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THE TRANSITION OF DUAL ELIGIBLES TO MEDICARE PART D PRESCRIPTION DRUG COVERAGE:

STATE ACTIONS DURING IMPLEMENTATION

Results from a 50-State Snapshot

Prepared by:
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KAISER COMMISSION ON MEDICAID AND THE UNINSURED

February 2006

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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THE TRANSITION OF DUAL ELIGIBLES TO MEDICARE PRESCRIPTION DRUG COVERAGE: STATE ACTIONS DURING IMPLEMENTATION

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Introduction and Background

On January 1, 2006, most prescription drug coverage for 6.2 million low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare ("dual eligibles") was transitioned from Medicaid to Medicare Part D. Almost immediately, the Centers for Medicare and Medicaid Services (CMS) at the federal level and officials at the state and local levels noticed problems that made it difficult for some dual eligibles to obtain needed prescriptions. Within days of implementation, it was clear that some dual eligibles had not been auto-assigned into Part D plans,[1] some were being charged incorrect cost-sharing amounts, and some were unable to obtain drugs that had previously been covered by Medicaid but that were not covered by their Part D plan. The transition of dual eligibles to Part D was critically important because overall, dual eligibles have more extensive health and prescription drug needs than other Medicare beneficiaries. Many states therefore implemented temporary programs to assure that dual eligibles obtained needed medications during the transition period. The purpose of this report is to identify the types of problems that states were experiencing during the early implementation stages of Part D; to describe actions taken by states to assure that dual eligibles had access to needed prescription medications that previously had been provided by Medicaid; and to assess how transition problems are being resolved and monitored.

PREPARING FOR PART D AT THE STATE AND FEDERAL LEVELS

Dual eligibles are poorer and sicker than other Medicare beneficiaries. Until this year, dual eligibles received prescription drug benefits through Medicaid, but, effective December 31, 2005, their Medicaid drug coverage ended and their drug coverage was switched to Part D plans on January 1, 2006. To maintain prescription drug coverage, dual eligibles must be enrolled in a Part D plan. To facilitate this transition, the federal government randomly assigned dual eligibles to Part D plans. Dual eligibles are fully subsidized for the Part D premium for average to lower-cost plans, but they can face new copayments of $1 to $2 for generics and up to $5 for brand name drugs, and they may face new or more stringent formularies.

State Preparation. After Part D was signed into law more than two years ago, states began actively preparing for implementation. They worked with CMS to provide timely, clean data on dual eligibles each month through a new data exchange system, implemented state-level system changes to support the data exchanges and new coordination of benefits functions, and undertook education and outreach efforts. After CMS announced the contracted Part D plans in each region in September 2005, some states also began to reach out to those plans to prepare for future coordination.

[1] Part D plans include stand-alone Prescription Drug Plans ("PDPs") and Medicare Advantage Prescription Drug Plans ("MA-PDs"). Approximately 600,000 dual eligibles were passively enrolled into MA-PDs and 5.6 million were auto-enrolled into PDPs. CMS, *Medicare Releases State-by-State Prescription Drug Enrollment Figures*, Medicare Fact Sheet, January 19, 2006.

Despite extensive state and federal efforts to ensure a successful transition, many Medicaid officials remained concerned prior to implementation that a significant number of dual eligibles could "fall through the cracks" and be left without drug coverage after December 31, 2005. At a November 6, 2005, focus group of Medicaid directors convened to explore the status and likely results of the Part D dual eligible transition efforts, 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. Participants also predicted that dual eligibles having trouble accessing their Part D benefit would turn to Medicaid agencies for help.[2]

The majority of Medicaid directors in focus group discussions anticipated that there likely would be significant problems associated with Part D implementation. However, since Part D implementation was a federal responsibility, few states planned to develop or implement comprehensive contingency plans to address those problems. Nevertheless, as early as November 2005 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, although callers might 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 said that his state was working in every way they could toward a smooth implementation.

Federal Preparation. CMS was the federal agency with responsibility for implementing Part D, and CMS also was aware of the potential for issues to develop with the transition of dual eligibles.[3] CMS efforts to ensure the successful transition of dual eligibles included 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 also required Part D plans to include in their formularies "all or substantially all" of the drugs in certain drug classes[4] – a requirement particularly important to dual eligibles who, on average, have more complex health needs and greater drug expenditures than other Medicare beneficiaries. Further, CMS required all Part D plans to have "transition plans" addressing the needs of new enrollees who were using non-formulary drugs prior to enrollment that might, for example, provide for a one-time supply of non-formulary medication. Finally, on December 1, 2005, CMS announced a "Point-of-Sale Protection" plan to ensure immediate coverage for individuals who present at the pharmacy with proof of Medicare and Medicaid enrollment, but do not have a current enrollment in a Part D plan.

[2] V. Smith, K. Gifford, S. Kramer and L. Elam, *A Medicaid Perspective on Part D Implementation; The Medicare Prescription Drug Program, Findings from a Focus Group Discussion with Medicaid Directors*, Kaiser Commission on Medicaid and the Uninsured, December 2005.

[3] General Accountability Office, "Contingency Plans to Address Potential Problems with the Transition of Dual-Eligible Beneficiaries from Medicaid to Medicare Drug Coverage," GAO-06-278R, Transmitted from GAO to Senate Finance Committee on December 16, 2005 by letter from Kathleen M. King, Director, Health Care, GAO to Senator Max Baucus. The report includes CMS comments.

[4] Antidepressants, antipsychotics, anticonvulsants, anticancer drugs, immunosuppressants and HIV/AIDS drugs.

CMS PART D TRANSITION ACTIVITIES

Soon after Part D implementation on January 1st, CMS recognized that some dual eligibles might not be receiving needed prescriptions and took a number of key corrective actions including:

January 4, 2006:	Expanded the CMS pharmacy line staff from 150 to 4,500 service representatives and requested that Part D plans increase their call line capacity.
January 13, 2006:	Required Part D plans to implement expedited approval of the $1 to $5 copays which apply to dual eligibles, based on information provided by pharmacies.
January 18, 2006:	Began verifying with plans the availability of new plan call lines dedicated to prescribers and pharmacies.
January 24, 2006:	Announced the Medicare demonstration project to reimburse states for Part D covered drugs and related administrative costs incurred during the dual eligibles' transition to Part D.
February 13, 2006:	Extended the transitional period and asked Part D plans in addition to the *first-fill* to pay two more 30-day prescriptions of non-preferred drugs until March 31, 2006. Also completed the posting of phone numbers on the CMS website for new Part D plan call lines dedicated to prescribers and pharmacies.

Throughout January, CMS also worked to increase the accuracy, timeliness and efficiency of data exchanges with Part D plans and the CMS contractor charged with processing real-time, point-of-sale transactions (called *E1 transactions*), so pharmacies seeking to obtain Part D eligibility information (e.g., plan assignments and cost sharing) could bill the appropriate Part D plan. Finally, CMS issued several mailings and held one conference call to clarify issues regarding coordination of benefits between Part D and Medicare Part B covered drugs.

Survey Design

To assess the states' early experiences and responses relating to the transition of dual eligibles to Medicare Part D prescription drug coverage, Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia for the Kaiser Commission on Medicaid and the Uninsured (KCMU). The survey was sent to all Medicaid directors on February 3, 2006 and responses were received between February 3 and February 21, 2006. The survey was designed to document actions states had taken at the time of the survey to assist dual eligibles in obtaining access to Part D covered prescriptions and to identify the types of problems that states were experiencing. For most questions, the survey asked Medicaid officials to select one or more answers from a list of available responses or enter a short answer or description. Some questions allowed the official to check "other" and then enter a short description or comment. A final question permitted officials to enter general comments regarding the impact of Part D implementation in their states. The survey instrument is included as Appendix A to this report. Medicaid officials in all 50 states and the District of Columbia responded to the survey.

Survey Results

SIGNIFICANCE OF TRANSITION DIFFICULTIES

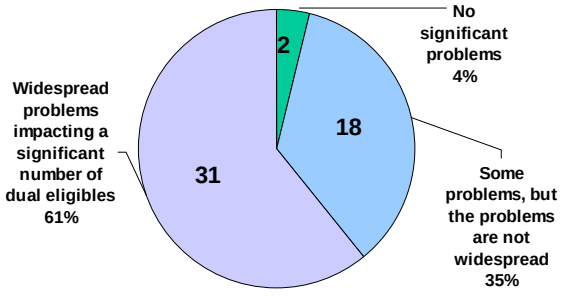
State officials were asked to describe the significance of any problems that dual eligibles in their states may be having in obtaining covered Part D drugs that had previously been paid for by Medicaid. Medicaid directors in a majority of states (31 or 61%) viewed problems as "widespread impacting a significant number of dual eligibles." (Figure 1) Eighteen respondents (35%) said that there were some problems, but that the problems were not widespread. In the remaining two states (Michigan and Louisiana) officials indicated that there were no significant problems in their states and each offered an explanation. (Table 1) The Michigan Medicaid director noted "There were a modest number of problems at first and they were addressed by the Medicaid staff and the Medicare-Medicaid Assistance Program staff, who were trained to handle them." The Louisiana Medicaid Director commented that her response reflected the status as of February 3, 2006 and that the state had seen "a dramatic improvement in the last 30 days." She further noted,

> *"This was a huge undertaking and some problems were unavoidable. Overall, it is working pretty well and we are working on the identified problems."*

> *"The worst week was the week of January 8 when we were at the point of a virtual meltdown. We continue to do troubleshooting and assist in problem resolution. However, pharmacies now know what to do and the early data file issues between CMS and the PDP's have been successfully resolved…."*[5]

Figure 1

In January 2006, how would you describe any problems that dual eligibles in your state had obtaining covered Part D drugs previously paid for by Medicaid?



KAISER COMMISSION ON Medicaid and the Uninsured

Includes 50 states and the District of Columbia

Source: KCMU/HMA Survey of Medicaid Directors, February 2006

[5] State Medicaid official as quoted from the HMA survey conducted February 3, 2006 through February 21, 2006. Quotations from Medicaid officials are typed in italics throughout this paper, both in the text and in text boxes. "PDP" refers to the Part D stand-alone Prescription Drug Plan.

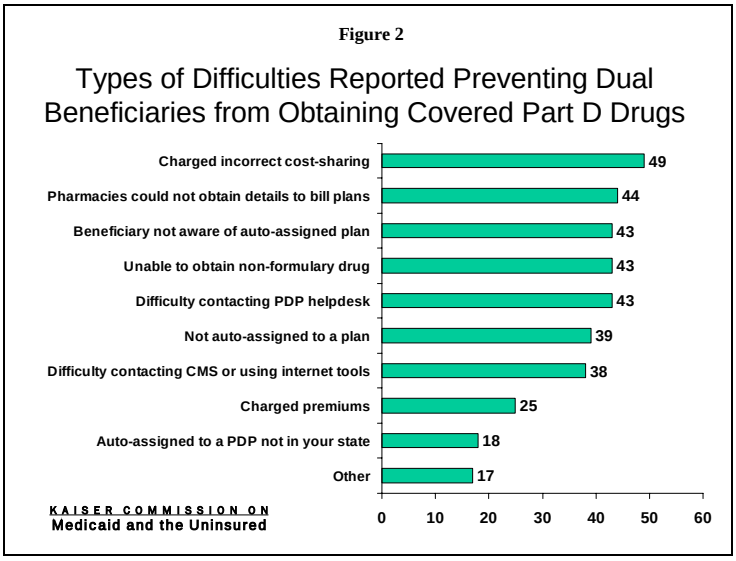
Table 1: Medicaid Directors' Views on Problems Dual Eligibles Experienced with Transition to Part D

Widespread problems, impacting a significant number of dual eligibles	Alabama, Arizona, Arkansas, California, Connecticut, District of Columbia, Illinois, Kansas, Kentucky, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, and Wisconsin
Some problems, but the problems are not widespread	Alaska, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Maryland, New York, North Carolina, Oklahoma, South Carolina, Tennessee, West Virginia, Washington, and Wyoming
No significant problems	Michigan (where some problems occurred early in implementation and were addressed by state staff) Louisiana (where problems were evident during initial implementation, but decreased by February 2006)

TYPES OF PROBLEMS OBSERVED BY STATES

Medicaid officials were asked to identify the types of problems that dual eligibles were having in obtaining covered Part D drugs in their state. The vast majority of officials reported that dual eligibles had been charged incorrect cost-sharing amounts (49 states), that they did not know to what plan they had been auto-assigned (43 states), and that pharmacies did not have sufficient billing information to bill the plans (44 states). (Figure 2) Less commonly reported were dual eligibles being charged Part D premiums they should not have been required to pay (25 states) or being assigned to a plan that did not operate in the state (18 states).

Figure 2



Source: KCMU/HMA Survey of Medicaid Directors, February 2006

Officials also indicated they were aware of additional problems, including the following:

- Gaps in coverage resulting from a lack of an enrollment cut-off date;
- Lack of connectivity between the pharmacy billing systems used by Indian tribes and Part D plans;
- Beneficiaries enrolled in more than one plan or assigned to a plan that does not have a participating pharmacy within 50 miles of the beneficiary's home;

- Some pharmacies deciding not to participate in Part D or refusing to check Part D plan assignments for duals;
- Coordination of benefits problems including confusion over whether certain drugs are covered under Medicare Part B or Part D;
- Failure of some plans to adhere to the CMS transition plan requirements or failing to cover all or substantially all of the drugs in the six protected categories;[6] and
- Healthcare providers receiving misinformation from 1-800-Medicare and Part D plans.

STATE ACTIONS

In 37 states, Medicaid officials reported that they had implemented a temporary coverage program to assure that dual eligibles receive their prescriptions. Officials consistently indicated state requirements that pharmacies must exhaust Medicare and plan options before billing Part D covered drugs to the state. Also, 14 states require documentation for payment (e.g., evidence of Medicare rejections, attestation that Medicare options were unsuccessful, paper claim submission, etc.). One unique approach was adopted by Alabama, which provided an advance payment to pharmacies to ease the financial burden with the dual transition to Part D. While many states choose to pay erroneous Part D copays above the low-income subsidy levels, one state's program included payment for these incorrect copayments only.. One state reported that it plans to wrap-around Part D, but noted that the coordination of benefits process was not yet working well, as of early February 2006.

Table 2 and the accompanying notes identify which states have implemented temporary programs and the documentation requirements and administrative costs reported by state officials. Payments listed on Table 2 are from various timeframes and accordingly cannot be extrapolated to national trends.

[6] Antidepressants, antipsychotics, anticonvulsants, anticancer drugs, immunosuppressants and HIV/AIDS drugs.

Table 2:

States Providing Temporary Assistance Plans to Reimburse Part D Covered Drugs for Duals

STATE	Total Duals in Part D PDPs (Jan 2006)	Temporary Assistance Plans Implemented by States and Estimated State Financial Impact (Reported as of Feb 2006) *					Estimated Administrative Costs (Timeframes Vary)
		Plan?	Duals Receiving Prescriptions	Prescriptions	Payments	Payment Timeframe	
Alabama±	82,098	Yes					
Alaska	11,255	Yes		<100		1 month	$100,000
Arizona±	49,528	Yes			$1,200,000		
Arkansas±	60,294	Yes	19,900	63,400	$4,455,130	5 weeks	
California	875,243	Yes	121,807	268,000	$19,649,896	4 weeks	
Colorado	37,546	No					
Connecticut±	66,388	Yes					
Delaware	9,432	No					
DC	15,115	Yes	706	1,327	$ 66,443	3 weeks	
Florida±	328,919	Yes		34	$ 3,437	3 weeks	
Georgia±	135,814	Yes					
Hawaii±	22,740	Yes	4,197	12,536	$464,064	5 weeks	$200,000
Idaho±	17,909	Yes	28	100 to 150	$ 8,750		
Illinois±	248,315	Yes	500		$100,000	1 month	$1 to 2 million
Indiana	94,379	No					
Iowa	54,545	No					
Kansas±	38,927	Yes	12,580	42,250	$3,100,000	2.5 weeks	
Kentucky	78,240	No					
Louisiana	134,174	No					
Maine±	44,945	Yes	50,000	54,763	$3,900,000	1 month	
Maryland±	56,536	Yes		90	$15,000	4 weeks	
Massachusetts±	183,359	Yes	100,000	448,510	$16,700,000	4.5 weeks	
Michigan	190,062	No					
Minnesota	58,047	Yes			$2,900,000	2 weeks	
Mississippi	129,089	No					
Missouri±	137,409	Yes	160	707	$35,500	4 weeks	
Montana±	14,750	Yes	< 50				$250,000
Nebraska	31,360	No					
Nevada±	17,126	Yes			< $100,000		
New Hampshire±	18,827	Yes	832	1,809	$92,800	6 weeks	
New Jersey±	135,048	Yes	30,000	366,000	$33,500,000	4 weeks	
New Mexico	31,385	Yes	850	1,700	$76,650	5 weeks	
New York	494,346	Yes		765,200	$80,000,000	3.5 weeks	$4 million
North Carolina	215,945	No					
North Dakota	10,413	Yes	2,800	7,600	$450,000	3 weeks	
Ohio±	172,056	Yes					
Oklahoma	73,297	No					
Oregon±	32,042	Yes	664	1,426	$103,618	3.5 weeks	
Pennsylvania	146,752	Yes	1,993	5,123	$193,000	2.5 weeks	$2 million
Rhode Island	25,939	Yes	5,128	13,210	$589,466	1 month	$50,000
South Carolina	113,045	No					
South Dakota	11,551	Yes	500				
Tennessee±	212,299	Yes					
Texas±	295,043	Yes	>24,000		$2,500,000	4 weeks	
Utah	19,987	Yes	2,375	5,265	$422,000		$75,000

STATE	Total Duals in Part D PDPs (Jan 2006)	Temporary Assistance Plans Implemented by States and Estimated State Financial Impact (Reported as of Feb 2006) *					Estimated Administrative Costs (Timeframes Vary)
		Plan?	Duals Receiving Prescriptions	Prescriptions	Payments	Payment Timeframe	
Vermont±	15,722	Yes		95,330	$5,217,492	5 weeks	
Virginia	102,290	Yes	8,082	18,470	$1,309,000	1 month	$100,000
Washington±	94,042	Yes					
West Virginia	40,801	No					
Wisconsin±	108,676	Yes					
Wyoming±	5,443	No					
Sources: Data Provided by State Officials to Health Management Associates for the Kaiser Commission on Medicaid & the Uninsured, Feb 2006 and *Medicare Release State-by State Prescription Drug Enrollment Figures*, CMS Medicare Fact Sheet, January 19, 2006							

Notes on Table 2:

**General Notes*: Values listed for Duals Receiving Prescriptions, Prescriptions, Payments, and Administrative Costs are state officials' best estimates. Some officials were not able to provide responses or were able to provide only several items. Also, entries are from different timeframes of varying length, and accordingly cannot be extrapolated to national trends.

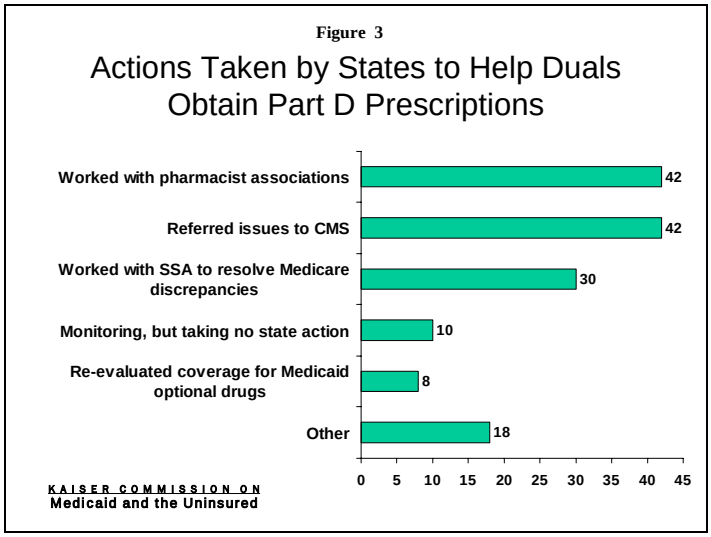
±*Pre-Payment Requirements:* For payment of Part D covered drugs, many states require prior authorization or other pre-payment screening, such as paper invoice submission or documentation of Part D plan rejections and failure of other Medicare remedies. These states include Arkansas, Florida, Georgia, Hawaii, Idaho, Illinois, Kansas, Maine (03-01-06), Maryland, Massachusetts, Missouri, Montana, Nevada, Oregon, and Texas.

Other noteworthy characteristics of state programs follow.

Alabama:	The state provides a 1-time advance equal to 75% of dual eligible payments to a pharmacy during December 2005. The advance must be repaid during 2006.
Arizona:	Governor authorized $600,000 in emergency funds to be used in life threatening instances where dual eligibles were not assigned to a Part D plan or could not obtain needed drugs.
Connecticut:	The state will pay beneficiary premiums over the low-income subsidy benchmark. Also, the state paid a $12 voucher to a pharmacy that assisted a dual eligible choosing a Part D plan.
Maine:	Payments include both dual and State Pharmaceutical Assistance Program eligibles.
Montana:	The state dedicated six staff persons to Part D implementation. Administrative costs through 12-2005 are over $250,000.
Nevada:	The state plans to pay the Part D $1 and $3 copays for duals on an ongoing basis.
New Hampshire:	State expenditures do not include home infusion.
New Jersey:	The state plans to wrap-around the Part D coverage on an ongoing basis.
Ohio:	The state will pay Part D copays over low-income subsidy levels, after attempts to resolve eligibility issues.
Tennessee:	The state continued its own pharmacy assistance program for selected duals – separate and independent from Medicaid.
Vermont:	State payments include both dual and State Pharmaceutical Assistance Program eligibles.
Washington:	The state continued to pay Part D covered drugs for institutionalized duals. Starting February 21, 2006, the state began paying dual eligible copays.
Wisconsin:	The state requires submission of a Medicare Part D attestation form prior to payment.

While the number of transition-related problems subsided after the first few weeks of January, state officials reported that dual eligibles, pharmacies, and prescribers were still having trouble navigating Part D in early February 2006. For example, one state reported that home infusion pharmacies were refusing to participate with Part D plans, compelling the state Medicaid agency to pay for home infusion to avoid dual eligibles being held in hospitals or nursing homes. Over 80% of states also reported working with state pharmacy associations to resolve issues (42 states) and referring issues to CMS (42 states). (Figure 3) Only ten states indicated that they were monitoring issues but taking no state action.

Figure 3



Source: KCMU/HMA Survey of Medicaid Directors, February 2006

Additional actions to assist dual eligibles identified under the category of "other" included the following:

- Established or expanded call centers to assist dual eligibles, providers, and pharmacies;
- Published contact numbers, sent multiple beneficiary notices and posted Part D information on the state agency websites;
- Provided early refills during the last ten days of December 2005;
- Worked with Part D plans including faxing confirmations of Medicaid eligibility and facilitated the gathering of other necessary information;
- Continued a separate, non-Medicaid state pharmacy assistance program for a select group of dual eligibles;
- Implemented aggressive case management efforts;
- Proactively communicated to care givers, case managers and community mental heath centers about the dual eligibles in their care, the drugs they were on and the need to assist them in the first few months, and

"Medicaid is working with plans, pharmacies and CMS to resolve both systemic and client specific problems. Local offices attempt to solve problems before sending them to a centralized process. We have developed relationships with some of the plans to develop backdoor solutions. We have also worked with [the] CMS [regional office] to work cases.

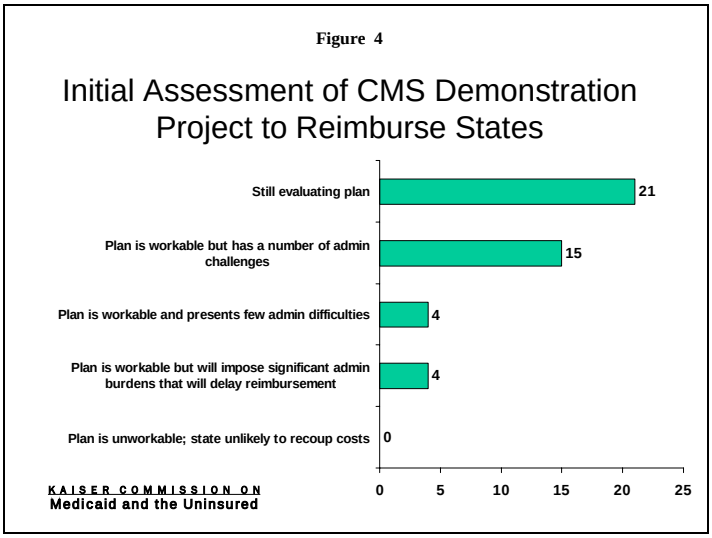
- Handled problem cases for both dual eligibles and non-dual eligibles that needed drugs urgently.

> *"This new federal program required a huge investment of state time and cost. Our work and support over the last year has only nominally been recognized. I believe this whole initiative will give states pause the next time we are asked to be involved in rolling out any federal program, especially one that affects our residents and our budgets."*

CMS DEMONSTRATION PROJECT

On January 24, 2006, CMS announced a new Medicare demonstration project[7] to reimburse states for the costs they had incurred in establishing temporary programs to assure dual eligibles obtained needed medications.[8] (A summary of the key features of the demonstration project is included in Appendix B to this report.) Survey respondents were asked for their opinion as to how the new demonstration project would work for their states. Because the survey instrument for this report was e-mailed to Medicaid directors one day after CMS had provided them with plan details (on February 2, 2006),[9] many states (21) predictably responded that they were still evaluating the Medicare demonstration project. While no state believed that the plan was unworkable, 15 thought it could involve a number of administrative challenges and four states believed that the administrative challenges would be significant and would likely result in reimbursement delays. (Figure 4).

Figure 4



Source: KCMU/HMA Survey of Medicaid Directors, February 2006

One Medicaid official commented that as long as the state's costs stayed "minimal," the state would likely *not* apply as the demonstration project was regarded as "too burdensome." An official from another state that had not implemented a temporary coverage plan stated "[We are]

[7] The demonstration is authorized under Section 402 of the Social Security Amendments of 1967, as amended.
[8] CMS Fact Sheet, "State Reimbursement for Medicare Part D Transition", January 24, 2006.
[9] CMS letter to state Medicaid directors, February 2, 2005, SMDL #06-001 and attachment titled "Section 402 Demonstration Application Template, Reimbursement of State Costs for Provision of Part D Drugs"

very glad we don't have to enter into this process." Another respondent reported that the "daily reporting requirements" were an administrative burden. Finally, two respondents expressed concern that the demonstration project would not reimburse 100% of administrative costs and instead reimburse only the 50% Medicaid administrative matching rate.

Other Medicaid comments regarding the demonstration project:

"Our application would be for reimbursement of administrative costs only."

"We are not planning to pay for the Part D drugs and will not need to recover for Medicaid covered claims. We have had significant additional administrative expenses in helping our duals through the transition and are receiving standard administrative match."

"It's too soon to tell, but I am very concerned about the administrative requirements. . . . It's a significant level of effort. We're applying as a place holder until we know what will be allowed."

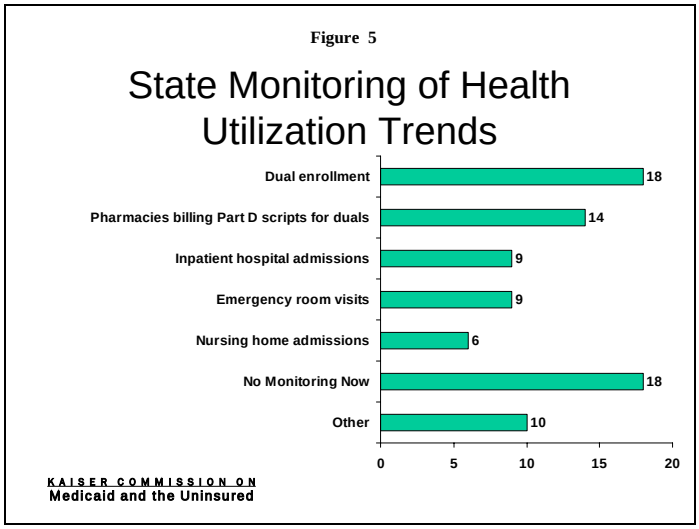
" [The State] will file the Waiver, but is concerned about the February 15 deadline. [The State] will seek an extension on the deadline. We are also concerned about allowable expenses. Currently, CMS position is unclear on this issue."

Medicaid officials were also asked whether or not it was "likely" that their states would apply for the demonstration project. At the time of the survey, thirty-six (36) states indicated that it was likely that their state would apply. Subsequently, CMS announced that forty-four (44) states and the District of Columbia would participate in the demonstration. CMS Administrator Mark McClellan said "Many states are not using their payment systems or using them in a very limited way at this point. We [CMS] are paying for the administrative costs of states that take steps with Medicare and pharmacists to use Medicare's billing systems, and this is paying off in low state billing and more use of Medicare coverage."[10]

MONITORING BY STATES

State respondents were asked to identify any health utilization trends that they were monitoring to evaluate the transition of dual eligibles to Part D drug coverage. Monitoring for impacts of the implementation of Medicare Part D on medical utilization or costs for Medicaid did not emerge as a priority for most states responding to this survey. About one-third of states indicated they were monitoring trends in dual eligible enrollments (18 states) and pharmacies billing Part D prescriptions for dual eligibles (14 states). (Figure 5) Several states indicated they were monitoring trends in inpatient hospital admissions (9 states), emergency room visits (9 states) and nursing home admissions (6 states). Officials in 18 states indicated that they were not monitoring any specific trends that might be associated with the transition of prescription drug coverage from Medicaid to Medicare Part D.

[10] *States Approved for Drug Reimbursement Demonstration to Complete Medicare Transition*, US Department of Health & Human Services News Release, February 16, 2006, accessed at www.hhs.gov/news/press/2006pres/20060216.html on February 21, 2006.



Source: KCMU/HMA Survey of Medicaid Directors, February 2006

- Part D enrollment and movement between plans;
- State expenditures as a percentage of dual spending per day before January 1, 2006;
- Inpatient psychiatric admissions and mental health services utilization;
- Cash flow from Part D plans to pharmacies and the impact on access and ongoing pharmacy viability; and
- Drug utilization trends before and after Part D implementation pursuant to potential data sharing agreements with Part D plans.

OTHER ISSUES AND FINAL COMMENTS

Officials were invited to offer any further comments they might have regarding the impact of Part D implementation as they were observing it in their state. This was an open-ended question and more than half of responding officials took advantage of this opportunity to identify other implementation issues and express concerns for the future. Several officials commented on the helpfulness and responsiveness of CMS. A majority of the comments reinforced concerns or commented on specific aspects of the implementation of Part D or of the Part D program itself. Specific issues included the following.

Copayments. Several officials expressed concern regarding the long-term impact of mandatory copayments on dual eligibles. One stated:

> *"Many duals have several prescriptions. Thus, while a $3 co-pay does not seem significant, it is when the duals have 7-8 prescriptions and they are asked to come up with $21-$24 for the co-pays. Many do not have this kind of money and pharmacies will not, for the most part, give the drugs without the co-pays as they feel it is too much money to lose."*

Impact on Pharmacies. A number of officials noted the negative impact of Part D on pharmacies. One respondent commented:

> *"This appears to be a long-term burden on pharmacies and the states to make this work with reduced reimbursement to the pharmacies. If pharmacies have long-term unreimbursed cost by the plans it certainly is a windfall for [the plans'] bottom line. CMS is still taking a hands-off approach and expecting competition to fix all the issues. I expect this is a long term cost shift that will result in some small pharmacies closing and tribal entities using grant funds to fill in the reimbursement gap."*

Passive Enrollment in Medicare Special Needs Plans. One feature of Medicare Part D that has received little attention relates to the "passive enrollment" of dual eligibles into Medicare Special Needs Plans (SNPs). A Medicare SNP is a Medicare coordinated care plan focused on individuals with special needs including persons who are institutionalized, dual eligibles and/or have severe or disabling chronic conditions. CMS permitted those dual eligibles enrolled in a *Medicaid* managed care plan to be "passively enrolled" into a *Medicare* SNP, when the SNP is operated by the same organization that provided these beneficiaries' Medicaid managed care coverage. Dual-eligibles passively enrolled with a Medicare SNP have the right to opt out of the plan enrollment and select an alternative plan. Officials in two states identified problems they observed with the passive enrollment process in their states. One official noted:

> *"We have had very significant issues with the 110,000 duals who were passively enrolled in SNPs. Besides the drug problems we had many problems with Medicare [fee-for-service] providers not participating in the SNP networks."*

Part D Plan Formularies. Some officials expressed concern about plan formularies. One noted that one out of four duals had been assigned to plans with less than 60 percent of their drugs covered. Another respondent expressed concern about the long-term health utilization impact once drug regimens had been fully transitioned to conform to formularies and other plan restrictions. Another predicted that mental health patients (about half of the dual eligibles according to this respondent) were at risk for long-term negative consequences.

> *"I visited a 68-year old, dual-eligible in her home, a run-down home with no heat and sheets on the wall to block the cold. She had mailed her Medicaid card to me because 'it didn't work anymore' and she didn't know how she was going to get the drugs her doctor had prescribed. She had to take two buses to get to the hospital pharmacy that she had been getting her drugs from since 1992 but they have not received their contracts with the PDP she was enrolled in. The local pharmacy told her she couldn't get three of her drugs."*

Potential Future Concerns. Some officials brought up longer-term issues related to future enrollment processes and plan participation.

> *"While circumstances have improved, we continue to see the same types of problems that were prevalent from the outset. We are concerned that another round of problems may occur when the partial duals are auto-assigned and whenever dual eligibility occurs."*

> *"I also expect the turmoil to continue as plans drop out and contracts with pharmacies churn over time."*

Conclusion

Implementing a new program as complex as Medicare Part D has been difficult. Perhaps for no other group among all 43 million Medicare beneficiaries has the transition been more important than for the more than six million dual Medicaid – Medicare beneficiaries. As a group, these beneficiaries have significant medical and prescription drug needs and ensuring continuity of their coverage is critical. Before implementation of Medicare Part D, this group had comprehensive prescription drug coverage through Medicaid. The challenge was to assure a seamless transition from Medicaid to the new coverage under Part D.

The transition of 6.2 million dual eligibles from Medicaid prescription drug coverage to Medicare Part D presented enormous challenges all around. Notwithstanding considerable effort on the part of CMS, states, the new private plans, pharmacies, providers, caregivers and others, it was difficult to have a perfect transition from Medicaid to Medicare Part D. The number of individuals involved, the complexities of the Part D structure, the characteristics of dual eligibles, the short timeframe, and the many providers, plans and beneficiaries that had to learn a new and complex system of coverage and billing all contributed to transition difficulties.

While the Part D benefit worked well for many at the outset, over 60% of the Medicaid officials reported "widespread" problems impacting a significant number of dual eligibles. As many state officials had anticipated,[11] dual eligibles experiencing problems accessing the Part D benefit frequently turned to State Medicaid agencies for assistance. The survey results indicate that most state Medicaid programs devoted significant time and effort to help resolve issues and a majority even implemented temporary coverage programs at considerable cost to ensure that dual eligibles would be able to get their prescriptions. A number of Medicaid officials believed that the situation was improving, while many raised concerns regarding the longer-term impacts of Part D including the impact of mandatory copayments, the impact of plan formularies and restrictions after the transition period, the impacts of future changes in the number of Part D plans and pharmacy participation, and the impacts of these changes on beneficiary access.

Given the number of potential issues indicated by the responses of Medicaid directors reflected in this report, this transition went remarkably well for most dual eligibles. However, the dual eligible population is large enough that even a small percentage represents a substantial number of people. Further, the characteristics of dual eligibles are such that continuous access to needed prescriptions is often critically important to their health and well-being. The fact that many dual eligibles experienced significant obstacles to access during the transition was clearly a major issue, and states were the only entities in a position to move quickly and address these problems. It is a credit to many states that they decided to provide transitional assistance even before it was known that they might be reimbursed for a portion of their costs for doing so.

A striking story re-told in many states during this survey was how state staff, volunteers, community based organizations, doctors and pharmacists jumped in to meet the needs of affected dual eligibles. As one state official observed, the real heroes were these individuals who got on the phones, often enduring literally hours of time on hold, to solve the immediate problems that were keeping these dual eligibles from getting the medicine they needed and for which they qualified.

[11] V. Smith, K. Gifford, S. Kramer and L. Elam, *A Medicaid Perspective on Part D Implementation; The Medicare Prescription Drug Program, Findings from a Focus Group Discussion with Medicaid Directors*, Kaiser Commission on Medicaid and the Uninsured, December 2005.

The issues associated with Part D implementation are improving but are not all resolved. It was clear from this survey that weeks, months or even years may be required to address them all. However, the early efforts of states described in this report averted more serious problems that might have occurred during the first weeks of transition.

Appendix A: Survey Document

Survey of State Actions in January 2006
Related To Medicare Part D Implementation
For the Kaiser Commission on Medicaid and the Uninsured

State of:	Name:	Date:

The purpose of this brief survey is to identify actions each state has taken since January 1 related to the implementation of Medicare Part D. This survey is being conducted for the Kaiser Commission on Medicaid and the Uninsured. A report based on this survey of all 50 states will be prepared as soon as we receive responses from all states. We will send the report to you as soon as it is available. If you have any questions, please call Kathy Gifford (317-575-4080) or me (517-318-4819). Please send your completed survey via email to (Vsmith@healthmanagement.com) or, if you would prefer regular mail or fax, to:

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I. Dual Eligible Issues

1. The media have reported problems in some states with dual eligibles transitioning from Medicaid to Part D prescription drug coverage. How would you describe any problems that dual eligibles in your state are having in obtaining covered Part D drugs previously paid for by Medicaid?

   Check one

   ☐ a. No significant problems
   ☐ b. Some problems, but the problems are not widespread
   ☐ c. Widespread problems impacting a significant number of dual eligibles

2. We are interested in the types of problems that dual eligibles in your state are having in obtaining covered Part D drugs previously paid for by Medicaid. We would like to get your sense of the primary causes of those problems.

   Check all that apply.

☐	a. Beneficiary does not know what plan he/she has been auto-assigned to.
☐	b. Beneficiary was not auto-assigned to a plan.
☐	c. Beneficiary was charged the incorrect cost-sharing.
☐	d. Beneficiary was charged Part D premiums.
☐	e. Beneficiary was unable to obtain a non-formulary drug from his/her Part D plan.
☐	f. Beneficiary was auto-assigned to a PDP not operational in your state.
☐	g. Beneficiary reported difficulties contacting the PDP helpdesks.
☐	h. Beneficiary reported difficulties contacting CMS (i.e. calling 1-800-Medicare or using the software tools available at www.medicare.gov (e.g., Part D Plan Finder).
☐	i. Pharmacies could not obtain enough details to bill Part D for a beneficiary's prescriptions from E1 transactions or from CMS call lines, etc.
☐	j. Other causes:
☐	k. Don't know.

KAISER COMMISSION ON
Medicaid and the Uninsured

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HEALTH MANAGEMENT ASSOCIATES

II. State Actions Related to Duals & Part D

3. Please check any actions your state has taken to help dual eligibles obtain needed Part D prescriptions.

Check all that apply.

State Actions ***My state has . . .***	Comments *(e.g., the time period temporary programs will be operational, potential for extensions, requirements for State payment, etc.)*
☐ a. Temporarily covered prescriptions for duals, when a pharmacy can show CMS remedies are not successful	
☐ Y ☐ N If yes, must a pharmacy obtain *prior authorization* or meet other requirements?	
☐ b. Temporarily covered for duals a one-time 30-day transitional prescription for a Part D non-covered drug	
☐ c. Temporarily covered Part D copays for duals, when PDPs charge amounts above MMA authorized levels	
☐ d. Provided loans to pharmacies	
☐ e. Worked with SSA to resolve Medicare eligibility discrepancies between the State and SSA files	
☐ f. Re-evaluated dual eligible coverage for Medicaid optional drugs, still qualifying for FMAP	
☐ g. Worked with your state's pharmacists association to resolve Part D issues	
☐ h. Referred dual eligible issues with Part D to CMS	
☐ i. Monitored dual eligible issues and taken no state action	
☐ j. Taken other actions listed below	

III. State Expenditures for Part D – Related Expenses

4. Has your state paid for prescriptions that should have been paid by Medicare Part D or for copays incorrectly charged to dual eligibles? ☐Yes ☐No *(If "no", skip to Question 6.)*

5. If you answered "yes" to Question 4 above, please indicate:

State Temporary Program for Duals During Part D Transition	Amount *If actual amts are not available, enter estimates.*		Timeframe *(In Weeks)*
	Actual	Estimate	
a. State expenditures:			
b. Number of prescriptions reimbursed:			
c. Number of beneficiaries covered:			
d. Extra administrative costs for the temporary program:			

IV. Recovery of Part D Related State Expenditures

6. CMS announced a demonstration plan to reimburse states for providing duals access to needed medications during the Part D transition. States would be reimbursed their drug costs through CMS payment reconciliation with PDPs. Also, CMS would reimburse states for any net drug cost differential after PDP reconciliation and for state administrative costs. We would like to get your sense as to how this plan will work for your state.

   Check one.

   ☐ a. The plan is workable and will present few administrative difficulties.
   ☐ b. The plan is workable, but will involve a number of administrative challenges.
   ☐ c. The plan is workable, but will impose significant administrative burdens on the state and will likely cause significant delays in the state's ability to recoup its Part D – related expenditures.
   ☐ d. The plan is unworkable and the state is unlikely to recoup its Part D – related expenditures.
   ☐ e. Don't know – we are still evaluating the plan.
   ☐ f. Other responses or comments:

7. My state is likely to:

   ☐ a. Apply for the demonstration plan.
   ☐ b. Consider the demonstration when more information is available.
   ☐ c. Not apply – even though my state implemented a temporary program to cover Part D drugs for duals.
   ☐ d. Not apply – since my state has *not implemented* a program to cover Part D drug for the duals.
   ☐ e. Don't know

V. Monitoring and Evaluation

8. We are interested in learning whether states are undertaking steps to evaluate Part D implementation for dual eligibles by monitoring health utilization trends. Please check which trends your state is monitoring to evaluate the transition of dual eligibles to Part D.

   Check all that apply.

   ☐ a. Inpatient hospital admissions
   ☐ b. Emergency room visits
   ☐ c. Nursing home admissions
   ☐ d. Dual eligible enrollment
   ☐ e. Pharmacies billing Part D covered prescriptions for dual eligibles
   ☐ f. None of the above
   ☐ g. Other:

VI. Auto-Enrollment Statistics

9. CMS has recently published new statistics on dual eligibles auto-enrolled into a PDP. For some states, the numbers vary significantly from the October 2005 counts provided by CMS. (See Appendix 1 to this survey.) Do you have any comments regarding the CMS auto-enrollment data for your state?

VII. Final Comments

10. In the space below, please provide any other comments you might have regarding the impact of Part D implementation on dual eligibles in your state.

This completes the survey. Thank you very much.

Appendix 1 - CMS Dual Eligible Auto-Assignments

	Auto-Assigned Number		Oct 2005 to Jan 2006	
State	*Oct 2005*	*Jan 2006*	*Change*	*Percent*
Alabama	82,974	82,098	-876	-1.1%
Alaska	10,674	11,255	581	5.4%
Arizona	44,413	49,528	5,115	11.5%
Arkansas	60,770	60,294	-476	-0.8%
California	847,996	875,243	27,247	3.2%
Colorado	37,342	37,546	204	0.5%
Connecticut	65,893	66,388	495	0.8%
Delaware	9,445	9,432	-13	-0.1%
District of Columbia	15,120	15,115	-5	0.0%
Florida	326,139	328,919	2,780	0.9%
Georgia	133,599	135,814	2,215	1.7%
Hawaii	22,460	22,740	280	1.2%
Idaho	17,866	17,909	43	0.2%
Illinois	247,254	248,315	1,061	0.4%
Indiana	93,062	94,379	1,317	1.4%
Iowa	54,548	54,545	-3	-0.01%
Kansas	38,828	38,927	99	0.3%
Kentucky	76,598	78,240	1,642	2.1%
Louisiana	89,493	134,174	44,681	49.9%
Maine	44,732	44,945	213	0.5%
Maryland	56,611	56,536	-75	-0.1%
Massachusetts	182,465	183,359	894	0.5%
Michigan	185,486	190,062	4,576	2.5%
Minnesota	56,903	58,047	1,144	2.0%
Mississippi	129,988	129,089	-899	-0.7%
Missouri	144,243	137,409	-6,834	-4.7%
Montana	14,724	14,750	26	0.2%
Nebraska	31,465	31,360	-105	-0.3%
Nevada	16,895	17,126	231	1.4%
New Hampshire	18,558	18,827	269	1.4%
New Jersey	135,498	135,048	-450	-0.3%
New Mexico	31,082	31,385	303	1.0%
New York	499,708	494,346	-5,362	-1.1%
North Carolina	216,703	215,945	-758	-0.3%
North Dakota	10,361	10,413	52	0.5%
Ohio	169,704	172,056	2,352	1.4%
Oklahoma	72,880	73,297	417	0.6%
Oregon	31,957	32,042	85	0.3%
Pennsylvania	135,359	146,752	11,393	8.4%
Rhode Island	26,093	25,939	-154	-0.6%
South Carolina	110,530	113,045	2,515	2.3%
South Dakota	11,653	11,551	-102	-0.9%
Tennessee	212,288	212,299	11	0.01%
Texas	294,295	295,043	748	0.3%
Utah	19,152	19,987	835	4.4%
Vermont	15,398	15,722	324	2.1%
Virginia	101,352	102,290	938	0.9%
Washington	93,233	94,042	809	0.9%
West Virginia	40,315	40,801	486	1.2%
Wisconsin	109,024	108,676	-348	-0.3%
Wyoming	5,475	5,443	-32	-0.6%
Total	5,498,604	5,598,493	99,889	1.8%

Appendix B:
CMS Medicare Demonstration Project:
Summary of Key Features

On January 24, 2006, CMS announced a new Medicare demonstration project[12] designed to reimburse states for the costs that they incurred establishing temporary programs to assure dual eligibles obtained needed medications. Under its provisions, federal reimbursement would be available for state payment of Part D covered prescriptions (only to the extent that costs are not recoverable from a Part D plan). Qualifying costs recoverable by states are limited to those occurring between January 1, 2006 and February 15, 2006. CMS developed the demonstration with input from a state workgroup and its key provisions include:

- A CMS payment reconciliation with Part D plans;
- Payment of any differential between what a state paid and what the Part D plan would have paid, where there is a difference in reimbursement rates to pharmacies; and
- Payment of administrative costs states incur for specific activities, including processing Part D covered claims, facilitating Part D enrollment, and obtaining benefits for dual eligibles and other low-income subsidy individuals. CMS has indicated that it anticipates some states will seek reimbursement only for administrative costs related to assisting beneficiaries who had difficulties using their Part D coverage.

A state participating in this demonstration project must agree to be the *payer of last resort* and instruct pharmacies to bill Part D plans or use Medicare point-of sale options before billing the state. Also, the demonstration project requires states to provide CMS with claims data (1) identifying prescription payments by beneficiary type and (2) separately identifying payments for the low-income subsidy's $1 to $5 cost sharing and for excluded Part D drugs.

CMS expects to compute an initial amount owed to a state – based on edit checks of expenditures states made to assure prescriptions were paid for dual (or other low-income subsidy) eligibles included in the demonstration. CMS will then remit that amount to a state and then use data submitted by states to recover from each plan the portion of CMS payments to the states that is the responsibility of the plan.[13]

[12] CMS Fact Sheet, "State Reimbursement for Medicare Part D Transition", January 24, 2006. The demonstration is authorized under Section 402 of the Social Security Amendments of 1967, as amended.
[13] CMS letter to state Medicaid directors, February 2, 2005, SMDL #06-001 and attachment titled "Section 402 Demonstration Application Template, Reimbursement of State Costs for Provision of Part D Drugs"

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