kaiser commission on medicaid and the uninsured

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

## Findings from a Focus Group Discussion with Medicaid Directors

### EXECUTIVE SUMMARY

Prepared by:

VERNON SMITH

KATHLEEN GIFFORD

SANDY KRAMER

HEALTH MANAGEMENT ASSOCIATES

AND

LINDA ELAM

KAISER COMMISSION ON MEDICAID AND THE UNINSURED

**December 2005**

THE HENRY J. KAISER FAMILY FOUNDATION

# kaiser commission medicaid and the uninsured

**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.**

kaiser commission on medicaid and the uninsured

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

## Findings from a Focus Group Discussion with Medicaid Directors

### EXECUTIVE SUMMARY

Prepared by:
VERNON SMITH
KATHLEEN GIFFORD
SANDY KRAMER
HEALTH MANAGEMENT ASSOCIATES

AND

LINDA ELAM
KAISER COMMISSION ON MEDICAID AND THE UNINSURED

**December 2005**

THE HENRY J. KAISER FAMILY FOUNDATION

## *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.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, Fax: (202) 347-5274
Website: www.kff.org/KCMU

Additional copies of this report (#7447) are available
on the Kaiser Family Foundation's website at www.kff.org.