.
- CMS distributed and posted a "Transition Toolkit," including information about exceptions and appeals and other elements of a smooth transition, to providers.
- CMS has provided links to plan formulary and coverage information.
- CMS has supported the work of health plans, physician groups, and other stakeholders to develop a consistent form for straightforward processing of formulary exception requests, as well as for common prior authorization requests.

For pharmacists:

- CMS communicated extensively with chain, independent and LTC pharmacies to make sure they were informed about transition issues and able, when called on, to assist their customers with Part D prescription coverage.

Issues of *Medicare Rx Update* with specific information about the transition process have reached pharmacists eight times since December, and we have held special "Open Door Forum" sessions during the transition period to provide pharmacy-specific information on the transition and to enable pharmacists to call in and speak directly to CMS staff.

- CMS has supported the work of health plans and pharmacy groups to develop consistent codes and responses for pharmacy billing systems, to significantly reduce the time and usual administrative costs faced by pharmacists in dealing with a range of health plans. In particular, the codes will provide consistent messages to the pharmacist on such issues as off-formulary drugs, prior authorization, quantity limits, and drugs not covered under Part D.
- CMS required pharmacists to post the Model Pharmacy Notice, which outlines the beneficiary's rights to exceptions and appeals.

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