



CMA Weekly Alert – January 4, 2007

## **MEDICARE PART D: TRANSITIONING INTO 2007**

### **INTRODUCTION**

Many Medicare beneficiaries will experience changes in their Medicare Part D prescription drug coverage in January 2007. Some beneficiaries may be in a new drug plan either because they chose a new plan or because they were reassigned from a drug plan that no longer qualifies as a “benchmark” plan for low-income subsidy purposes. Other beneficiaries may be in the same drug plan, but the formulary or utilization management tools may be different in 2007. Beneficiaries need to be aware of what protection is available to allow them to continue with their medication during the transition from their 2006 to their 2007 coverage.

### **TRANSITION GUIDANCE**

The Centers for Medicare & Medicaid Services (CMS) issued Guidance to address some potential transition problems. See, “Calendar Year 2007 Transition Guidance,” <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CY07TransitionGuidance.pdf>. The Guidance provides answers to the following problems:

#### **A Beneficiary Enrolls In, During an Initial Enrollment Period, a Part D Plan That Does Not Cover All of Her Drugs:**

- The plan should fill a one-time, 30-day transition supply of the medication (“transition fill”) within the first 90 days of enrollment.<sup>1</sup>
- The plan should charge the relevant low-income subsidy (LIS) cost-sharing or, if the individual does not qualify for LIS, the cost-sharing used for non-formulary drugs approved through the exception process.
- The plan should mail a notice to the beneficiary within 3 days of the transition fill describing the need to request an exception or to change to a formulary drug.
- The plan should make prior authorization and exception request forms available by mail, fax, e-mail, on the plan’s website, and by link to the CMS web site.

*The transition process described above is the standard process available to all beneficiaries who are eligible for a transition fill.*

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<sup>1</sup> A beneficiary who currently resides in, moves into, or moves out of a skilled nursing facility may be entitled to a 31-day transition fill, with multiple refills as needed, for up to the first 90 days in the plan.

### **A Beneficiary Changes to a Drug Plan in 2007 That Does Not Cover All of Her Drugs:**

- The beneficiary is entitled to the standard transition process described above.

### **A Beneficiary Who Changes Drug Plans in 2007 is Prescribed a New Medication Within the First 90 Days of Coverage Under the 2007 Plan and the New Medication is Not On the Plan's Formulary:**

- If the plan can distinguish that the drug is a new prescription, the plan does not have to provide a transition fill, and the beneficiary must seek an exception or change medicines.
- If the plan cannot distinguish a newly prescribed medication, the plan transition process described above should apply.

### **Medications Taken by a Beneficiary In 2006 are On Her New (2007) Drug Plan's Formulary But are Subject to Utilization Management Requirements:<sup>2</sup>**

- The transition process described above should apply to any medication the beneficiary had previously taken.
- No transition process applies, however, if the prescription is for a new medication and the plan can distinguish, at the point-of-sale, a new prescription from a prescription the beneficiary had previously been taking.

### **A Beneficiary Remains In the Same Drug Plan In 2007, But the Drug Plan Removes a Prescription the Beneficiary Uses From Its Formulary or Adds Utilization Management Requirements:**

- The beneficiary should have received an Annual Notice of Change (ANOC) from the drug plan that described the formulary change.
- If the beneficiary did not seek an exception before December 31, 2006, the transition process described above should apply.

### **A Beneficiary Remains In the Same Drug Plan In 2007 and Continues to Require a Prescription for Which the Plan Granted the Beneficiary an Exception In 2006:**

- The drug plan *may* continue the exception in 2007.
- If the drug plan chose not to honor the exception in 2007, the plan should have notified the beneficiary 60 days before the end of 2006<sup>3</sup>, and it should either
  - Have offered to process a prospective exception for 2007, or

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<sup>2</sup> Utilization management requirements include quantity limits, step therapy (an enrollee must try a less costly drug before the prescribed drug is covered) and prior authorization (the prescribing physician must get the drug plan's approval before the plan will pay for the prescribed drug.)

<sup>3</sup> Plans that informed beneficiaries in their written decision granting an exception that the exception would end on December 31, 2006, did not have to provide separate notice. Other plans could have included the information that exceptions would terminate at the end of 2006 in their Annual Notice of Change or in a separate letter sent to enrollees.

- Provide the beneficiary with a temporary supply of the drug in the beginning of 2007 as well as with notice of the need to change to another drug or seek another exception, i.e., the standard transition process should apply.

## **IF PROBLEMS OCCUR**

If a transition prescription fill is denied:

- The beneficiary should contact the drug plan right away to determine the drug plan's transition policy and to alert the plan to the problem.
- If the beneficiary disagrees with the determination of the drug plan, the beneficiary may
  - File a grievance with the drug plan,
  - File a complaint with the CMS regional office.
- Regardless of whether a transition fill is provided, the beneficiary must either
  - Seek an exception so that the plan will cover the drug, or
  - Talk to the prescribing physician about changing to a formulary drug.
- A beneficiary may contact the local State Health Insurance Assistance Program (SHIP) for assistance in resolving the problem. Beneficiaries may call the Elder Care Locator, 1-800-677-1116, for a referral to their SHIP.

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