# Bound By Bureaucracy:

## How Medicare Part D Is Tying the Hands of Neurologists

From confused patients to payer plans with ridiculous restrictions, the new Medicare drug benefit has proven more bane than benefit to many practitioners.

By Nathan Hall, Associate Editor

At the end of last year the mainstream media was filled with stories about Medicare Part D. While the government tried to reassure the public that this program would allow more options than the previous "one-size-fits-all" plan, many analysts and policy pundits said the idea of getting elderly patients to sign up for their benefits via web site was unfeasible, due to the plethora of pamphlets for plans being pushed onto patients by eager salespersons and the lack of alternative means of registration for a population not widely known for being tech-savvy. Meanwhile, physicians braced themselves for the worst, doubting that the choices of bureaucrats would be wisely made or that any changes in how payers operate would be for the better.

Unlike many oft-reported year-end scares, such as Y2K, the fears surrounding Part D proved to be perfectly justified. Pessimists unabashedly called the launch "a disaster" while the more optimistic said there were "glitches" that had to be worked out for everyone involved. Whatever it was labeled, the system has meant changes at all stages of the prescription drug process, from getting prior authorization for treatments to making sure the patient actually gets the drug dispensed as written at the pharmacy.

One of the most persistent problems, according to a 50-state survey by the Kaiser Commission on Medicaid and the Uninsured, was the situation with low-income "dual eligibles" who did not choose a plan and found themselves assigned one without regard to what medications were covered by the formularies and without being given basic information about their coverage. The survey found that 37 states had to implement temporary coverage as a stop-gap measure for these individuals; the most common problems included beneficiaries not being able to obtain non-formulary drugs and pharmacists not being able to properly bill the plans. Patients who picked their own plans did not fare much better, because they often found themselves suffering from restrictions that interrupted their care.

Part D may have been intended as a benefit, but it has proven to be a bane for practicing physicians. They and their staffers have been inundated with calls from pharmacists with questions about how to process payment or requests for prior authorization, questions from patients about which plan is best for them, and questions of their own about how these new plans work and whether things are going to get better or worse in the future. Here's a status report on the program's shaky start, and a little crystal ball gazing for the road ahead.

### Pre-Authorization Blues

Physicians spend years becoming experts in their chosen field, and while they may not have the rigorous pharmacological background that pharmacists do, clinical experience gives practicing physicians valuable insight into which medication is best for which disorder. As a result, they invariably find it frustrating when they have to explain why they want to write a pre-

scription to an insurance company representative with no medical training just so it'll be reimbursed. This has long been a pet peeve for many practitioners, but now that it is a requirement of many Part D plans it may change the way medicine is practiced.

Scott Weaner, DO, a private practice neurologist in Mercerville, NJ, says almost all of his patients on anti-dementia drugs need pre-approval and authorization for their treatments, which is putting an almost unreasonable demand on him, his staffers and even his patients. "This Medicare Part D is really annoying," Dr. Weaner says. "We've had patients who have been on Aricept or other dementia drugs for months or years now, but the plans demand they have an MMSE in the last three months. So, they have to be brought in and given new MMSEs."

To keep up with these new regulations, Dr. Weaner says he has had patients come in for an extra appointment so they can go through all the requirements and extra paperwork and get everything done at once. For the most part Dr. Weaner says he has learned how to cope with the new system, and now only one or two plans still give him trouble.

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In Lima, OH, private practitioner Douglas B. Karel, MD, says he has heard that pharmacies aren't dispensing the desired prescriptions, that the insurance companies will not cover treatments and that patients are not getting the medications they were promised. What's worse, he fears the hassles associated with getting a treatment authorized may affect the way physicians make their decisions. "If a doctor is going to have to get preauthorization for a particular treatment, he might prescribe something else," he says, adding he now has a "phenomenal" amount of paperwork associated with each Medicare patient and is personally "sick" of calling in for pre-authorization, where he is put on hold, disconnected, then put on hold when he calls back again. These new responsibilities cut into the amount of time a physician spends seeing patients, he says.

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"It's going to hurt physicians significantly, but it's going to hurt patients more," Dr. Karel says. He worries patients may not get their medications when they need due to these problems, and that some may attempt a substitution for their prescribed treatment to get around formulary requirements. He says in some cases pharmacies have been working with patients to either give them the medication for free or put payment on the back burner until all the requirements for authorization are met. "This situation is critical for anti-epilepsy drugs," Dr. Karel says. "Here, no substitution is possible and the patients must get the treatments right away."

Dr. Karel's concerns are not uncommon, according to Amy Kaloides, health policy administrator for the American Academy of Neurology. She has been listening to the weekly CMS phone conferences and has heard quite a few physicians ask specifically about AEDs. "There's a concern that there are very specific drugs for very specific patients that may not be on the formularies," she says.

## Fighting the Formularies

When a physician wants to prescribe a medication that is not listed on the patient's formulary, he or she must go through an appeals process. And since this process is not standardized, each plan will present new hurdles to overcome.

William Rosenfeld, MD, Director of The Comprehensive Epilepsy Care Center for Children and Adults in Chesterfield, MO, says he has also seen some problems when prescribing anti-epilepsy drugs to his patients. Specifically, he says he has seen more pre-certification required for different dosages and patients having trouble getting the specified treatment from their Medicare plan. "In our case, it hasn't changed the way we prescribe treatments, but it does require more paperwork," Dr. Rosenfeld says. When complications arise, he says he and his staff "go out and fight for our patients."

Dr. Rosenfeld compares the formulary system to a department store's rebate program: they want physicians to prescribe older drugs and/or generic drugs even if they are not the best for the patient. They offer an option for savings, but they know only a small percentage of physicians will follow through with the necessary paperwork. "What some formulary groups seem to do is hope people will not fight them," he says. "When we go through all the hoops, it does increase the time for my staff."

These restrictions almost proved hazardous to one of his patients. The individual was recently changed from Diastat to Diastat AcuDial, and late one night he felt a seizure coming. He went to the pharmacy for the medication but was told he needed prior authorization. Fortunately, the pharmacist managed to come through and help that particular patient avert a serious lapse of seizure control. Situations such as this show the penny-wise, pound-foolish logic behind the restrictions, Dr. Rosenfeld says. "Medicare plans may save a few dollars by asking for prior approvals, but if someone has a seizure and ends up in the hospital it will cost as much as they would have saved in a year."

## A Day in the Life of an Office Manager

Dr. Rosenfeld says the requirements also put a great deal of constraints on his time as well as his staff's. His assistant office

manager, Christine Fishback, handles most of the billing and pre-certification. She says most of her time is spent on the phone, trying to get through to someone, only to be often told she has to talk to someone else, so she has to make another call and wait on hold, only to be told the same thing again when she finally gets through to a person. "In particular, I went through five phone numbers to get through to someone just to get prior authorization for one patient," Ms. Fishback says.

Another problem, she says, comes from providing the right information. To get prior authorization on refills, she has to take the patient's Medicare number and call it in. However, this can present a problem for those who have not yet received their cards, which has happened to a number of patients who were assigned a plan. "I could have every other piece of identification, their birth date, their social security number, but they won't help me if I don't have the ID number," she says. "And if the patients don't have a card, they don't have an ID number." But even though the work has been demanding, Ms. Fishback says she is getting the approvals necessary for treatment. "It's just a lot of time on the phone and with forms," she says.

To make the process more efficient, Ms. Fishback says she tries to get the prior authorizations to last a full year so she won't have to constantly call up for approval. She also learns the "ins-and-outs" of the local plans. She says she has become very knowledgeable of the most common 10 plans she sees, although there are about 65 available in her state and every now and then she has to learn about a new one.

Ms. Fishback says she also finds out what the pharmacies have to do to fill the patients' prescription and ask for the right co-pay to make sure the patients do not pay out of pocket due to a miscommunication. "The pharmacists are often not informed or are not knowledgeable, and neither are the insurance companies," she says. "I end up doing the pharmacists' job with the insurance company to make sure patients get their medication."

Ms. Fishback also says it's important to remind patients, particularly those who take medications to prevent seizures, to be sure they stay up on their refills. "The biggest thing with the insurance companies is that they stall," she says. "If a patient doesn't think to get a refill a week or two in advance, he or she may be in trouble."

Despite the frustrations and curveballs that come from dealing with the Medicare plans, Ms. Fishback still fights to get her patients what they need. "We're getting approvals, and we're not making changes," she says.

## Patience With Patients' Plans

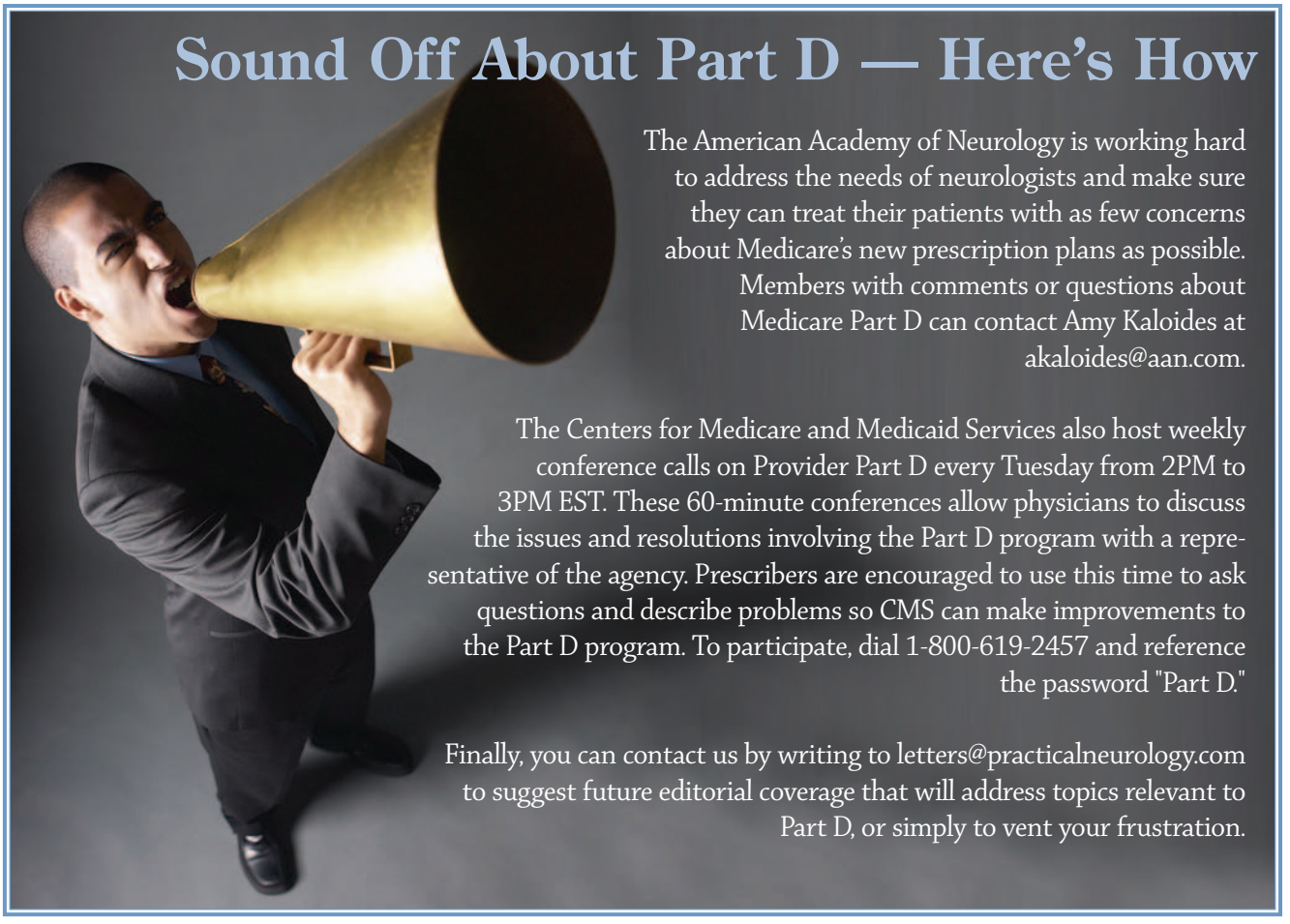
When Medicare rolled out the new plans, the agency asked physicians to help their patients select the most suitable one. This may have seemed like a good idea to those who have never spent any longer in an exam room than the time it takes for a check-up. But physicians who spend their whole days in clinical practice know that every minute counts when the schedule is filled and there are no unoccupied chairs in the waiting room. Hence, the typical clinician will not have time to give each patient a thorough review of the available plans while still evaluating the patient's health and planning a treatment strategy.

> seem like they have fewer choices," says William Rosenfeld, MD.

Dr. Rosenfeld says he finds himself spending time talking about the plans and options when he could be doing an examination or taking a history. "It does prolong the visits and affects the schedule," he says, adding that physicians are not reimbursed or otherwise compensated for this service but still do it purely in the interest of helping their patients. "Some practitioners may not have the staffers or the time to handle this," he says. What's more, the sheer quantity of options and the lack of suggestions for choosing a plan may seem intimidating to patients. "Medicare offers many plans but little guidance, so in a way, patients seem like they have fewer choices," he says. "Choice is good, but you need better guidance."

Dr. Weaner says he has tried to help patients navigate Part D, but even with his training and experience found the program needlessly complicated. "Personally, I don't understand the whole thing," he says. "It's very convoluted." And Dr. Weaner has had more of a personal reason to sort through the

## Sound Off About Part D — Here's How



The American Academy of Neurology is working hard to address the needs of neurologists and make sure they can treat their patients with as few concerns about Medicare's new prescription plans as possible. Members with comments or questions about Medicare Part D can contact Amy Kaloides at akaloides@aan.com.

The Centers for Medicare and Medicaid Services also host weekly conference calls on Provider Part D every Tuesday from 2PM to 3PM EST. These 60-minute conferences allow physicians to discuss the issues and resolutions involving the Part D program with a representative of the agency. Prescribers are encouraged to use this time to ask questions and describe problems so CMS can make improvements to the Part D program. To participate, dial 1-800-619-2457 and reference the password "Part D."

Finally, you can contact us by writing to letters@practicalneurology.com to suggest future editorial coverage that will address topics relevant to Part D, or simply to vent your frustration.

regulations than most physicians. He says his own parents have had to go through the program, and he experienced firsthand how confusing the program is when he helped them pick their plan.

### Advocacy From the Academy

Neurologists who want to either find out more about how Part D affects their practice or would like to make sure their complaints about the program are known need look no further than the largest organization dedicated to their specialty.

Rod Larson, Health Policy Director for the American Academy of Neurology, says the organization has been involved with Part D since it was in the planning stage, at which time the AAN gave its suggestions for rules and what the formularies should include. "We got very involved early in the process," he says.

When the rules were set and the deadlines for each step of the process were established, the AAN became an informational resource. Mr. Larson says it has been putting all the information on its web site (www.aan.com) as it becomes available and sending out the latest updates on CMS or insurer issues that could affect a practitioner via a weekly electronic newsletter. The AAN will also have an informational booth at its 58th annual meeting in San Diego from April 1 to 8. He says his staff has also traveled throughout the nation to meet with state neurology societies. "We're just trying to use every avenue we can to help our members understand and to let us know what the issues are," Mr. Larson says.

In addition to disseminating information, Mr. Larson says the AAN is collecting comments to find out the concerns of practitioners. We're not hearing a lot yet from our members, but we are hearing some things," he says. "It's still in a transitional period, because people are still signing up for plans."

Ms. Kaloides has also been collecting information about how Part D is affecting neurologists. So far she says she hasn't seen a deluge of e-mails coming in, but she predicts that will change when the "transition" coverage period ends on March 31. Then patients will have their options limited to

their formularies, and she predicts many physicians will be complaining about the complex appeal processes created by most plans.

## A Simplified Tomorrow

The struggles associated with Medicare Part D's launch may seem like a wave of complications rippling through the field of medicine. However, the overall mood of those affected by it seems to be one of guarded optimism. Part of this comes from CMS's apparent acknowledgement of Part D's flaws; the rest comes from those who are starting to get used to the leviathan system and understand how to make it work.

"CMS is recognizing the whole program will need to be simplified," Mr. Larson says. He says the agency is starting to see how having more than 60 different formularies in each state complicates matters for everyone. He also says there has been talk from CMS about extending the May 15 enrollment deadline, just as the "transition" coverage deadline was extended. Extending the time may help, and not hoping for sweeping solutions in the near future could thwart disappointment. "I'm optimistic the problems will get worked out, I'm also optimistic that the Iraq war will end," Dr. Karel says. "I just don't see either happening in the foreseeable future."

Dr. Weaner has taken a philosophical approach to Part D. "I think people will get used to it, and my staff will get used to it, and I'll get used to it and I'll be doing things to make it go smoothly, like giving patients the MMSE for prior authorization," he says. "But there will still be roadblocks along the way. Hopefully, in the end there will be some people helped, but it will still continue to be aggravating."

Dr. Rosenfeld also says that he is sure the problems will eventually be worked out, but until then it will continue to cut into his staff's work hours and his practice hours. He also says he is somewhat worried about how the plans will work when they can change their formularies. "What will be interesting is to see is how long the plans stay like they are," he says. "Right now, all the drugs are covered, but once they get people to join, they may start cutting their formularies. It could be bait and switch, where patients buy into a plan, then they get their benefits cut. I hope they won't do this." This caveat aside, Dr. Rosenfeld says he still harbors some optimism. "All systems need some time to get broken in after they start," he says. **PN**