



CMA Weekly Alert – December 5, 2005

LOST IN TRANSITION: WHAT IF A DUALY ELIGIBLE BENEFICIARY ISN'T AUTO-ENROLLED IN A MEDICARE PART D PLAN?

What will happen to dual eligible individuals who have not been automatically enrolled in a Medicare Prescription Drug Plan or who have not chosen a plan on their own, if they try to obtain prescriptions at a pharmacy on January 1, 2006?

According to CMS there were 6,130,120 full benefit dually eligible individuals, plus a predicted 200,000 new duals over time based on those applying for the low income subsidy (LIS) who were screened and determined Medicaid eligible. Dually eligible individuals were supposed to be automatically enrolled in a Medicare Part D plan. CMS mailed personalized notices during the first week in November, to the nearly 5.5 million beneficiaries who were auto-assigned to a PDP, announcing the plans in which they were enrolled. But despite these efforts, there will likely be dually eligible beneficiaries who attempt to obtain prescription drugs on or after January 1, 2006 whose auto-enrollment has not been completed.

On December 1, 2005, CMS announced a process known as a Point-of-Sale solution (POS) to ensure that full dually eligible individuals experience no coverage gap. The POS process is a special type of facilitated enrollment that will allow beneficiaries who present at a pharmacy with evidence of both Medicaid and Medicare eligibility, but without current enrollment in a Part D Plan, to have a claim submitted to a single account for payment. The beneficiary is supposed to be able to leave the pharmacy with a prescription, and a CMS contractor will immediately follow up to validate eligibility and facilitate enrollment. This special facilitated enrollment will only apply to full-benefit dual eligible individuals and not to the deemed (SLMB, QMB, QI-1) population or Medicare-only beneficiaries.

CMS has contracted with a single national plan to manage one national account for payment of such claims. The contractor is Wellpoint Inc. of Indianapolis, and the plan is a national plan that offers the standard benefits for a premium at or below the regional low-income premium subsidy amount in every PDP region. In addition, CMS has contracted with an Enrollment Contractor, Z-Tech Corp. of Rockville, MD to facilitate the enrollment process by expediting such things as validation of dual eligibility.

The process of facilitated enrollment will start right at the pharmacy. The pharmacist will begin a series of steps by billing a special account. The POS Contractor will maintain a pre-established service account to handle the initial processing of the claims, and will clear transactions from this account as soon as the Enrollment Contractor returns validated information. Claim transactions for verified duals will be cleared by

retroactively enrolling the dual eligible individual into the plan and reprocessing the initial claim with the correct member number.

CMS envisions the process to look like this:

- A full dually eligible individual presents at the pharmacy in January 2006, with either a Medicaid card, or previous history of Medicaid billing in the pharmacy system patient profile.
- Pharmacist bills Medicaid and the claim is denied.
- Pharmacist requests photo identification and checks for Part D enrollment by submitting an “E1 query to the TrOOP facilitator” and the pharmacist also checks for A/B Medicare eligibility by requesting Medicare card; or calling 1-800-Medicare; or requesting to see a Medicare Summary Notice (MSN).
- If the individual is verified to have dual eligibility and has not been enrolled in a Part D plan, the POS Contractor will immediately submit an enrollment transaction on behalf of the dual to enroll him or her into a POS Contractor plan retroactively to the effective date of dual eligibility (or January 1, 2006). Normal rules for duals opting out of the plan would apply.

CMS explains that the details of this process will be communicated to pharmacies and pharmacists on the Contractor’s industry “payer sheet” – the mechanism utilized in the pharmacy industry to communicate billing processes among pharmacies, switches and processors (payers). Payer sheets are picked up by pharmacy IT staff and software vendors and systems are coded to automate as much as possible. CMS is producing a CD-ROM for distribution to the bench pharmacists that will address the instructions, as well as the use of the EI query, coordination of benefits, and other issues of concern to pharmacists.

Questions remain, however. Will implementation be complete by January 1, 2006? If it is, will all the parties involved be conversant enough with the process? Ominously, when we contacted a local CVS Pharmacy, nobody there had any knowledge of what the industry “payer sheet” is, nor had they even heard of the POS Contractor process.

For more information on the transition of dually eligible beneficiaries to Medicare Part D, please contact attorney Pamela Meliso (pmeliso@medicareadvocacy.org) or Rebecca Ganci, paralegal (rganci@medicareadvocacy.org) in the Center for Medicare Advocacy’s Connecticut office at (860) 456-7790, or visit the CMS Website at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=6248 for a detailed description of POS.