

Medicare Prescription Drug Plans as Perceived by Public Health Providers

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The Medicare Modernization Act was passed in 2003 with the intention to improve prescription drug access for Medicare beneficiaries. Since its implementation in 2006, enrollment in Medicare Part D (MPD) plans continues to increase, having reached 28 million in 2011.^{1,2} Although more research is needed to study the effects of MPD on health outcomes, research has shown that cost-related medication nonadherence has decreased after MPD implementation.³⁻⁵ The Affordable Care Act, passed in 2010, further expands prescription drug coverage by gradually eliminating the coverage gap by year 2020. Although prescription drug access has improved for patients, providers face an increased challenge when prescribing for patients with stand-alone MPD plans. In 2011, 33 stand-alone prescription drug plans were offered in California.² Each plan had a different drug formulary and prior authorization (PA) process, which made determining drug coverage and preparing PA requests time consuming. Falling into the coverage gap also increases patients' out-of-pocket cost, which can decrease adherence.⁶ These challenges can be especially daunting to providers in the public health setting, where human resources and information technology are lacking.

The purpose of this study was to assess providers' knowledge of MPD in the San Francisco Department of Public Health and the impact of MPD plans on their practice. The community-based and hospital-based clinics had 206,010 and 156,207 visits from July 2010 to June 2011, respectively, 18.7% and 17.4% of which were covered by Medicare. The top 5 diagnoses were hypertension, type 2 diabetes, hyperlipidemia, depression, and obesity. Our experience in these clinics suggested that MPD was complicated and providers' understanding of MPD was lacking, which led to difficulties in prescribing. Most studies in the past were conducted to assess the impact of MPD on beneficiaries rather than providers.⁷⁻⁹ The results of this survey can serve as a basis for devising strategies to overcome barriers when prescribing for MPD beneficiaries.

METHODS

Sample Selection

We surveyed providers practicing in the San Francisco Department of Public Health who were authorized to prescribe. The medical staff office provided a current list of 1283 providers and their e-mail addresses. These providers worked

Providers' knowledge of and satisfaction with Medicare Part D (MPD) remained poor 6 years after the initial implementation in 2006. In the San Francisco Department of Public Health, despite providers' extensive prescribing experience and efforts to prescribe generic over brand medications, identifying a patient's MPD plan, conforming to the formulary, and completing prior authorization requests remain time consuming and challenging to many providers. We advocate for the federal government to take an active role in simplifying, standardizing, and unifying enrollment and formulary information available to providers by creating a provider portal. New regulations should also require MPD companies to conspicuously post formulary information online for easy access. Educational seminars and online tools are available to help providers understand and navigate MPD.

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Take-Away Points

Medicare Part D plans increases providers' workload substantially due to the various formularies and prior authorization processes.

- Providers are in need of education on Medicare Part D to bridge the knowledge gap.
- The federal government should take an active role in simplifying, standardizing, and unifying enrollment and formulary information by creating a provider portal. Regulations are needed to ensure easy access to formulary information and to simplify the prior authorization process.
- Information technology should be introduced to help providers cope with Medicare Part D.

in San Francisco General Hospital (acute care hospital and trauma center, on-campus primary care, and specialty clinics), 11 community primary care clinics (located in different neighborhoods), and community behavioral health services (psychiatric services located in different neighborhoods). Some providers worked in both the inpatient and outpatient settings. San Francisco General Hospital serves as a training facility for University of California–San Francisco, but providers in training programs are not included in the medical staff. From that list, we excluded 516 providers who worked in departments where they were unlikely to prescribe outpatient prescriptions for MPD beneficiaries. Since the provider list did not distinguish between inpatient and outpatient providers, and we could not infer the number of interactions a provider might have had with MPD, 2 additional screening questions were used to exclude providers who worked exclusively in the inpatient setting and providers who had not prescribed for MPD patients in the past 3 months. The **Figure** illustrates how the final list of providers was obtained.

Survey Instrument

The survey study was approved by the Committee of Human Research at University of California–San Francisco. It was conducted using Survey Monkey, a web-based survey service. Due to the relatively small number of providers in our health system, no personal identifiers were collected except sex and practice characteristics (**Table 1**). The survey was divided into 2 parts. Part 1 of the survey asked providers to rate their level of agreement (scale of 1-10, where 0 = disagree and 10 = agree) with 16 statements concerning the quality of MPD plans, potential barriers to providing patients with needed medications, and current practice with regard to medication costs (**Table 2**). Part 2 of the survey tested participants' understanding of MPD plans via a hypothetical patient scenario (**Table 3, Appendix**). We also asked survey participants whether they had attended educational seminars on MPD. The online survey was tested for content validity by about 10 providers in paper format in 2 primary care clinics. Providers eligible for the online survey received an initial recruitment e-mail and 2 reminder e-mails. The survey was

open for 5 weeks beginning on June 29, 2011. A \$5 gift card was offered at the conclusion of the survey as compensation for time and effort.

RESULTS

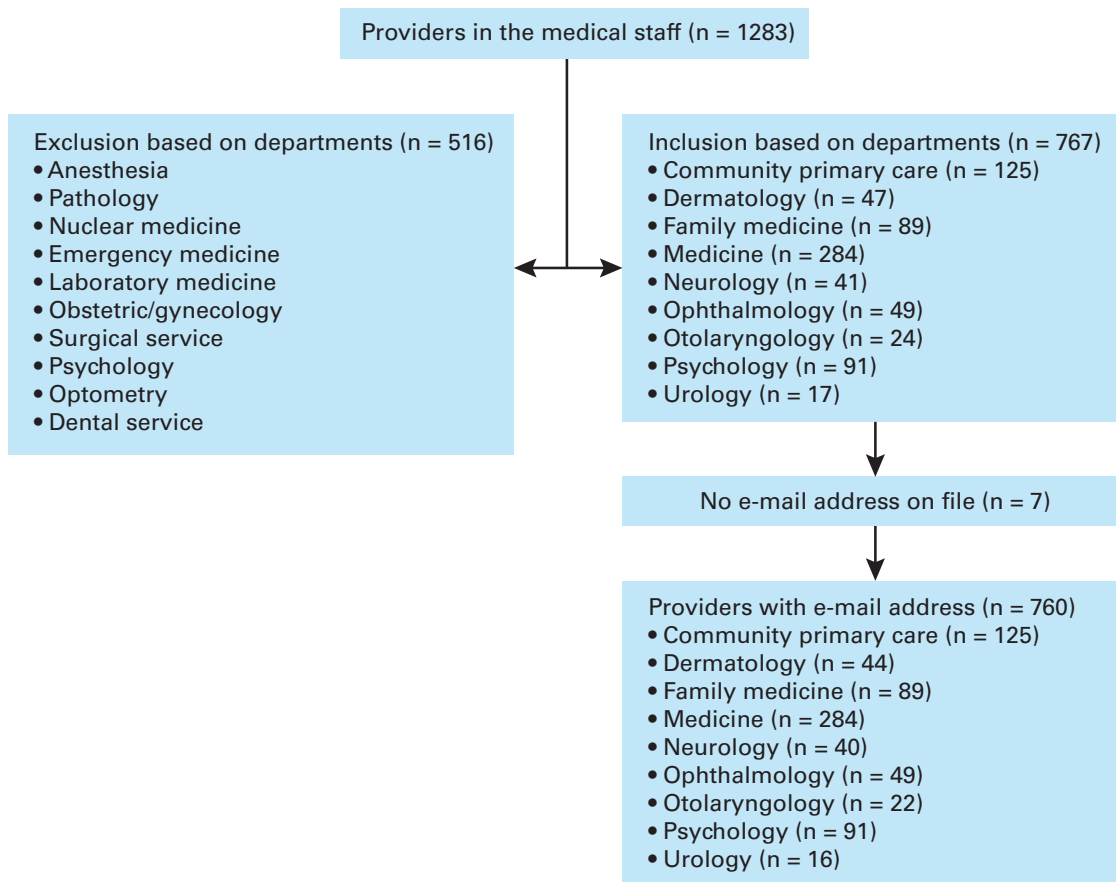
The response rate was 19% (146 out of the 760 medical providers). A total of 31 providers were excluded after the initial screening questions, 2 did not finish the screening questions, 4 did not give consent to participate, and 3 did not answer any question except the screening questions; therefore, all were excluded. Results were tabulated for the 106 providers who completed at least part of the survey and met study inclusion criteria (**Table 2, Table 3**).

Table 2 shows the survey questions in Part 1, the number of responses for each statement, and the median and the interquartile range on the agreement scale of 0 to 10. A median score of 4 to 6 showed that providers were neutral about the statement. A score of 7 to 10 conveyed agreement, and a score of 0 to 3 conveyed disagreement. A score closer to the ends of the scale (0 or 10) indicated a stronger agreement or disagreement with the statement. The interquartile range measured the variability of the opinion. A narrow range indicated that opinion was concentrated around the median.

Most providers were unsatisfied with their professional interactions with MPD plans (statement 1, median = 2). They felt that MPD plans did not make needed medications accessible compared with other accepted insurance plans (statement 2, median = 2). Providers also did not feel that they knew how to identify a patient's MPD plan (statement 3, median = 3), whether a drug was covered (statement 4, median = 1), or how to request nonformulary drugs (statement 5, median = 3).

Providers neither agreed nor disagreed that nonformulary drugs could be obtained when medically justified (statement 6, median = 4). Providers were neutral when asked if they had switched patients to drugs that were less effective or safe because of plan coverage (statement 7, median = 6). They were also neutral when asked whether they often needed to switch patients' medications because they did not have time to submit PAs (statement 8, median = 6). When a medication was changed because of formulary coverage, the patient usually needed to be contacted (statement 9, median = 8), but additional blood tests (statement 10, median = 2) were often not required. Providers were neutral with regard to the need for additional provider visits because of these medication changes (statement 11, median = 4). Providers were neutral when asked whether retail pharmacists were able to

■ **Figure.** Identifying Providers for the Survey Study



provide plan and formulary information (statement 12, median = 5). Conforming to the formulary and completing PA requests increased workload substantially (statement 13, median = 8). Most providers we surveyed considered generic options before brand medications (statement 14, median = 10), and explained to patients that brand and generic medications were therapeutically equivalent (statement 15, median = 10).

Table 3 shows the concepts tested by the hypothetical case and the number of correct, incorrect, and unanswered or “do not know” responses. Of the 106 providers, 78 (74%) knew that a brand medication would be more costly to the patient. A total of 22 of the 106 providers (21%) understood the concept of open enrollment. Of the 106 providers, 15 (14%) knew that Medicare-Medicaid dually eligible patients would be responsible for much lower copayments than patients who had stand-alone MPD plans. Less than half (49%, 52/106) of providers were able to provide at least 1 reliable formulary resource. Less than half of them (43%, 46/106) could locate information on patient assistance programs for those in the coverage gap or had any practical strategies to lower patient out-of-pocket costs on medications (45%, 48/106). A total of 16 (15%) respondents had attended seminars on MPD.

DISCUSSION

The response rate was low in this survey study. Providers who worked predominately in the inpatient setting could not be excluded using the list obtained from the medical staff. These providers were unlikely to be interested in our study on MPD. In addition, the low response rate was attributable to the low participation from the specialty clinic providers. Only 11% (18 of 171) of providers from dermatology, neurology, ophthalmology, otolaryngology, and urology participated in the study. In retrospect, the study should have focused on primary care providers instead of all outpatient clinic providers, because primary care providers generally have more interactions with MPD plans in the medical system. A post hoc subgroup analysis was done to examine responses from providers who worked in the community primary care clinics, in which 34% of providers participated in the survey (43/125). Their responses were found to be similar to those from the overall providers (Tables 2 and 3).

The results from Part 1 of the survey were consistent with our experience that most providers were unsatisfied with their professional interactions with MPD plans. With average

■ **Table 1.** Basic Demographics and Practice Characteristics

Characteristics	Providers (n = 106)
Sex, n (%)	
Male	32 (30)
Female	73 (69)
Not answered	1 (1)
Primary role, n (%)	
Physician	72 (68)
Nurse practitioner	27 (25)
Pharmacist	4 (4)
Others	3 (3)
Practice settings,^a n (%)	
Hospital-based primary care	51 (48)
Hospital-based specialty care	18 (17)
Community-based primary care	43 (41)
Community-based behavior health	4 (4)
Hospital-based inpatient	17 (16)
Percentage of patients who had Medicare Part D plans as estimated by providers, mean ± SD	22.4 ± 16
Percentage of Part D patients who had low income as estimated by providers, mean ± SD	80 ± 33
Average prescribing experience, y	16.1 ± 9.3
SD indicates standard deviation.	
^a A provider could work in more than 1 practice setting.	

prescribing experience of 16.1 years, this particular group of providers was highly experienced. They were also conscientious about cost in that they considered generic options before branded medications. Yet these providers indicated that MPD plans did not make needed medications more accessible compared with other plans accepted by the San Francisco Department of Public Health. The difficulties in navigating through an MPD formulary were evident when a majority of these experienced providers did not know how to identify a patient's MPD plan, whether a drug was covered, or how to request an exception when a drug was not covered.

The model of privatized, stand-alone prescription drug plans each with their own formulary inherently creates the issue of scattered information. Identifying a patient's MPD plan is difficult compared with other plans because medical services (Parts A and B) and prescriptions (Part D) can be covered by different payers. Although clinics can readily identify a patient's eligibility for Medicare Part B as part of the registration process, the patient's MPD plan is often not recorded on the medical record. This information is available on a separate prescription drug card, but the patient often does not bring it to the clinic. A provider can also use the Medicare website to check the patient's enrollment. The website is primarily de-

signed for patient use and requires information that may not be easily accessed (eg, the effective date of the patient's Part A coverage). Pharmacy staff can identify the plan for providers, but calling the pharmacy can be time consuming. Further complicating the effort is the fact that patients who are eligible for both Medicare and Medicaid can change plans on a monthly basis, whereas patients with Medicare can change plans only during the yearly enrollment period.

Once the plan is identified, determining the tier of a drug is also challenging. Different plans have different requirements on quantity limits and step therapy, and determining whether a drug requires PA is not a trivial task. The PA process is also inconsistent across different plans. Prior authorization forms of many MPD plans are often buried deep on websites. While there is a universal MPD coverage determination request form available from Centers for Medicare & Medicaid Services (CMS), the fax number is not readily available. These reasons explain why providers' experience with MPD plans remains suboptimal 6 years after the initial implementation of the Medicare Modernization Act.

Medicare Part D plans may not have immediate incentives to improve the existing system. These private insurance plans develop formulary and PA processes that are deemed the most

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■ Table 2. Survey Part 1: 16 Statements and Median Agreement Score Among Providers^a

Statements	Median (Interquartile Range 25%-75%)	
	All Providers (n = 106)	CPC Providers (n = 43)
Statement 1. Compared with other insurance (eg, Medi-Cal, Healthy San Francisco, private insurance plans), Medicare Part D plans make it easier for me to prescribe medications I consider medically necessary for my patients.	2 (0-4)	2 (0-4)
Statement 2. Overall, I am satisfied with my professional interactions (eg, access to formulary, phone conversations, handling of prior authorizations) with Medicare Part D prescription drug plans.	2 (0-4)	2 (0-4)
Statement 3. I know how to determine the prescription drug plan in which my patient is enrolled.	3 (1-5)	2 (1-4)
Statement 4. It is easy to find out if a drug is covered on a Medicare Part D plan.	1 (0-3)	1 (0-3)
Statement 5. I know how to request nonformulary drugs (including tier 3, nonpreferred brands) for my Medicare Part D patients.	3 (1-5)	3 (1-6)
Statement 6. Most of the time, my patients can obtain nonformulary drugs (including tier 3, nonpreferred brands) when medically justified.	4 (2-6)	5 (3-6)
Statement 7. I often need to switch my patient to a different medication because it is not on the patient's Medicare Part D plan formulary, even though I know it is not as effective or safe in treating my patient's condition.	6 (4-8)	6 (4-8)
Statement 8. I often need to switch my patient to a different medication because it is not covered by the patient's Medicare Part D plan formulary, because I do not have time to submit a prior authorization request.	6 (3-8)	6 (5-8)
Statement 9. When I switch my patient's medication because it is not covered by the Medicare Part D plan, the patient needs to be contacted about the switch.	8 (6-10)	10 (7-10)
Statement 10. When I switch my patient's medication because it is not covered by the Medicare Part D plan, additional blood tests are required for monitoring.	2 (1-5)	3 (1-6)
Statement 11. When I switch my patient's medication because it is not covered by the Medicare Part D plan, additional provider visits are required for monitoring.	4 (2-6)	5 (2-7)
Statement 12. In general, retail pharmacists are familiar with my patients' prescription drug plans and are able to provide the patients' plan and formulary information.	5 (2-7)	5 (2-7)
Statement 13. Prescribing or switching my Medicare Part D patients' medications to conform to their formulary and completing prior authorizations have added substantially to my workload.	8 (6-10)	9 (6-10)
Statement 14. I ask my Medicare Part D patients if they can afford the costs of their medications.	5 (2-8)	4 (2-7)
Statement 15. I consider generic options before brands.	10 (9-10)	10 (9-10)
Statement 16. I explain to patients that generic medications are therapeutically equivalent to brands.	10 (8-10)	10 (9-10)

CPC indicates community-based primary care.
^aScale of 1 to 10, where 0 = disagree and 10 = agree.

profitable under the current regulations. The federal government, in contrast, can plausibly benefit when providers spend less time navigating MPD and more on patient care. To lessen the difficulties in navigating MPD, CMS should take an active role in organizing the availability of MPD enrollment and plan information. First, CMS can set up a provider portal. With the patient's Medicare number and a pass code unique to the patient, the provider can easily identify the patient's MPD plan. Second, all plans should be required to carry for-

mulary information online in a standardized fashion. This information should also be submitted to CMS so that after a patient's plan is identified on the provider portal, the formulary specific to the patient's plan can be displayed. Third, the PA process should be standardized across plans. CMS has developed a model Medicare Part D Coverage Determination Request Form and should eventually require a unified form to be used across plans. CMS can further facilitate the PA process by allowing the PA form to be completed online,

■ **Table 3.** Survey Part 2: Concepts Tested in a Hypothetical Medicare Part D Patient Scenario to Assess Providers' Understanding of Medicare Part D

Concept Tested	No. (%)			
	Correct	Incorrect	Do Not Know	Not Answered
Generic medications are more likely to be covered and require a lower copayment				
All ^a	78 (74)	3 (3)	24 (23)	1 (1)
CPC ^b	33 (77)	2 (2)	9 (21)	0 (0)
Dual-eligible patients can change plan monthly while Medicare-only patients can change plan yearly during the enrollment period				
All	22 (21)	23 (22)	60 (57)	1 (1)
CPC	11 (26)	12 (28)	20 (47)	0 (0)
Copayments for dually eligible patients are lower than those with only Medicare Part D				
All	15 (14)	32 (30)	58 (55)	1 (1)
CPC	4 (9)	18 (42)	21 (49)	0 (0)
Unbiased tools comparing different Medicare Part D prescription drug plans				
All	32 (30)	3 (3)	68 (64)	1 (1)
CPC	14 (33)	1 (2)	27 (63)	1 (2)
Ways a provider can use to find out if a drug is covered under a Medicare Part D formulary				
All	52 (49)	9 (9)	41 (39)	4 (4)
CPC	24 (56)	5 (12)	14 (33)	0 (0)
Where to find information on patient assistance program for patients who cannot afford medications in the coverage gap				
All	46 (43)	11 (10)	47 (44)	2 (2)
CPC	19 (44)	4 (9)	20 (47)	0 (0)
Ways to lower patient-out-of-pocket costs on medications				
All	48 (45)	4 (4)	52 (49)	2 (2)
CPC	23 (54)	1 (2)	19 (44)	0 (0)

CPC indicates community-based primary care.
^aAll providers (n = 106).
^bCommunity-based primary care providers (n = 43).

which can be forwarded to the patient's plan for processing. In addition, new regulations should require companies to conspicuously post formulary and PA information online for easy access (eg, setting a limit on the number of times a provider needs to click before the formulary or PA form is available). These changes, if implemented, could lead to less provider frustration, and a decrease in time and workload associated with navigating MPD.

Information technology can help alleviate the problems providers face today because standardization and organization of MPD information will take time. Some electronic medi-

cal record systems now support formulary checking and provide up-to-date plan and formulary information at the time of prescribing. Drug databases such as ePocrates with updated formularies are available online and on portable devices. Nongovernment websites such as www.q1medicare.com also provide easier access to formulary information compared with MPD company websites. The availability of information is, however, subject to negotiations between the plans and the respective information providers. These solutions also do not address the issue of PA. Therefore, while useful, they should not be considered long-term solutions.

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In addition to policy changes and information technology solutions, provider education on MPD is critically needed. Medicare Part D seminars were offered periodically by University of California–San Francisco pharmacists and students on the San Francisco General Hospital campus. Only a small number of surveyees were able to attend these seminars, possibly because of the time and location of these seminars. These seminars were previously shown to improve prescribers' perceived knowledge of MPD.¹⁰ We planned to determine whether there was a correlation between seminar attendance and actual MPD knowledge, but the small number of seminar attendees precluded any meaningful analysis. Future research could assess the reasons why providers did not seek out educational seminars on MPD despite a perceived lack of understanding. If time and location were the barriers, MPD education provided online may help bridge the knowledge gap for those who were unable to attend live MPD seminars.

Providers' reluctance to use retail pharmacists as a resource to get plan and coverage information came as a surprise. Pharmacy staff can submit test claims in order to know whether a drug is covered and therefore can offer a unique service to providers. We surmise that the reluctance was a result of the wait time over the phone and the inability of retail pharmacists to consistently provide therapeutic alternatives. Unless the pharmacist is already familiar with the plan's formulary, it can take time to identify alternatives, as formulary differences exist between plans and claim rejection messages often do not provide alternatives.

Limitations

This survey study had a low response rate, which could potentially contribute to nonresponse bias. Providers who might have been very satisfied with MPD plans might have chosen not to participate. There could also be response variation as we did not assess survey reliability when creating the instrument because it would have increased the length of the survey, serving as a disincentive for providers to complete it. Experience drawn from the providers in the San Francisco Department of Public Health may not be generalizable to other public health system because of differences in the Medicare patient population, differences in visit scheduling, and the information technology available.

CONCLUSIONS

Providers at the San Francisco Department of Public Health were not satisfied with their professional interactions

with MPD plans. Despite their extensive prescribing experience and efforts to prescribe generic over brand medications, identifying a patient's MPD plan, conforming to the formulary, and completing PA requests remained challenging to many providers. We advocate that the federal government take an active role in simplifying, standardizing, and unifying enrollment and formulary information available to providers by creating a provider portal. In the meantime, information technology solutions and education may help providers understand and navigate MPD.

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■ **Appendix. Survey Part 2: Hypothetical Patient Scenario**

CJ is a 69-year-old male with PMH of hypertension, diabetes, and GERD who presents to your clinic to establish primary care on January 23, 2011. He has recently lost his retiree benefits and is now enrolled in a Medicare Part D plan but does not know the name of the plan. He is compliant with his medications but reports he sometimes has trouble paying for them.

Medications:

- Hydrochlorothiazide (HydroDIURIL) 25 mg daily
- Lisinopril (Zestril) 20 mg daily
- Metformin (Glucophage) 850 mg TID
- Glipizide (Glucotrol) 10 mg BID
- Rabeprazole (Aciphex) 40 mg daily

Labs:

BP: 128/76; HR: 78; A1C: 8.3; FBG: 178

1. Assuming all of CJ's medications are covered by his Part D plan, which of his medications is most costly to him?

- Lisinopril (Zestril) 20 mg daily.
- Metformin (Glucophage) 850 mg TID.
- Glipizide (Glucotrol) 10 mg BID.
- Rabeprazole (Aciphex) 40 mg daily.
- I do not know.

2. CJ reports having significant acid reflux. He has stopped taking his rabeprazole (Aciphex), an effective PPI for him, because his new Part D plan does not cover it anymore this year. Assuming CJ is dual-eligible (qualified for Medicare and Medi-Cal), when can CJ change his Part D plan?

- February 1, 2011. CJ can change his plan monthly.
- October 15 to December 7, 2011.
- October 15 to November 31, 2011.
- November 15 to December 31, 2011.
- I do not know.

3. In most circumstances, switching from brand to generic will provide significant cost savings to your patients. You can lower CJ's copayment by switching him to another generic PPI. To your understanding, will the cost savings be bigger if CJ has a dual-eligible plan, or a stand-alone Part D plan?

- Dual-eligible plan.
- Stand-alone Plan D plan.
- Cost saving will be the same.
- I do not know.

4. Bravo! CJ happens to visit your clinic during the time when he can change his Part D plan. That means we can potentially switch him to a plan that covers all of his medications. Knowing all the options CJ has, where can we find an unbiased tool to compare all different Medicare Part D prescription drug plans based on my patient's current regimen?

- I do not know.

Answer: _____

5. CJ's A1C and fasting blood sugar are not at goal. You are considering adding sitagliptin (Januvia) 100 mg daily as the third agent. What resources do you use to find out if Januvia, a brand-name medication, is on the formulary (covered by his Part D plan)?

- I do not know.

Answer: _____

6. As you may know, some patients stop taking some of their medications once they encounter the coverage gap (aka, donut hole). You know that many pharmaceutical companies offer patient assistant programs for a free supply of brand-name medications to qualified Medicare patients. Where would you go to locate the information?

- I do not know.

Answer: _____

7. Please list 1 resource you have used to help your Part D patients lower their out-of-pocket medication costs.

- I do not know.

Answer: _____

A1C indicates glycosylated hemoglobin; BID, twice daily; BP, blood pressure; FBG, fasting blood glucose; GERD, gastroesophageal reflux disease; HR, heart rate; PMH, past medical history; PPI, proton pump inhibitor; TID, 3 times daily.