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A MEDICAID PERSPECTIVE ON PART D IMPLEMENTATION; THE MEDICARE PRESCRIPTION DRUG PROGRAM

Findings from a Focus Group Discussion with Medicaid Directors

Prepared by:

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December 2005

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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ACKNOWLEDGEMENTS

This paper is based on findings from a focus group of Medicaid officials who gathered on November 6, 2005 to discuss the implementation of Medicare Part D prescription drug coverage and its impact on state Medicaid programs while they were in Arlington, Virginia for the annual National Association of Medicaid Directors (NASMD) meeting. We acknowledge and thank the Medicaid directors and other state officials who took the time to participate in this discussion, and who reviewed and offered feedback on an earlier version of this report. Especially, we thank Medicaid officials from Alabama, California, Iowa, Kansas, Michigan, New Mexico, New York, Ohio, Utah, West Virginia, and Wisconsin.

This report reflects views expressed by the focus group participants. Their comments do not necessarily reflect the views of other officials within their states, a consensus position of the Medicaid directors who participated in the group, or the National Association of State Medicaid Directors. Additionally, this report does not necessarily represent views of the Kaiser Family Foundation or the Kaiser Commission on Medicaid and the Uninsured.

EXECUTIVE SUMMARY

After many years of discussion and debate, and two years of intensive program planning and development, Medicare prescription drug coverage will become available beginning January 1, 2006. This historic expansion of Medicare also brings enormous change to state Medicaid programs as over 6.1 million low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare ("dual eligibles") are transitioned from Medicaid drug coverage to Medicare "Part D" coverage offered through private plans. These dual eligibles have more extensive health needs than other Medicare beneficiaries and a shorter timeframe in which to move to Part D, making their transition critically important.

Over the past two years, the Centers for Medicare and Medicaid Services (CMS) has worked diligently to plan for Part D implementation including specific efforts, such as the auto-enrollment of dual eligibles on a random basis into basic Part D plans, to help ensure the successful transition of dual eligibles. States have been actively preparing for the implementation as well. A smooth transition without lapses in coverage will be imperative to avoid adverse health outcomes for this medically vulnerable population.

Background on the Focus Group. To explore the current status and likely results of the Part D dual eligible transition efforts as well as other Part D-related issues of particular importance to states, the Kaiser Commission on Medicaid and the Uninsured asked Health Management Associates to conduct a focus group. Twelve Medicaid officials, including Medicaid directors from 11 states participated on November 6, 2005 while they were in Arlington, Virginia for the annual National Association of Medicaid Directors (NASMD) meeting. These state officials were asked to comment upon several topics relating to:

- The transition of dual eligibles from Medicaid to Medicare drug coverage;
- Evaluating Part D plan options;
- States' role in the low-income subsidy program;
- The fiscal implications of Part D on states; and
- The longer term policy implications at both the state and federal levels of the Part D implementation.

The participants were asked to speak off-the-record based on their personal experience and knowledge gained as administrators of the Medicaid program. Thus, their comments do not necessarily reflect the views of other officials within their states, nor do they necessarily represent a consensus position of the Medicaid directors who participated in the group or the National Association of State Medicaid Directors.

The Transition of Dual Eligibles. Although many noted the extensive efforts of CMS to ensure a successful transition for dual eligibles, focus group participants remained concerned that a significant number of dual eligibles could "fall through the cracks" and be left without drug coverage after December 31, 2005. Participants noted that even a small auto-enrollment error rate would result in an unacceptably large number of beneficiaries without coverage, a situation

that would be beyond the capacity of states to manage. Their specific observations included the following:

Data discrepancies between the states and CMS will prevent a number of dual eligibles from being auto-enrolled into a Part D plan. While the percentage of data files with discrepancies is relatively small (one-half of one percent according to one participant), the number of affected individuals is still significant and the consequences of reduced access for this population can be serious.[1]

Dual eligibles with private employer health coverage may be unable to continue medical, non-pharmaceutical coverage if they are auto-enrolled in Part D. Dual eligibles in this situation may choose to opt out of Part D coverage to preserve dependent coverage for a spouse, for example, or because they fear losing Medicaid coverage in the future.

States reported few specific contingency plans applicable to the early weeks of Part D implementation. Some states, as a matter of policy, have not considered or adopted contingency plans, as they believe that Part D is an entirely federal responsibility. On the other hand, one official stated that his state was working in every way it could toward a smooth implementation.

Dual eligibles are likely to turn to the state Medicaid program with questions, but states lack the information to effectively respond. Part D plans are not required by law to share beneficiary enrollment or drug use information with states.

Evaluating Part D Plan Options. Only plan options with premiums at or below the low-income subsidy benchmark will receive dual eligible auto-enrollments. The focus group participants made the following observations regarding the evaluation of plan options:

The large number of plan options will likely complicate the Part D transition for the dual eligibles. Dual eligibles desiring to choose a plan rather than relying on auto-enrollment are likely to be confused, increasing the complexity of outreach efforts at both the federal and state levels.

The CMS web-based applications designed to compare plans (the Formulary Finder and the Prescription Drug Plan Finder) are not practical for many dual eligibles. Few dual eligibles use the Internet and are unlikely to begin with sophisticated web applications such as these.

[1] CMS subsequently announced on December 1, 2005 a "Point-of-Sale Protection" plan for situations where individuals present at the pharmacy with proof of Medicare and Medicaid enrollment, but do not have a current enrollment in a Part D plan. This process would allow the beneficiary to leave the pharmacy with a prescription and allow the pharmacy to be reimbursed. A CMS contractor would then follow up to facilitate enrollment into a Part D plan.

CMS has not provided electronic Part D formularies to states so that state hotlines could assist dual eligibles to assess plan options. Instead, CMS instructed states to work directly with Part D plans or to use the Formulary Finder. These alternatives are not viable for states.

CMS assurance that formularies are robust is clouded by confusion with plan cost-sharing tiers and utilization controls. State officials concurred that plan formularies appear to be "robust", but cautioned that utilization controls, definitions of tiers, actual cost sharing and approval processes might still be of concern.

States' Role in the Low-Income Subsidy Program. Focus group participants generally reported that their states had played little or no role thus far in the process of determining eligibility for the Part D low-income subsidy, nor had they been pressured to do so. Instead, they are referring beneficiaries to the Social Security Administration.

Fiscal Implications. The MMA transfers responsibility for prescription drug coverage for dual eligibles entirely to Medicare but requires states to continue to help finance that benefit through a kind of "maintenance of effort" mechanism known as the "clawback." The focus group participants had the following comments regarding the fiscal implications of Part D to states including the impact of the clawback requirement:

State officials expressed concern about the fairness of the clawback formula and the lack of state control over the future growth in state clawback obligations. The group believed that it is unprecedented and inappropriate for the federal government to mandate that states contribute – forever – to the financing of a federal program that the states will have no control over. Further, in most cases, officials believed that the clawback itself would actually exceed what they would have paid if the benefit had remained under their control in Medicaid. No state believed that they would achieve the ten percent savings implied by the application of the 90 percent phase-down percentage factor.

State Medicaid clawback obligations are not tied to the value of the Part D benefit provided to dual eligibles. The clawback is based on comprehensive Medicaid drug coverage. Under Part D, however, dual eligibles will be auto-assigned to plans with premiums at or below the low-income subsidy premium benchmark, which will likely offer more restricted benefits.

Per capita state clawback amounts vary widely. Some Medicaid directors were concerned about the wide variation in clawback amounts from state to state (derived from a calculated per capita drug cost ranging from a high of $354.69 in New Jersey to a low of $166.33 in Arizona.)

States have not yet experienced an identifiable "woodwork" effect but still expect this to occur as Part D enrollment ramps up during 2006. When identifying low-income beneficiaries who might be eligible for subsidies, states expect to find some who are eligible for Medicare Savings Plans and who would therefore be added to Medicaid rolls.

For states with supplemental rebate programs, the transition of dual eligibles to Part D will likely diminish the size of the supplemental rebates that they are able to negotiate for the

non-dual eligible population. States will see their Medicaid drug expenditures decrease by roughly half upon the transition of the duals to Medicare drug plans.

Longer Term Policy Implications and Other Issues. By necessity, states have focused on tasks related to the initial transition of the dual eligible population. Soon, however, states will turn more of their attention to the longer term implications of the Part D benefit as it relates to Medicaid pharmacy policies, the Medicaid program generally and other state health care programs. Focus group participants had the following comments on those longer term implications:

State officials are concerned that the market will not support the current number of Part D plans causing some to drop out after 2006. If and when plans drop out, impacted dual eligibles will likely be faced with another confusing transition process and the need to select, or be auto-enrolled into, a new plan.

There is concern that after 2006 many Part D plans may adopt more restrictive formularies and utilization controls and/or substantially increase premiums. Impacted dual eligibles may then have to change plans to maintain access to current pharmacies, avoid new premium obligations (if the higher premiums for their current plans exceed the low-income subsidy benchmark), or preserve access to a critical drug that may not be covered by their Drug D plan.

States may face increasing pressure to subsidize the copayments required for dual eligibles under Part D. Once dual eligibles become subject to the Part D copayment requirements that will, in many cases, exceed the amounts that they are currently accustomed to paying, some states may be pressured to subsidize the cost of these copayments, but will be unable to receive federal Medicaid matching funds for these expenditures.

There is significant interest in exploring areas of coordination with Medicare Special Needs Plans, but most states have not yet had the time or staff resources to do so. Focus group participants expressed great interest in the potential opportunities that SNPs presented for improved coordination of Medicare and Medicaid services for dual eligible beneficiaries, but only one state had specific plans to work with them.

For future policy development, state officials cited the importance of evaluating the implementation of Part D and the transition of dual eligibles but were concerned that CMS has not made plans to do so and that states individually lacked the resources to carry out this function on their own. Some participants were concerned that Part D – particularly its total reliance on private plans, consumer cost-sharing, and controversial clawback funding mechanism – might become a model to reform other aspects of Medicaid without the benefit of a thorough evaluation to determine the strengths and weaknesses of the model in practice.

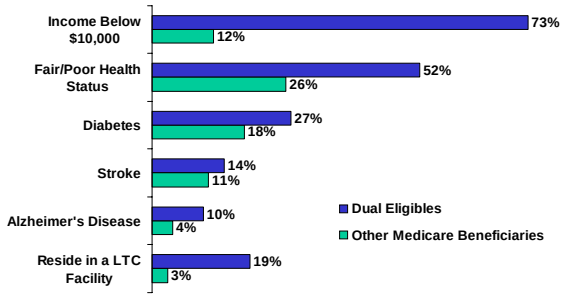
INTRODUCTION

After many years of discussion and debate, and two years of intensive program planning and development, Medicare prescription drug coverage will become available beginning January 1, 2006. This historic expansion of Medicare also brings enormous change to state Medicaid programs. For 40 years, Medicaid has filled the gaps in Medicare's basic health coverage for low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare ("dual eligibles"). While some dual eligibles (1.2 million in 2003) only receive assistance with their Medicare premiums and cost-sharing ("Medicare Savings Plan" dual eligibles), the majority (6.2 million) receive full Medicaid coverage including critical benefits that Medicare does not cover, such as long-term care services and, until now, prescription drugs.[2] In January 2006, these full benefit dual eligibles must be transitioned from Medicaid drug coverage to Medicare "Part D" coverage offered through private plans.

Compared to other Medicare beneficiaries, dual eligibles are much more likely to be in poor health, have significant limitations in activities of daily living and reside in nursing homes (see Figure 1). To avoid adverse health outcomes for this medically vulnerable population, it is imperative that the transition from Medicaid to Medicare Part D drug coverage in January 2006 occur for all dual eligibles without a lapse in coverage.

Figure 1

Characteristics of Dual Eligibles Compared to Other Medicare Beneficiaries, 2002



SOURCE: Medicare Chart Book, 2005, Kaiser Family Foundation

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Table 1 summarizes for each state and the District of Columbia the total number of Medicare beneficiaries categorized as aged or disabled and the number of dual eligibles (including Medicare Savings Plan dual eligibles) categorized as aged or disabled.

[2] Source: www.statehealthfacts.org, as compiled by the Urban Institute based on data from the Medicaid Statistical Information System (MSIS) prepared for the Kaiser Commission on Medicaid and the Uninsured, accessed December 13, 2005.

Table 1: Distribution of Medicare Beneficiaries by Eligibility Category, July 2003[3]

	All Medicare Beneficiaries			Medicare/Medicaid Dual Eligibles[4]		
	Aged	Disabled	Total	Aged	Disabled	Total
United States	34,259,546	5,913,059	40,172,605	4,935,000	2,533,000	7,468,000
Alabama	568,673	150,573	719,246	112,000	57,000	169,000
Alaska	39,038	8,711	47,749	5,000	4,000	9,000
Arizona	627,858	101,027	728,885	47,000	27,000	74,000
Arkansas	362,410	90,266	452,676	67,000	57,000	124,000
California	3,555,996	522,430	4,078,426	722,000	256,000	978,000
Colorado	424,093	69,361	493,454	46,000	27,000	73,000
Connecticut	458,120	64,283	522,403	58,000	30,000	89,000
Delaware	101,915	17,387	119,302	10,000	6,000	16,000
District of Columbia	63,505	10,289	73,794	12,000	6,000	19,000
Florida	2,558,145	362,826	2,920,971	295,000	142,000	437,000
Georgia	785,341	188,453	973,794	119,000	65,000	184,000
Hawaii	157,116	17,517	174,633	16,000	7,000	23,000
Idaho	152,936	24,764	177,700	6,000	6,000	13,000
Illinois	1,446,315	215,139	1,661,454	137,000	75,000	212,000
Indiana	746,421	131,533	877,954	79,000	51,000	130,000
Iowa	425,653	56,687	482,340	42,000	27,000	69,000
Kansas	344,714	49,492	394,206	28,000	20,000	48,000
Kentucky	499,086	149,314	648,400	95,000	61,000	156,000
Louisiana	503,783	116,413	620,196	98,000	50,000	148,000
Maine	184,556	42,140	226,696	59,000	23,000	82,000
Maryland	589,119	85,329	674,448	61,000	32,000	94,000
Massachusetts	821,977	143,966	965,943	136,000	88,000	224,000
Michigan	1,217,722	227,265	1,444,987	134,000	89,000	224,000
Minnesota	594,619	81,537	676,156	84,000	39,000	123,000
Mississippi	335,544	101,133	436,677	97,000	51,000	148,000
Missouri	740,392	144,057	884,449	98,000	61,000	158,000
Montana	122,557	19,900	142,457	10,000	6,000	16,000
Nebraska	226,820	30,351	257,171	24,000	15,000	38,000
Nevada	236,492	37,232	273,724	20,000	10,000	30,000
New Hampshire	152,462	27,102	179,564	13,000	7,000	20,000
New Jersey	1,072,994	146,941	1,219,935	129,000	49,000	177,000
New Mexico	211,103	39,010	250,113	27,000	13,000	41,000
New York	2,360,878	402,421	2,763,299	448,000	176,000	624,000
North Carolina	980,304	225,162	1,205,466	184,000	97,000	281,000
North Dakota	92,123	11,097	103,220	11,000	5,000	16,000
Ohio	1,486,146	240,950	1,727,096	139,000	82,000	221,000
Oklahoma	442,200	79,086	521,286	66,000	34,000	100,000
Oregon	445,505	67,748	513,253	46,000	33,000	79,000
Pennsylvania	1,845,483	264,987	2,110,470	201,000	117,000	318,000
Rhode Island	145,734	26,740	172,474	22,000	12,000	34,000
South Carolina	485,766	120,557	606,323	78,000	46,000	124,000
South Dakota	107,439	14,338	121,777	12,000	6,000	18,000
Tennessee	702,651	169,287	871,938	158,000	134,000	292,000
Texas	2,061,072	328,981	2,390,053	363,000	141,000	504,000
Utah	193,067	27,154	220,221	11,000	8,000	19,000
Vermont	78,062	14,662	92,724	21,000	9,000	30,000
Virginia	795,438	151,032	946,470	98,000	56,000	153,000
Washington	666,834	108,524	775,358	71,000	47,000	118,000
West Virginia	271,198	76,261	347,459	33,000	23,000	56,000
Wisconsin	702,630	101,048	803,678	80,000	47,000	127,000
Wyoming	59,549	9,041	68,590	5,000	4,000	9,000
Residence Unknown	9,992	1,555	11,547	N/A	N/A	N/A

Source: www.statehealthfacts.org**,** as compiled by the Urban Institute based on data from the Medicaid Statistical Information System (MSIS) prepared for the Kaiser Commission on Medicaid and the Uninsured, accessed December 13, 2005.

[3] Ibid.

[4] Includes both full and Medicare Saving Program dual eligibles. Totals may not sum due to rounding.

Since the Part D benefit was signed into law two years ago,[5] the Centers for Medicare and Medicaid Services (CMS) has worked diligently to plan for Part D implementation including specific efforts to help ensure the successful transition of dual eligibles without a lapse in drug coverage. These efforts have included development of a data exchange system between CMS and the states to accurately identify dual eligibles, the auto-enrollment of dual eligibles into Part D plans, and outreach and education efforts to alert dual eligibles and their caregivers about the impending changes.

CMS has also imposed other Part D program requirements that are broadly applicable to all Medicare beneficiaries, but will be particularly important to dual eligibles who, on average, have more complex health needs and greater drug expenditures than other Medicare beneficiaries. In particular, Part D plans will be required to include on their formularies "all or substantially all" of the drugs in certain drug classes (e.g., antidepressants, antipsychotics, anticonvulsants, anticancer drugs, immunosuppressants and HIV/AIDS drugs). Further, all Part D plans are required to have "transition plans" that will address the needs of new enrollees who are using non-formulary drugs prior to enrollment. Transition plans could include, for example, a one-time supply of non-formulary medication.

States have been actively preparing for the implementation of Part D. They have worked with CMS to provide timely, clean data on dual eligibles each month through the new data exchange system, implemented state-level system changes to support the data exchanges and the new coordination of benefits functions necessitated by Part D, and undertaken education and outreach efforts of their own. Since CMS announced the contracted Part D plans in each region in September 2005, some states have also begun to reach out to those plans to prepare for future coordination.

BACKGROUND ON THE FOCUS GROUP

The Kaiser Commission on Medicaid and the Uninsured (KCMU) asked Health Management Associates (HMA) to convene a focus of Medicaid officials to discuss the implications of the MMA for Medicaid beneficiaries and state Medicaid programs. The 12 participants represented 11 states from different geographic regions and with diverse administrative styles for their Medicaid prescription drug programs. Officials from Alabama, California, Iowa, Kansas, Michigan, New Mexico, New York, Ohio, Utah, West Virginia, and Wisconsin participated in the focus group. Dual eligibles in these states account for over 38 percent of all such enrollees nationwide. [6]

[5] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173 (often referred to as the Medicare Modernization Act, or "MMA") added a new Part D to the Medicare Program to provide a voluntary prescription drug benefit for all Medicare beneficiaries, effective January 1, 2006.

[6] Auto-Enrollment Statistics, MMA_STATES@LIST.NIH.GOV on behalf of CMS MMA_States, Sent November 9, 2005, hereinafter referred to as "CMS Auto-Enrollment Statistics."

The participants were asked to speak off-the-record based on their personal experience and knowledge gained as administrators of the Medicaid program. Thus, their comments do not necessarily reflect the views of other officials within their states, nor do they necessarily represent a consensus position of the Medicaid directors who participated in the group or the National Association of State Medicaid Directors.

The focus group discussion was held on November 6, 2005, a date made possible because Medicaid directors were convening for their annual conference in Arlington, Virginia the following day. At the time of the discussion, the Department of Health and Human Services (HHS) had recently:

- Announced the Part D plans and rolled-out several of its Internet tools to help beneficiaries choose the plan that best meets their medication needs;
- Begun processing applications for the Part D "Extra Help" (otherwise known as the low-income subsidy), which provides financial assistance to Medicare beneficiaries with limited incomes and resources;
- Distributed each state's per capita amount to be used for the monthly phased-down state contribution (commonly referred to as the "clawback") paid to the federal government for full-benefit dual eligibles enrolled in Part D; and
- Sent out notices on November 5, 2005 to nearly 5.5 million full-benefit dual eligibles, explaining that they had been auto-assigned to a plan into which they would be enrolled as of January 1, 2006 unless they selected a different plan.

The remainder of this report provides a detailed review of the Medicaid officials'comments on several topics including:

- The transition of dual eligibles from Medicaid to Medicare drug coverage;
- Evaluating Part D plan options;
- States' role in the low-income subsidy program;
- The fiscal implications of Part D to states; and
- The longer term policy implications at both the state and federal levels of the Part D implementation.

TRANSITION OF DUAL ELIGIBLES FROM MEDICAID TO MEDICARE DRUG COVERAGE

Background

Since the passage of the MMA, Medicaid officials and others have expressed concerns regarding the task of successfully transitioning more than six million dual eligibles from Medicaid prescription drug coverage to Medicare Part D coverage on January 1, 2006. For dual eligibles who fail to sign up for a Part D plan on their own prior to January 1, 2006, CMS proposed early on to auto-enroll dual eligibles on a random basis into a basic Part D plan (i.e., a plan with a monthly premium at or below the average for the region). To accomplish this, CMS has worked

with states over the past 12 to 18 months to identify the dual eligible population using a new data exchange system created for this purpose. Through this process, CMS identified 6.1 million dual eligibles.

On November 5, 2005, CMS mailed notices to nearly 5.5 million full-benefit dual eligibles, explaining that: (1) effective January 1, 2006 Medicare (rather than Medicaid) would be responsible for their drug coverage; (2) they must choose a Part D plan by December 31, 2005; and, (3) if they did not, the federal government would assign them to the prescription drug plan identified in the notice.[7] If a dual eligible visits a pharmacy after January 1st but is unaware of her Part D plan assignment the pharmacist can identify her plan by sending an eligibility transaction to the CMS TrOOP facilitator contractor.[8] Also, on December 1, 2005, CMS announced a "Point-of-Sale Protection" plan for situations where individuals present at the pharmacy with proof of Medicare and Medicaid enrollment, but do not have a current enrollment in a Part D plan. This process would allow the beneficiary to leave the pharmacy with a prescription and allow the pharmacy to be reimbursed. A CMS contractor will then follow up to facilitate enrollment into a Part D plan.[9] Finally, CMS also announced that special protocols and specially trained operators and case work coordinators would be available in January to provide focused assistance to dual eligibles who have questions or concerns.[10]

Observations of Focus Group Participants: Concerns Remain about a Gap in Coverage

Despite the extensive efforts of CMS to ensure a successful transition for dual eligibles, the focus group participants remained concerned that a significant number of dual eligibles could "fall through the cracks" and be left without drug coverage after December 31, 2005. Participants noted that even a small auto-enrollment error rate would result in an unacceptably large number of beneficiaries without coverage that would be beyond the capacity of states to deal with. Some focus group participants used the term "disaster" or "chaos" to describe their expectations for Part D implementation. Others were less pessimistic but expected pharmacies and nursing home operators to bear the primary burden of dealing with Part D coverage problems. Their specific observations included the following:

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[7] Of the remaining 631,516 dual eligibles, 626,214 will receive drug coverage through their current Medicare Advantage health plan, PACE organization or Medicare demonstration project plan. According to CMS, the remaining dual eligibles are either incarcerated or living outside the United States.

[8] In order to track and report eligibility, and correctly pay for catastrophic drug coverage (for non-dual eligibles or those not eligible for the low-income subsidy), CMS has contracted for the services of a "TrOOP Facilitator Contractor". The TrOOP Facilitator Contractor is to work with CMS, Part D plans and third-party payers to coordinate benefits and track the sources of cost-sharing payments including "True Out-of-Pocket" (TrOOP) expenses. *See also*, Medicare News, *Making It Easier at the Pharmacy Counter, The Medicare Benefit Will Use New Electronic Technologies to Simplify Drug Purchasing*, CMS Press Release dated March 4, 2005, accessed at: http://www.cms.hhs.gov/media/press/release.asp?Counter=1371 on November 30, 2005

[9] *Ensuring an Effective Transition of Dual Eligibles from Medicaid to Medicare Part D*, CMS Fact Sheet, December 1, 2005, accessed on December 12, 2005 at http://www.cms.hhs.gov/media/press/release.asp?Counter=1736, hereinafter referred to as "CMS December 1, 2005 Fact Sheet."

[10] Ibid.

- **Data discrepancies between the states and CMS will prevent a number of dual eligibles from being auto-enrolled into a Part D plan.** Focus group participants reported that a number of individuals included as dual eligibles in state data file submissions to CMS could not be matched by CMS against its Medicare eligibles database due to technical data file discrepancies. As a result, these individuals will not be auto-enrolled into a Part D plan and may therefore experience a gap in coverage if they fail to actively enroll in a plan on their own. Given the monumental task of matching millions of beneficiary records, it would not be surprising for some percentage to be impacted by data discrepancies. One participant estimated that data match discrepancies were occurring on approximately one-half of one percent of the beneficiary data files, and that while the percentage was relatively small, the number of affected individuals was still relatively large.[11]

"Our problem is that if we have a five percent error, we have a very big problem. We can't afford a one percent error."

- **Dual eligibles with private employer health coverage may be unable to continue medical, non-pharmaceutical coverage if they are auto-enrolled in Part D and therefore may elect to opt out of Part D coverage.** Private retiree health plans often bundle prescription drug and other medical health coverage. Some (but not all) employer plans have advised their beneficiaries that if they enroll in Part D, the beneficiaries will lose all private health coverage under the plan – not just drug coverage (which would also result in higher costs to Medicaid). Dual eligibles in this situation may choose to opt out of Part D coverage to preserve dependent coverage for a spouse, for example, or because they fear losing Medicaid coverage in the future. Medicaid, however, will be unable to cover drug copayments under the private plan (which could be significant) because federal Medicaid matching funds would be unavailable. Also, because different employers have varying policies, it will be extremely hard for help desk staff to evaluate what decision is in a particular individual's best interests.

"Literally, from the first day this came out, we have disavowed any knowledge of any of it. It is not a Medicaid program."

. . .

"We don't want to get drawn into CMS's problem but real people will have problems and we don't want to leave them hanging."

. . .

"We don't want to be accused of not doing everything possible we can do. We are bending over backwards."

- **States reported few specific contingency plans applicable to the early weeks of Part D implementation.** While the majority of focus group participants expected significant problems associated with Part D implementation, few reported the adoption of specific contingency plans to

[11] For example, a one percent error rate would affect 61,000 dual eligibles nationally, which is about the median number of duals per state. Across all states, a total of 24 states have fewer than 61,000 dual eligibles. On December 1, 2005, CMS stated: "CMS has worked especially closely with states on ensuring their monthly data feed identifying full-benefit dual eligible individuals to CMS is complete and accurate. CMS has a nationally recognized expert in Medicaid data validate each state's monthly feed, and the number matched consistently exceeds 99%." See CMS December 1, 2005 Fact Sheet.

address those problems. Some states, as a matter of policy, have not considered or adopted contingency plans, as they believe that Part D is an entirely federal responsibility. One participant stated "Literally, from the first day this came out, we have disavowed any knowledge of any of it. It is not a Medicaid program." Another participant said "I don't know how we would even consider putting a contingency plan together" due to lack of access to auto-enrollment information. On the other hand, one official noted "We don't want to get drawn into CMS's problem but real people will have problems and we don't want to leave them hanging." Similarly, another participant predicted that Part D implementation could be a "disaster" and continued that they were working in every way they could toward a smooth implementation. He said: "We don't want to be accused of not doing everything possible we can do. We are bending over backwards."

Some Medicaid officials indicated that, through December 31, 2005, their states would allow dual eligibles to continue to take advantage of long-standing, current policies allowing 90 or 100-day supplies for maintenance medications. Another state official reported that state Medicaid help-line staff would be "beefed-up" in early January, but callers would be referred back to Medicare. One official said that his state was just beginning to work on a contingency plan for emergency prescriptions. Finally, another official described his state's contingency plans simply by stating: "I'm hoping it will work."

- **Dual eligibles are likely to turn to the state Medicaid program with questions, but states lack the information to effectively respond.** Focus group participants felt that CMS has not provided states with easily useable information necessary to determine which dual eligibles have been auto-enrolled into which plans and CMS has also declined to provide states access to the online pharmacy claim system that pharmacists will be able to use to verify what plan each dual eligible has been enrolled in.[12] Further, at the time of the discussion, focus group participants had little plan specific information.

- **There is a perception among some state officials that CMS may be positioning states to be held responsible for dual eligible transition problems.** One participant commented that CMS continues to refer information requests to State Health Insurance Assistance Programs (SHIPs). Another participant noted that in recent conversations, CMS officials had asked state Medicaid staff "How can we help you?" implying that the burden was on the state. Finally, one participant observed that CMS does not have a contingency plan[13] but recently advised Medicaid staff participating on a Technical Advisory Group conference call that states would need to develop a contingency plan for January.

[12] One Medicaid Director noted however, that accessing the online pharmacy system would result in administrative "transaction fees" that the state could not afford.

[13] CMS subsequently announced on December 1, 2005 a "Point-of-Sale Protection" plan for situations where individuals present at the pharmacy with proof of Medicare and Medicaid enrollment, but do not have a current enrollment in a Part D plan. This process would allow the beneficiary to leave the pharmacy with a prescription and allow the pharmacy to be reimbursed. A CMS contractor would then follow up to facilitate enrollment into a Part D plan.

EVALUATING PART D PLAN OPTIONS

Background

Eighty-eight at-risk companies will administer Part D drug plans. Each of the Part D 34 regions will have multiple companies offering various plan options – each with different premiums, beneficiary cost sharing, and coverages (also known as formularies). For example, one state participant noted that the 18 Part D companies approved to operate in Michigan will offer 40 plan options.

The MMA authorized CMS to fully subsidize Part D premiums for dual eligibles in Part D plans with premiums falling at or below a low-income subsidy benchmark premium. This benchmark is different for each of the 34 regions and is calculated from the average within a region. A dual eligible may choose a plan with a premium higher than the low-income subsidy benchmark, but will be required to pay the difference between the chosen plan's premium and the benchmark. The MMA precludes a state from receiving federal Medicaid matching funds if it chooses to provide coverage for excess premium amounts for dual eligibles.

The auto-enrollment notices mailed in early November advised dual eligibles to call 1-800-MEDICARE with questions about assigned plans or to request a list of other Part D plans with no premium. Dual eligibles were also encouraged to call their assigned plan or their State Health Insurance Assistance Program (SHIP) for help.

Table 2 identifies for each state and the District of Columbia the number of auto-assigned dual eligibles along with the number of Part D companies and plan options eligible for auto-assignment and the total number of Part D companies and plan options.[14]

[14] Source: Compiled by HMA from CMS data available at: www.cms.hhs.gov/medicarereform/mmaregions/pdpmaosum.asp and www.cms.hhs.gov/map/map.asp accessed on December 12, 2005 and CMS Auto-Enrollment Statistics.

Table 2: Stand-Alone Part D Prescription Drug Plans (PDPs) by State

State	Duals Auto-Assigned Nov 2005	Eligible for Auto-Assignment *Count & % of Total*				Total	
		Companies		Plans		Companies	Plans
Alabama	83,000	8	44%	9	22%	18	41
Alaska	10,700	7	64%	8	30%	11	27
Arizona	44,400	5	26%	6	14%	19	43
Arkansas	60,800	12	75%	13	33%	16	40
California	848,000	8	42%	10	21%	19	47
Colorado	37,300	10	56%	10	23%	18	43
Connecticut	65,900	9	50%	11	25%	18	44
Delaware	9,400	14	67%	15	32%	21	47
District of Columbia	15,100	14	67%	15	32%	21	47
Florida	326,100	6	32%	6	14%	19	43
Georgia	133,600	13	72%	14	33%	18	42
Hawaii	22,500	7	58%	8	28%	12	29
Idaho	17,900	12	63%	14	32%	19	44
Illinois	247,300	12	71%	15	36%	17	42
Indiana	93,100	12	67%	13	31%	18	42
Iowa	54,500	11	65%	14	34%	17	41
Kansas	38,800	10	63%	11	28%	16	40
Kentucky	76,600	12	67%	13	31%	18	42
Louisiana	89,500	10	59%	11	28%	17	39
Maine	44,700	12	67%	14	34%	18	41
Maryland	56,600	14	67%	15	32%	21	47
Massachusetts	182,500	9	50%	11	25%	18	44
Michigan	185,500	13	72%	14	35%	18	40
Minnesota	56,900	11	65%	14	34%	17	41
Mississippi	130,000	11	69%	12	32%	16	38
Missouri	144,200	9	53%	10	24%	17	41
Montana	14,700	11	65%	14	34%	17	41
Nebraska	31,500	11	65%	14	34%	17	41
Nevada	16,900	7	37%	7	16%	19	44
New Hampshire	18,600	12	67%	14	34%	18	41
New Jersey	135,500	10	53%	14	32%	19	44
New Mexico	31,100	8	44%	8	19%	18	43
New York	499,700	11	52%	15	33%	21	46
North Carolina	216,700	11	69%	13	34%	16	38
North Dakota	10,400	11	65%	14	34%	17	41
Ohio	169,700	9	47%	10	23%	19	43
Oklahoma	72,900	10	59%	12	29%	17	42
Oregon	32,000	12	57%	15	33%	21	45
Pennsylvania	135,400	14	61%	15	29%	23	52
Rhode Island	26,100	9	50%	11	25%	18	44
South Carolina	110,500	14	70%	16	36%	20	45
South Dakota	11,700	11	65%	14	34%	17	41
Tennessee	212,300	8	44%	9	22%	18	41
Texas	294,300	14	67%	16	34%	21	47
Utah	19,200	12	63%	14	32%	19	44
Vermont	15,400	9	50%	11	25%	18	44
Virginia	101,400	14	78%	16	39%	18	41
Washington	93,200	12	57%	15	33%	21	45
West Virginia	40,300	14	61%	15	29%	23	52
Wisconsin	109,000	13	72%	14	31%	18	45
Wyoming	5,500	11	65%	14	34%	17	41

Source: Compiled by HMA from CMS data available at: www.cms.hhs.gov/medicarereform/mmaregions/pdpmaosum.asp and www.cms.hhs.gov/map/map.asp accessed on December 12, 2005 and CMS Auto-Enrollment Statistics.

CMS has also developed two Internet tools (available at www.medicare.gov) to help beneficiaries pick a plan: the Formulary Finder and the Prescription Drug Plan Finder. The *Formulary Finder* allows individuals to enter their medications and then identifies which plans in their area cover them. This web-based tool prompts for a state entry and then allows up to 25 drugs to be queried at a time. Based on the drugs entered, a response screen is produced which lists plans that cover all the drugs entered and plans that cover some but not all. Highlighting a plan provides formulary details including the cost-sharing tier for each drug (e.g., tier 1, 2, 3, 4, etc., but not the actual cost-sharing amount), and whether the drug is subject to prior authorization, quantity limits or step therapy requirements.

The *Prescription Drug Plan Finder* was designed to help beneficiaries (1) learn about the new Medicare prescription drug coverages; (2) find plans and compare premiums and drug costs; and (3) enroll in a plan. Individuals can use this tool to perform a "general" search or a "personalized" search. In the general search mode, this Internet tool prompts for a ZIP code entry and then asks questions about the beneficiary's current pharmacy coverages (e.g., Medicaid, employer/union, Medicare Advantage, etc.). There is an option to filter subsequent responses by type of plan (i.e., Medicare Advantage plan or Medicare Prescription Drug Plans), specific company, or a desired premium amount. The responses provide a list of plans operating for the identified ZIP code. If Medicaid pharmacy coverage is indicated, the software gives the following alert:

> "You indicated that you are approved for extra help paying for Medicare prescription drug coverage. Starting January 1, 2006, Medicare will cover prescription drug costs instead of Medicaid. You will have continuous Medicare prescription drug coverage and, in most cases, will pay a small amount out of your own pocket. You will need Medicare prescription drug coverage. You need to make a choice and join a plan. If you do not join a plan by December 31, 2005, Medicare will enroll you in a plan effective January 1, 2006. You can switch to another plan at any time. If you live in a nursing home, you will pay nothing for your covered prescriptions…"

The software can also provide plan options with information on monthly premiums, deductibles, cost sharing, and the percentage of the top 200 drugs covered in the plan's formulary. For dual eligibles, premiums are listed at $0 for plans with premiums under the low-income subsidy benchmark. For plans with higher premiums, the dual eligible's actual premium liability (i.e., the difference between the low-income subsidy benchmark and the plan's premium) is listed. The annual deductible is marked $0. Other cost sharing is consistently labeled $1- $3.[15]

Highlighting a plan provides its address, phone number, website, premium, deductible, copay or coinsurance tiers (with definitions and amounts), and participating pharmacies. After entry of medications, another feature provides side-by-side comparisons of up to three plans, including

[15] Actual copays for dual eligibles will vary by income. In 2006, dual eligibles with incomes under 100 percent of the federal poverty level have copays of $1 (generics) and $3 (brands); other dual eligibles have copays of $2 (generics) and $3 (brands). Dual eligibles residing in an institutional setting will have no copay.

cost sharing for individual drugs. Throughout the logic sequence, there are numerous prompts to enroll in a particular plan option. In a "personalized" plan search, inquirers enter a Medicare identification number and receive responses indicating whether a beneficiary is a dual eligible or otherwise approved for a low-income subsidy and whether the beneficiary is enrolled in Part D and, if so, with what plan option.

Observations of Group Participants

- **The large number of plan options will likely complicate the Part D transition for the dual eligibles.** Many participants were surprised at the wide array of plans in their states with premiums at or below the low-income subsidy benchmark and therefore fully subsidized for dual eligibles. For dual eligibles desiring to choose a plan rather than relying on auto-enrollment, participants observed that the many choices are likely to be confusing for beneficiaries and their families and would increase the complexity of outreach efforts at both the federal and state levels.

"CMS' perception is that all these duals are Internet savvy. A lot of these seniors don't have Internet access at all."

- **The web-based applications designed to compare plans are not practical for many dual eligibles and are hard to use.** Participants noted that most dual eligibles do not have access to the Internet. In particular, one participant noted, "CMS' perception is that all these duals are Internet savvy. A lot of these seniors don't have Internet access at all." Even if a family member or friend had access and was willing to help them, a number of participants observed that the Formulary Finder and Plan Finder applications were difficult to navigate, would not necessarily provide meaningful information and might result in additional confusion.

- **CMS has not provided electronic Part D formularies to states.** States requested electronic copies of plan coverages from CMS so that state hotlines could assist dual eligibles to assess plan options. CMS did not approve the request, opting instead to instruct states to work directly with Part D plans or to use the Formulary Finder. These alternatives are not viable for states. Plans are not always willing to share their formularies in a format easily used for comparison analysis and one official commented "We can't get any information from the plans." Also, the Internet tools have limited use for states, since they allow queries of only one dual eligible at time and do not allow identification of a plan's entire formulary.

"We can't get any information from the plans."

- **CMS assurance that formularies are robust is clouded by confusion with plan cost-sharing tiers and utilization controls.** State officials concurred that plan formularies appear to be "robust", but cautioned that the key issue was how the formularies were implemented. Utilization controls, definitions of tiers, actual cost sharing and approval processes might still be of concern. Officials said the question is larger than whether a drug is covered, including whether or not the drug is subject to prior authorization, step therapy where another drug must be tried first or if restrictive quantity limits are imposed. Available information is not clear on these issues. Further, because dual eligibles will

only be auto-enrolled into plans with premiums at or below the low-income subsidy benchmark, participants expressed concern that dual eligibles are likely to be enrolled in plans having the most restricted benefits.

- **The assistance for the dual eligible transition to Part D will vary by state.** Several participants stated their agencies did not have the funding or staffing to aggressively assist dual eligibles as they transition to Part D. Others explained that they would take a more active role to assist dual eligibles. One new transition tool discussed was *Beneficiary Centered Enrollment (BCE)* available from A Gold Standard Company. BCE is a data-engine software that compares historical drug utilization data with the Part D plan formularies and pharmacy networks. It creates beneficiary "scorecards" showing the availability of current medications and dispensing pharmacies in a dual eligible's randomly assigned plan and in other desirable plans. A real-time website for physicians and pharmacists will also be available to show assigned plans and provide a 90-day medication history for an individual to allow providers to assist beneficiaries to make an informed choice of plans.[16]

"We decided that the idea of sending out letters to dual eligibles with personal and sensitive information was just a non-starter… If it [a plan's formulary] is robust, our biggest concern is that they not be frightened. So we have taken the position that we hope it works."

While some states have decided to take advantage of the BCE application, some focus group participants were concerned that sending out letters to dual eligibles with personal information may not be warranted and cautioned that Health Insurance Portability and Accountability (HIPAA) privacy issues may evolve.

- **States are concerned that beneficiaries not be frightened.** One participant stated that dual eligibles in her state have been advised that "they don't need to do anything" and that they can always change plans later. Another participant noted, "We decided that the idea of sending out letters to dual eligibles with personal and sensitive information was just a non-starter… If it [a plan's formulary] is robust, our biggest concern is that they not be frightened. So we have taken the position that we hope it works."

STATES' ROLE IN THE LOW-INCOME SUBSIDY PROGRAM

Background

Beginning in July 2005, non-dual eligible Medicare beneficiaries with limited income and assets were able to start applying for the Part D low-income subsidy, which provides financial assistance to offset much of the beneficiary premiums, deductibles and other cost-sharing

[16] Summary paper from A Gold Standard Company, dated October 2005. The paper indicates that Beneficiary Centered Enrollment is supported by those interested in the success of the Medicare Drug Benefit, including the National Association of Chain Drug Stores, the National Community Pharmacists Association, and pharmaceutical manufacturers.

otherwise required by Part D.[17] In addition to the Social Security Administration, the MMA also requires state Medicaid agencies to accept and process low-income subsidy applications. However, the MMA did not provide additional funds for states for this purpose, allowing only the standard 50 percent federal administrative match to help states fund this activity. States were advised that they would be required to begin processing applications on July 1, 2005.

Observations of Focus Group Participants

Focus group participants generally reported that their states had played little or no role thus far in the process of determining eligibility for the Part D low-income subsidy, nor had they been pressured to do so. Instead, they are referring beneficiaries to the Social Security Administration. Three participants stated that they had seen no application activity yet although they had designated certain state staff to handle requests. Two participants said that their states had made a decision not to process applications, and to refer all applicants to SSA. Directors concurred that many potential applicants were still waiting to apply.[18]

FISCAL IMPLICATIONS OF PART D TO STATES

Background

States have a significant financial interest in the new Medicare drug benefit. On average, twelve percent of all Medicaid spending has been for prescription drugs, and about half of this amount has been for elderly and disabled Medicaid beneficiaries who also are enrolled in Medicare. The MMA transfers responsibility for prescription drug coverage for these dual eligibles entirely to Medicare. However, the MMA also requires states to continue to help pay for the prescription drugs for these individuals, even after the responsibility for coverage is transferred to Medicare. As a result, states will not realize savings and most expect to pay more than their current spending.

The mechanism for states to continue to assist in the financing of the Medicare prescription drug benefit is referred to as the "clawback." The clawback was designed as a kind of "maintenance of effort" to assure that states did not benefit from a large financial windfall when Medicare assumed responsibility for prescription drug coverage for this group of Medicaid beneficiaries. However, the MMA specified a clawback formula for future years that was intended to provide modest savings to states over time.

The clawback formula itself is fairly complex. It starts by calculating actual per capita Medicaid spending for Part D covered drugs in calendar year 2003, the most recent year for which data are available. Calculating the per capita amount involves a number of factors, including identifying

[17] Dual eligibles are "deemed" eligible for the low-income subsidy and need not apply.

[18] On December 3, 2005, the Social Security Administration announced that of the 3.8 million low-income subsidy applications it had received as of the end of November 2005, 2.8 million had been processed. Of the 2.8 million applications processed, over 660,000 were approved and 400,000 did not require approval because they were deemed eligible or were duplicate applications. Of those rejected, 57 percent had excess assets, 32 percent had excess income and 11 percent exceeded both the income and asset tests. *"Only 660,000 Okayed So Far by Social Security Administration for Low-Income Drug Benefit,"* CQ HealthBeat, on-line newsletter, December 5, 2005.

the actual number of enrollee-months for full-benefit dual eligibles, actual prescription drug costs for Part D covered drugs for these individuals for these months, actual (not incurred) manufacturer rebates received during this time, and other technical adjustments. Once the 2003 per capita amount is calculated, it is trended forward to 2006 using national expenditure projections calculated by CMS. To this amount is applied a discount factor of 90 percent in 2006. This "phased-down percentage" decreases gradually until it reaches 75 percent over ten years, and remains at that level for all future years.

States may face other financial implications of the Part D benefit if state policy makers decide to supplement or "wrap around" the Part D coverage to address gaps in coverage or new requirements for cost sharing for dual eligible beneficiaries.

Observations of Focus Group Participants

A few weeks prior to the discussion group, Medicaid directors had received from CMS the actual per capita clawback amounts for their states. As a result, they were able to describe in specific terms their detailed assessment of the impact of the clawback on state costs.

- **State officials continued to express concern about the fairness of the clawback formula and the lack of state control over the future growth in state clawback obligations.** Medicaid director comments on the clawback might be classified in two ways. First, Medicaid directors continued to express concern about the idea itself that the federal government could mandate that states contribute to the financing of a federal program. States have no control or influence over the structure, content or financing of Medicare Part D, even though they are mandated by the federal law to help finance the benefit. Medicaid officials saw this requirement as unprecedented and inappropriate. As one official observed, "The bottom line is that we are going to be paying for a drug benefit over which we have no control."

"The bottom line is that we are going to be paying for a drug benefit over which we have no control."

Second, Medicaid directors also were concerned about the specific amount they would have to pay. In most cases, officials believed that the clawback itself would actually exceed what they would have paid if the benefit had remained under their control in Medicaid. Aware of the recently announced actual clawback amounts provided by CMS, state officials in this discussion group agreed that the state cost would be no less, and in many cases, it would be greater than what would have occurred. No state believed that they would achieve the ten percent savings implied by the application of the 90 percent phase-down percentage factor. Indeed, the reverse was the case. Even though the actual clawback amounts generally were less than what states had expected based on their own calculations, they did not foresee savings in the near future, if at all. One participant stated, "We don't think we will break even until 2015."

"We don't think we will break even until 2015."

The focus group participants criticized the clawback formula as it is specified in federal law, including how manufacturer rebates are accounted for and how states did not get

credit for the effects of aggressive pharmacy cost containment actions that reduced their per capita spending for prescription drugs after the base year of 2003.

- **State Medicaid clawback obligations are not tied to the value of the Part D benefit provided to dual eligibles.** Medicaid directors also expressed concern that states will not get their full value for the clawback payments they do make. The clawback is based on Medicaid drug coverage, which is comprehensive. Dual eligibles will not find the benefit under Part D plans to be as comprehensive. Thus, the concern was that the clawback was based on a more comprehensive benefit than Part D plans were going to provide to the same dual eligibles. This concern was amplified since dual eligible enrollees are limited to plans with lower premiums, which are likely to offer more restricted benefits.

- **Per capita state clawback amounts vary widely.** Some Medicaid directors were concerned about the wide variation in clawback amounts from state to state. CMS calculated the calendar year 2006 per capita drug costs from a high of $354.69 in New Jersey to a low of $166.33 in Arizona.[19] Nationally the median per capita rate was $283. There was no apparent explanation for the wide variation, but it was a concern especially in states with amounts that were well above the national average. Table 3 below provides the 2006 per capita amount for each state and the District of Columbia.

[19] Federal Funds Information for States (FFIS), Issue Brief 05-45, Data Released for Calculating State Medicare Clawbacks, October 27, 2005.

Table 3: Monthly Clawback Per Capita Amounts for Calendar Year 2006[20]				
State	**CY 2006 Total Per Capita Rx Cost**	**FFY 2006 FMAP**	**FFY 2006 State Share (Q2 – Q4)**	
			Per Capita Amount	**After 90% Phased-Down**
Alabama	$223	69.51%	$68.12	$61.31
Alaska	$324	50.16%	$161.47	$145.32
Arizona	$166	66.98%	$54.92	$49.43
Arkansas	$205	73.77%	$53.68	$48.31
California	$219	50.00%	$109.49	$98.54
Colorado	$282	50.00%	$141.07	$126.97
Connecticut	$347	50.00%	$173.56	$156.20
Delaware	$278	50.09%	$138.86	$124.97
District of Columbia	$207	70.00%	$62.25	$56.02
Florida	$303	58.89%	$124.50	$112.05
Georgia	$251	60.60%	$98.89	$89.00
Hawaii	$202	58.81%	$83.15	$74.83
Idaho	$312	69.91%	$93.96	$84.56
Illinois	$284	50.00%	$141.81	$127.63
Indiana	$292	62.98%	$108.27	$97.45
Iowa	$299	63.61%	$108.97	$98.07
Kansas	$296	60.41%	$117.11	$105.40
Kentucky	$281	69.26%	$86.34	$77.71
Louisiana	$278	69.79%	$83.91	$75.52
Maine	$248	62.90%	$91.88	$82.70
Maryland	$297	50.00%	$148.26	$133.43
Massachusetts	$232	50.00%	$116.21	$104.59
Michigan	$210	56.59%	$91.26	$82.13
Minnesota	$286	50.00%	$143.10	$128.79
Mississippi	$218	76.00%	$52.31	$47.08
Missouri	$350	61.93%	$133.29	$119.96
Montana	$284	70.54%	$83.72	$75.35
Nebraska	$297	59.68%	$119.57	$107.61
Nevada	$269	54.76%	$121.50	$109.35
New Hampshire	$330	50.00%	$164.82	$148.33
New Jersey	$355	50.00%	$177.35	$159.61
New Mexico	$198	71.15%	$57.08	$51.37
New York	$262	50.00%	$130.75	$117.67
North Carolina	$291	63.49%	$106.24	$95.61
North Dakota	$249	65.85%	$84.93	$76.43
Ohio	$353	59.88%	$141.49	$127.34
Oklahoma	$215	67.91%	$69.08	$62.17
Oregon	$290	61.57%	$111.29	$100.16
Pennsylvania	$306	55.05%	$137.50	$123.75
Rhode Island	$282	54.45%	$128.46	$115.62
South Carolina	$200	69.32%	$61.40	$55.26
South Dakota	$289	65.07%	$101.00	$90.90
Tennessee	$324	63.99%	$116.72	$105.05
Texas	$222	60.66%	$87.16	$78.44
Utah	$330	70.76%	$96.61	$86.95
Vermont	$271	58.49%	$112.41	$101.17
Virginia	$305	50.00%	$152.44	$137.20
Washington	$283	50.00%	$141.35	$127.21
West Virginia	$263	72.99%	$70.99	$63.89
Wisconsin	$295	57.65%	$125.02	$112.52
Wyoming	$312	54.23%	$142.85	$128.57
National Median	**$283**			

[20] Sources: Federal Funds Information for States (FFIS), Issue Brief 05-45, Data Released for Calculating State Medicare Clawbacks, October 27, 2005, page 4 and State Financing of the Medicare Drug Benefit: New Data on the "Clawback" available at www.kff.org/medicaid/upload/7438.pdf

- **States have not yet experienced an identifiable "woodwork" effect but still expect this to occur as Part D enrollment ramps up during 2006.** Medicaid directors also expressed a concern that there would be an increase in the number of new Medicaid enrollees as Medicaid beneficiaries began to apply for the low-income subsidy and discovered that they were eligible for Medicaid. Medicaid directors had not yet seen evidence of such a "woodwork effect" but believed it was virtually certain to occur. The reason is that the Part D benefit is much more comprehensive for low-income Medicare beneficiaries who qualify for the "extra help" available to enrollees below 150 percent of the federal poverty level. As a result, lower-income Medicare beneficiaries will have a strong incentive to apply for the "extra help," and inevitably a certain proportion will find they qualify for Medicaid. States expect to find the numbers of individuals for whom they must pay the per capita clawback increasing over time as these individuals are enrolled in Medicaid. For these newly-enrolled dual eligibles, states will also incur new costs associated with its Medicaid payments for Medicare Part B premiums, non-drug copays and coinsurance and for other benefits where Medicaid supplements Medicare coverage.

- **For states with supplemental rebate programs, the transition of dual eligibles to Part D will likely diminish the size of the supplemental rebates that they are able to negotiate for the non-dual eligible population.** Medicaid directors were also concerned that manufacturer rebates, which have become a significant offset to total Medicaid spending for prescription drugs, will be negatively affected by the loss of Medicaid market share. Medicaid has been a dominant purchaser of prescription drugs in recent years, accounting for 19 percent of all prescription drug spending in the nation. With Part D, half of the Medicaid market share will shift to Medicare. Medicaid directors were concerned that this will diminish Medicaid's ability to negotiate supplemental rebates from manufacturers, and such rebates on the remaining Medicaid share will be affected. One participant observed, "Our relationship with the pharmaceutical industry is based on the number of covered lives. We won't have as many lives now. It is going to have an impact."

"Our relationship with the pharmaceutical industry is based on the number of covered lives. We won't have as many lives now. It is going to have an impact."

LONGER TERM POLICY IMPLICATIONS AND OTHER ISSUES

Since the passage of the MMA, state Medicaid programs have faced a number of challenges to prepare for the January 1, 2006 Part D implementation. By necessity, the focus has been on system changes, CMS data exchanges, outreach efforts and other tasks related to the initial transition of the dual eligible population. Soon, however, states will turn more of their attention to the longer term implications of the Part D benefit as it relates to Medicaid pharmacy policies, the Medicaid program generally and other state health care programs. One state official noted that his state had already decided to end its (non-Medicaid) state pharmacy assistance program as a result of Part D and another participant stated that his state would end its previous policy of Medicaid coverage for Medicare Advantage premiums. As was discussed above, state officials are also expecting, but have not yet felt, enrollment impacts (the woodwork effect) and impacts

to their supplemental rebate programs. Other Part D issues and longer term implications raised by the focus group participants follow.

- **State officials are concerned that the market would not support the current number of Part D plans causing some to drop out after 2006.** Focus group participants commented on the larger than expected number of Part D plans eligible for auto-enrollment of dual eligibles, even in regions with small populations. For example, while 848,000 dual eligibles in California have been tentatively assigned to ten different plans offered by eight companies, 19,200 dual eligibles in Utah (less than two percent of the California total) have been tentatively assigned to 14 different plans offered by 12 companies. (See Table 1.)[21] State officials expressed concern that PDP regions with smaller populations may not be able, in the longer term, to sustain the current number of contracted plans. One official predicted that plans would begin to drop out as early as the summer of 2006. If and when plans drop out, impacted dual eligibles will likely be faced with another confusing transition process and the need to select, or be auto-enrolled into, a new plan.

- **There is concern that after 2006 many Part D plans may adopt more restrictive formularies and utilization controls and/or substantially increase premiums.** One official commented that the 2006 premium rates for some Part D plans were surprisingly low. After a year of actual claims experience, plans that may have bid unrealistically low rates for 2006 may be forced to increase premiums and/or restrict coverage in future years. Impacted dual eligibles may then have to change plans to maintain access to current pharmacies, avoid new premium obligations (if the higher premiums for their current plans exceed the low-income subsidy benchmark), or preserve access to a critical drug that may not be covered by their Part D plan.

- **States may face increasing pressure to subsidize the copayments required for dual eligibles under Part D.** While institutionalized dual eligibles, such as nursing home residents, are relieved of all copayment requirements, Part D requires dual eligibles living in the community to pay $1 to $5 in 2006 for each prescription covered by their Medicare plan. In later years, their copayment obligations will increase with inflation. Currently, Medicaid prescription drug copayment requirements range from $.50 to a maximum of $3 per prescription. Some states, such as New Jersey, impose no Medicaid drug copayments at all. Once dual eligibles become subject to the Part D copayment requirements that will, in many cases, exceed the amounts that they are currently accustomed to paying, focus group participants predicted that some states will be pressured to subsidize the cost of these copayments, but will be unable to receive federal Medicaid matching funds for these expenditures.

- **There is significant interest in exploring areas of coordination with Medicare Special Needs Plans (SNPs), but most states have not yet had the time or staff**

[21] Utah and Idaho combine to form Medicare Drug Plan Region 31. The number of dual eligibles tentatively auto-enrolled in Idaho totaled 17,900 for a combined total of 37,100 dual eligibles auto-enrolled in Region 31. See Table 1 above.

resources to do so. The MMA created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs including persons who are institutionalized, dually eligible, and/or have severe or disabling chronic conditions. For 2006, 275 SNPs are approved to operate: most (226) are plans for dual eligibles, 37 are plans for institutional beneficiaries and 12 are for persons with chronic conditions.[22] A SNP is not required to have a state Medicaid contract to serve dual eligibles. Focus group participants expressed great interest in the potential opportunities that SNPs presented for improved coordination of Medicare and Medicaid services for dual eligible beneficiaries. Only one participant indicated that her state had specific future plans to contract with SNPs and intended to issue an RFP for this purpose. Another official said that he had been contacted by a few SNPs and felt that they were a "good idea" but noted that he did not currently have the manpower to work on SNP coordination opportunities.

- **For future policy development, state officials cited the importance of evaluating the implementation of Part D and the transition of dual eligibles but were concerned that CMS has not made plans to do so and that states individually lacked the resources to carry out this function on their own.** Focus group participants endorsed the importance and value of conducting a longitudinal study of the implementation of Part D benefit, particularly as it relates to the transition of the dual eligibles. In addition to better understanding the impacts on patients' outcomes and Medicare and Medicaid services and expenditures (e.g., inpatient admissions, emergency room visits, etc.), participants commented that the results of an evaluation could have implications beyond Part D, particularly in the context of the debate surrounding Medicaid reform at both the state and federal levels. Some participants were concerned that Part D – particularly its total reliance on private plans, consumer cost-sharing, and controversial clawback funding mechanism – might become a model to reform other aspects of Medicaid without the benefit of a thorough evaluation to determine the strengths and weaknesses of the model in practice.

- **Native Americans have unique Part D related transition issues that may receive inadequate attention.** One state official observed, "There are issues with Native Americans which you won't read about unless you read the Navaho Times. Native Americans don't have a way to get out of the doughnut hole. There are outreach issues that affect them. Coordination of care issues affects them. I don't think we will see a lot on these issues which is unfortunate."

CONCLUSION

On the eve of the most significant program expansion in the history of the Medicare program, state Medicaid officials participating in the focus group continued to express concern about the potential impact on dual eligibles despite diligent efforts on the part of CMS to plan for a smooth transition. Given the monumental nature of the task, the limited time available, and the millions of beneficiary records involved, it seemed unavoidable to the participants that some small

[22] CMS Special Needs Plan – Fact Sheet & Data Summary, accessed on December 13, 2005 at http://www.cms.hhs.gov/healthplans/specialneedsplans/finalsnpfactsheetsum111505.pdf.

percentage of dual eligibles would fall through the cracks and experience a gap in coverage. Even a small percentage, however, would result in an unacceptably large number of beneficiaries without coverage that would be beyond the capacity of states to manage. CMS appears to share this concern as it announced on December 1, 2005 (shortly after the focus group was held) a ”Point-of-Sale Protection” plan to deal with dual eligibles that had fallen through the cracks and not been auto-enrolled into a Part D plan.

Another key concern was the difficulty that dual eligibles would encounter in trying to evaluate the surprisingly large number of available plan options. The focus group participants did not believe that the Internet tools created by CMS to assist beneficiaries in selecting a plan would be helpful as few dual eligibles are likely to have Internet access. Even if dual eligible beneficiaries have family or friends able to help them, they could find the tools difficult to navigate and confusing. State officials also indicated that state Medicaid hotlines lacked the information and tools necessary to assist beneficiaries and would therefore have to refer callers back to Medicare.

The focus group participants also commented on the clawback which they perceive to be an unfair and inappropriate state funding obligation to finance the federal Part D benefit. The group believed that it is unprecedented and inappropriate for the federal government to mandate that states contribute – forever – to the financing of a federal program over which the states will have no control. Further, many Medicaid directors believe the clawback mandate will have a negative fiscal impact on their states rather than being fiscally neutral or resulting in savings as originally intended. In all cases, participants noted that the per capita clawback obligation is not tied to the value of the Part D benefit and is likely to exceed the value of the lower cost plans into which dual eligibles will be enrolled.

Finally, the Medicaid officials commented on the longer term implications of the new Part D program – some anticipated and some as yet unknown. The implementation of Part D comes at a time when the entire Medicaid program is under enhanced scrutiny as policy makers at both the state and federal levels look for new program models that might be capable of restraining the growth in Medicaid spending. The potential lessons that could be learned from Part D implementation – both positive and otherwise – could help inform this discussion if the federal government, in cooperation with the states, were to undertake a thorough evaluation to elucidate the Part D impacts and outcomes over time at all levels: on dual eligibles and their families, on providers, on states and on the Medicare and Medicaid programs generally.

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