kaiser commission on medicaid and the uninsured

# COORDINATING MEDICAID AND MEDICARE PRESCRIPTION DRUG COVERAGE

## Findings from a Focus Group Discussion with Medicaid Directors

Prepared by:
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AND

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**November 2003**

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.**

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This paper is based entirely on discussions with a group of Medicaid officials who gathered to discuss the Medicaid administrative ramifications of a Medicare prescription drug benefit. 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 directors and officials from: Illinois, Iowa, Minnesota, New York, Oklahoma, Texas, Utah and West Virginia.

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## *EXECUTIVE SUMMARY*

On October 26, 2003, ten Medicaid officials, including Medicaid Directors from eight states, came together to discuss the implications of the proposed Medicare drug benefit for states and "dual eligibles" (i.e., people who are enrolled in both Medicare and Medicaid coverage). Health Management Associates conducted the discussion for the Kaiser Commission on Medicaid and the Uninsured. The discussion was wide-ranging, with particular focus on: 1) The implications of a requirement that states determine eligibility for the Medicare Part D low-income subsidy program; and 2) the tools that states would need to coordinate the prescription drug coverage provided to dual eligibles under Medicare and Medicaid if they are included in the new Medicare prescription drug benefit (as is now widely expected).

## *OVERALL REACTION*

It is often assumed that a Medicare drug benefit will provide substantial benefits to states. However, many focus group participants noted that the current proposals under discussion might inadvertently leave states worse off in a number of unanticipated ways.

- **Limited fiscal relief.** Participants noted that much of the fiscal relief states otherwise would secure as a result of the federal government providing some prescription drugs to dual eligibles must be returned to the federal government if a House provision designed to limit the cost of the Medicare bill (known as the "clawback" requirement) is adopted.

- **Major new responsibilities for administering Medicare's low-income subsidies**. States are expected to face major new – and costly -- responsibilities for evaluating the eligibility of low-income seniors for a Medicare Part D subsidy program and enrolling them in Part D plans at a time when state budgets and staff are being reduced.

- **Loss of control over prescription drug benefit for dual eligibles.** Participants were concerned that states would largely lose control over the management of the prescription drug benefit for dual eligibles even though they likely will still provide some drug coverage to this population.

- **Possible prohibition on using Medicaid to supplement the Medicare drug benefit.** Some participants were concerned states might not be allowed to supplement the Medicare Part D benefit to ensure it meets their Medicaid standards, a scenario they suggested could harm beneficiaries and/or impose new fiscal burdens on states. If Medicaid funds are not available to supplement Medicare coverage, states would have to use state general revenue funds for this purpose.

## *ADMINISTERING THE LOW-INCOME SUBSIDY*

The participants expressed serious reservations about their capacity to be prepared by 2006 to conduct eligibility determinations for the Medicare Part D low-income subsidy program. A number of them suggested that an entity other than states, such as a national enrollment broker

acting on behalf of Medicare, could be more effective at enrolling eligible people in coverage than Medicaid agencies. If required to administer the low-income subsidy program, they suggested that the following would ease the burden:

- **Uniform, national eligibility standard.** In the absence of a national eligibility standard for Medicare's low-income subsidy program, participants were concerned that issues would be raised about the inequitable treatment of Medicare beneficiaries across states.

- **No asset test.** A number of participants suggested that including an asset test in the Medicare low-income subsidy program would greatly and un-necessarily increase the complexity and expense of evaluating eligibility. An asset test likely would not substantially reduce the number of people eligible for coverage, but it would make the application process much more cumbersome. It would require states to ask detailed questions about Medicare beneficiaries' possessions and to make complicated decisions about the value of such possessions. Medicaid officials believed an asset test likely would not work well, but that it would be burdensome to administer.

- **Substantial federal assistance.** Medicaid officials believed they would be mandated to take on additional responsibilities if a Medicare prescription drug bill is enacted, but that they would not be provided with the resources necessary to fulfill these new responsibilities. They strongly argued for additional matching funds (beyond those specified in existing versions of the Medicare bills) to make it possible for them to hire the staff needed to evaluate eligibility for the low-income subsidies; to modify their computer systems to support the process; and to enroll dual eligibles in Part D plans. In addition, they will need new resources to ensure they can effectively supplement the Medicare drug benefit (if a "wrap" is required, as discussed below) and to update their manufacturer rebate contracts and billing processes.

### *COORDINATING MEDICARE AND MEDICAID DRUG COVERAGE*

When the focus group was held on October 26, 2003, conferees were considering prohibiting states from using Medicaid to supplement the Medicare drug benefit to raise coverage for dual eligibles to states' Medicaid standards. As a result, HMA asked participants to address both the implications of a prohibition on state Medicaid programs supplementing the Medicare prescription drug benefit, as well as the tools they would need to make a "wrap" work effectively if it were required.

**If a wrap is prohibited:** As noted above, a number of the participants expressed serious concerns about the possibility that states might not be allowed to use Medicaid to wrap around the Medicare Part D benefit. They suggested this could harm beneficiaries and/or impose new fiscal burdens on states. On the other hand, some Medicaid directors from states with more limited Medicaid drug benefits were supportive of the possibility that Medicaid would not be required to wrap because it would eliminate many of their coordination concerns.

**If a wrap is not prohibited:** Several participants were concerned that Medicaid might not be allowed to supplement the Medicare Part D benefit as needed. But if Medicaid is allowed to wrap around the Medicare benefit, they also were concerned about the difficulties of doing so.

Many challenges would arise because states would likely need to wrap around a number of different Part D plans, each potentially with a different formulary and a different cost-sharing structure. When we asked the participants for discussion purposes to assume that a wrap would be required and to offer specific suggestions to streamline the process, the group mentioned the following:

- **Provide states with timely information on dual eligibles' enrollment in Part D plans and low-income subsidy status**. States need timely information from the federal government / Part D plans about who is eligible for a low-income subsidy and the Part D plan in which each dual eligible is enrolled.

- **Ensure states have updated information on Part D plan formularies.** States need up-to-date information on the formularies of the plans in which dual eligibles are enrolled to determine when Medicaid, rather than Part D, might be the appropriate source of drug coverage.

- **Provide states with timely information on dual eligibles' Part D drug expenditures and utilization patterns.** States need timely information on dual eligibles' drug expenditures and use of drugs to ensure they are wrapping for cost-sharing obligations appropriately and that they can include dual eligibles in their disease management initiatives and drug utilization review systems.

## *CONCLUSION*

Participating Medicaid officials were hopeful about the possibility of a Medicare prescription drug benefit, but were concerned that the current proposals under discussion do not fully take into account the reality of states' current budget situations and their capacity to take on significant new responsibilities for a major new Medicare initiative. They noted that the administrative and coordination issues that they identified in this discussion likely represented only the "tip-of-the-iceberg." As such they suggested that it would be vital in the years ahead for states and the federal government to have an ongoing system or process in place for addressing coordination issues as they arise (e.g., a commission or task force).

## I. Introduction

State Medicaid programs currently provide prescription drug coverage to close to six million Medicare beneficiaries who also are enrolled in Medicaid. These dual eligibles – who are much poorer and much sicker than other Medicare beneficiaries – turn to Medicare first when they need health care services, but then rely on Medicaid to fill the gaps in their Medicare coverage. Most significantly, Medicaid covers their long-term care services and prescription drugs.

Prescription drugs are a vital part of the array of services that Medicaid currently provides to dual eligibles. The cost of this coverage has risen rapidly, contributing to sharp increases in the rate of Medicaid spending growth across the country. In response, states have developed new strategies to contain prescription drug growth (e.g., preferred drug lists, supplemental rebates, pharmacy reimbursement reductions, incentives to use generics, etc.). In some cases, states have also reduced the comprehensiveness of their Medicaid prescription drug benefit by limiting the number of prescriptions an individual can receive in a month. Because states are the primary payer of prescription drugs for dual eligibles, state Medicaid programs and their beneficiaries have much at stake in the outcome of the debate on a Medicare prescription drug benefit.

Throughout the debate over the Medicare drug bill, there has been extensive discussion about the implications of *including* versus *excluding* dual eligibles from the new "Part D" Medicare prescription drug benefit. Under the Senate bill, dual eligibles would be ineligible for the Medicare prescription drug benefit if they have prescription drug coverage through Medicaid. In contrast, the House bill would allow all Medicare beneficiaries, including dual eligibles, to enroll in the new Medicare prescription drug benefit. As of the end of October 2003, it appeared the Medicare conferees were leaning toward including dual eligibles in the Medicare prescription drug benefit.

However, far less attention has been paid to the administrative and process issues that will arise if dual eligibles are included in the Medicare drug benefit and states must coordinate the prescription drug coverage that they qualify for under Medicare and Medicaid. These issues are critically important to dual eligibles -- who may need to navigate two relatively complex health care programs to secure prescription drug coverage – and are equally important to states since they would be required to play a key role in coordinating coverage.

To explore the implications for beneficiaries and state Medicaid agencies of including dual eligibles in the Medicare prescription drug benefit, Health Management Associates conducted a focus group discussion with Medicaid directors for the Kaiser Commission on Medicaid and the Uninsured. In addition, since the issues are closely related, the focus group also discussed the implications for states and beneficiaries of the Medicare subsidy program for low-income individuals in need of assistance with their Part D premiums and cost-sharing obligations.

## II. Background on the Focus Group

Health Management Associates (HMA) convened a focus group with ten Medicaid officials, including Medicaid directors from eight states, to discuss the implications of the proposed Medicare drug benefit for Medicaid beneficiaries and states. When selecting participants for the meeting, HMA sought to include a diverse group of states from across the country. The ten

participants represented states in different geographic regions, states with varying degrees of restrictions in their Medicaid prescription drug benefit, and states involved with the Pharmacy Technical Advisory Group convened by the Centers for Medicare and Medicaid Services (CMS) and the National Association of State Medicaid Directors.

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 October 26, 2003, a date made possible because Medicaid directors were convening for their annual conference in Bethesda, Maryland the following day. At the time of the discussion, members of Congress were still working to develop a conference report on the Medicare bill. For purposes of the conversation, participants were asked to assume that dual eligibles would be included in the proposed Part D prescription drug benefit. With regard to several other issues, however, participants were asked to consider the implications for states and Medicaid beneficiaries if the issues were resolved by Congress in a number of different ways.

The remainder of this report is based on the discussion with participating Medicaid officials. It begins in the next section with an overview of the key themes expressed by focus group participants. It then continues with a more detailed discussion of the implications of the low-income subsidy program for states and beneficiaries (Section IV); the tools states will need to effectively coordinate the prescription drug coverage provided to dual eligibles under Medicaid and Medicare (Section V); and an array of other, more discrete coordination and administrative issues (Section VI).

## III. Overall Implications for State Medicaid Agencies and Beneficiaries

The Medicare prescription drug benefit has the potential to be of great benefit to seniors and other Medicare beneficiaries, and also has significant potential to relieve states of the fiscal burden of providing prescription drug coverage to dual eligibles under Medicaid. Yet it was not apparent to participants that the current proposal would provide substantial assistance in this regard. A number of focus group participants voiced the strong concern that – depending on the details of how it is crafted – the Medicare prescription drug benefit could inadvertently leave states worse off in a number of ways. Participants also raised the concern that dual eligibles might end up with worse prescription drug coverage than they now have under Medicaid if the conferees adopt a provision currently under discussion that would prohibit states from using Medicaid to supplement the prescription drug coverage available under Medicare.

Several participants identified the following provisions as raising issues that could offset much of the potential benefit of a Medicare prescription drug benefit and/or potentially adversely affect Medicaid beneficiaries:

- **The clawback requirement**. Under the "clawback" requirement included in the original House bill, states must return to the federal government much of the fiscal relief that they otherwise would accrue as a result of the Medicare bill. The federal government "reclaims" the fiscal relief by reducing states' Medicaid matching payments using a formula. Particularly in the early years of implementation, states would retain only a small amount of the potential Medicaid savings associated with a Medicare prescription drug benefit. In some states, the amount of retained savings may not be enough to offset other new costs states are required to bear. (The details of the final clawback requirement were uncertain on October 26th, making it difficult for the participants to concretely assess the magnitude of the loss to their states associated with this provision).

> ***"Even under the best scenarios, the state will be shouldering a significant financial responsibility in the drug area, for the foreseeable future. The feds will pick up more, but we will maintain a significant financial responsibility."***

- **New responsibilities for low-income subsidy eligibility determinations.** It will be costly for states to implement new requirements that they determine eligibility for the Medicare low-income subsidy program and enroll dual eligibles in Part D plans. In a time when states are cutting back, the administrative resources may not exist in some states to undertake these new responsibilities. Most participants also suggested that Medicaid beneficiaries would be more likely to enroll in the new low-income subsidy program if they could sign up through a national Medicare enrollment broker or other route – rather than a Medicaid agency.

- **Possible prohibition on using Medicaid to supplement the Medicare drug benefit.** Some participants expressed concern about the possibility that states might not be allowed to supplement the Medicare Part D benefit to ensure it met their Medicaid standards, a scenario that they suggested could harm beneficiaries and/or impose new fiscal burdens on states. They noted that advocacy groups in their state and policymakers would not readily accept a decline in the quality of drug coverage available to dual eligibles. Thus, states might have to use their general revenue funds to finance at least some of the "wrap-around" on their own. (As discussed later, however, some participants saw the possibility that they would not have to supplement the Medicare drug benefit to raise it to Medicaid standards as a way to simplify coordination efforts.)

> ***"We've been saying for 15 years, this population is the responsibility of Medicare – not the states. But we are not saying we want to cut drug coverage for our elderly Medicaid recipients."***

- **Loss of ability to manage the prescription drug coverage that states must continue to provide to dual eligibles.** A number of the participants noted their states would largely lose control over the management of the prescription drug benefit for dual eligibles even though they likely will still need to provide some drug coverage to this population. For example, states will potentially

> ***"Are we now going to be forced to pay for these drugs, but we won't be able to do PA [prior authorization], we won't be able to do PDLs [Preferred Drug Lists], we won't be able to get OBRA 90 rebates?"***

lose savings from manufacturer rebates (either from the federal program or from state supplemental rebate programs), as well as control over reimbursement rates for prescription drugs.

Overall, a number of participants were concerned that states and beneficiaries might not fare as well if a Medicare prescription drug bill is adopted as is widely assumed in the absence of significant modifications to the bill.

## IV. States' Role in the Administration of Low-Income Subsidies

### *BACKGROUND*

#### Basic Structure of the Medicare Prescription Drug Benefit (Part D)

The basic Medicare prescription drug benefit in both the Senate and the House bills is based on a structure that includes a deductible; an initial coverage period in which the federal government picks up a substantial share of the beneficiary's drug costs; a coverage gap (i.e., "doughnut hole") during which the federal government does not subsidize the cost of drugs; and catastrophic coverage (although the details between the two bills vary significantly). Conferees also are considering allowing Part D plans to propose "actuarially equivalent" packages to the standard benefit – thus beneficiaries may have a choice of numerous types of benefit plans with cost-sharing requirements and monthly premium rates that vary significantly from the standard benefit and from one to the other.

#### Low-Income Subsidies For the Medicare Prescription Drug Benefit

Both the Senate and House bills require states to play a central role in determining eligibility for the Medicare prescription drug subsidy program available to low-income individuals. The final form of the subsidy program was not known as of October 26, 2003, although the conferees appeared to be leaning toward providing comprehensive premium and cost-sharing assistance to low-income individuals with incomes below 135 percent of poverty who can meet an asset test, as well as more limited assistance to individuals with income up to 150 percent of the poverty line who can meet an asset test.

Both the original House and Senate bills anticipated providing additional federal financial assistance to states to conduct eligibility determinations for the Medicare low-income subsidy program. However, neither bill offered financial assistance that would fully cover the new administrative costs for states over the next 10 years. States also are likely to face higher Medicaid costs as a result of people discovering they are eligible for Medicaid when they apply for Medicare's low-income subsidy program.

### *PARTICIPANTS' OBSERVATIONS AND SUGGESTIONS*

The participants expressed serious reservations about their capacity to be prepared by 2006 to conduct eligibility determinations for the proposed Medicare low-income subsidy program. They were concerned that they do not have the staff to evaluate the eligibility of millions of seniors for low-income subsidies. Moreover, their computer systems are not equipped to handle

this new function, and the systems changes that are needed would be costly, cumbersome, and time-consuming for states to implement. Their specific suggestions/thoughts on determining eligibility for the low-income subsidies included the following.

- **A uniform, national eligibility standard for the low-income subsidy program would promote equity across states.** Many of the participants suggested a uniform, national standard should be used when setting the rules used to determine eligibility for the Medicare low-income subsidy program. In the absence of such a standard, they were concerned that issues would be raised about the inequitable treatment of Medicare beneficiaries across states.

  ***"The feds need to contract with a national enrollment broker. Instead of paying all the states… It will work more effectively, efficiently, more fairly, more consistently."***

  ***"Medicare is a social insurance program paid into by participants that should not be subject to the relative vagaries of a state's administrative capacities."***

  For example, if eligibility for the Medicare low-income subsidy program were linked to a state's rules for determining eligibility for selected Medicaid eligibility categories, Medicare beneficiaries in some states would be eligible for the low-income subsidy at higher income and asset levels than their counterparts who happened to reside in other states with more restrictive Medicaid eligibility criteria. Similarly, some states might adopt requirements that Medicare beneficiaries participate in on-site interviews to sign up for the low-income subsidy, while others might allow them to mail in their applications, creating disparities across states in the rate at which Medicare beneficiaries take advantage of the low-income subsidy program.

- **If the Medicare low-income subsidy program includes an asset test, it will add enormous complexity to the eligibility determination process.** A number of participants suggested that the inclusion of an asset test in the low-income subsidy program is a major problem for states, greatly complicating the complexity and expense of evaluating eligibility for Medicare's low-income subsidy program.

  Indeed, one participant listed the asset test in the low-income subsidy program as one of the top administrative challenges that would likely confront states if it were to be included in the Medicare bill. The participant noted that an asset test requires states to ask detailed questions about the equipment and other possessions owned by seniors, as well as to make complicated decisions about the value of such equipment. The challenges, she suggested,

  ***"An asset test in the eligibility determination process will present tremendous challenges for states, especially states with a large number of rural residents who own assets that are difficult to value, like a tractor that a retired farmer bought in the 1970s and keeps in his barn or out back in a field, or livestock owned by multiple family members."***

  ***"Do we really want to spend time determining which 85-year-olds own fishing boats?"***

  ***"Eligibility based on income but not assets would streamline the process and assure consistent determinations."***

will be particularly daunting for states with a large number of rural residents since they are more likely to have assets that are difficult to value, such as a tractor purchased in the 1970s that a retired farmer keeps in his barn or out back in a field, or livestock that is jointly owned by multiple family members. This Medicaid director and others suggested that the asset test should be completely eliminated, but anything to make it easier would help, such as explicitly setting rules that would allow them not to consider things such as farm equipment, or allowing options for self-declaration.

- **States need substantial federal assistance with the cost of making eligibility determinations and enrolling dual eligibles in Medicare Part D plans.** The participants strongly argued for additional matching funds (beyond those specified in existing versions of the Medicare bills) to make it possible for them to hire the staff needed to evaluate eligibility for the low-income subsidies and to modify their computer systems to support the process.

  The participants pointed out that they also will need federal financial assistance for expenses associated with helping dual eligibles to select and enroll in a Part D plan, a major task that is distinct from evaluating eligibility for low-income subsidies.

  Some participants wanted the flexibility to mandate that dual eligibles enroll in a single Part D plan, or a choice of two Part D plans. Others thought it was not appropriate to restrict the enrollment choice of dual eligibles any more than other Medicare beneficiaries. Still others wanted to assign dual eligibles to a plan if they did not select one on their own within a set timeframe. (This last option would allow states to use procedures similar to those they currently employ when enrolling Medicaid beneficiaries into managed care plans.)

- **More Medicare beneficiaries will enroll in the low-income subsidy program if an entity other than Medicaid agencies conducts eligibility determinations.** A few participants suggested that a national enrollment broker acting on behalf of Medicare or the Social Security Administration (SSA) could more effectively enroll Medicare beneficiaries in the low-income subsidy program than state Medicaid agencies. They noted that many of their constituents continue to equate Medicaid with welfare, making it possible that many Medicare beneficiaries would be reluctant to apply for a low-income subsidy at a Medicaid office. (Indeed, in many states the welfare agency or its counterpart in the counties – rather than the Medicaid agency – conducts eligibility determinations for Medicaid.) They suggested the stigma associated with applying for assistance through a Medicaid/welfare agency is greater for seniors than other groups of Medicaid beneficiaries because there is widespread concern among seniors about Medicaid's estate recovery practices. At a minimum, the participants' comments suggested that it would increase enrollment in the low-income subsidy program if SSA offices/Medicare played at least some role in signing people up for the new subsidy.

  ***"To think you would go to SSA for your social security and SSA for your regular Medicare, and then you'd have to go to your state [welfare office] for your drug coverage."***

  ***"From a beneficiary perspective, the people who are elderly now really do associate the local social services agencies with the county poor farms and poor relief during the depression and for those of us who are quite aggressive with estate recovery, with people who will take your home."***

  ***"There's the issue of senior citizens, many of them not wanting to go to a welfare office to apply for benefits, and that's not going to change, so many of them won't do it."***

- **States need tools for handling Medicare beneficiaries who reside in more than one state over the course of a year.** Medicaid officials also pointed to the challenges created by the mobility of the Medicare population. Participants raised the question of who would be responsible for enrollment of the "snowbirds," seniors who live in northern states during part of the year, and in southern states the rest of the year? If states are expected to determine eligibility for the Medicare low-income subsidy program, they will need tools for handling these and other part-year residents.

## V. Medicaid's Role in Supplementing the Medicare Prescription Drug Benefit for Dual Eligibles

### *BACKGROUND*

Under the House Medicare bill, dual eligibles were included in the Medicare prescription drug benefit. Medicaid, however, was still expected to play a role in supplementing the Part D benefit as needed to raise it to Medicaid standards (or "wrapping" around it).

#### Wrap-Around on Cost-Sharing

Under the House bill, Medicaid was expected to pay Part D cost-sharing obligations of dual eligibles when they exceeded the levels allowed under Medicaid law. (The one exception is that

Medicaid was not expected to offset any of the $2 and $5 cost-sharing charges that dual eligibles enrolled in the low-income subsidy program would incur until their total drug costs reached an initial limit of $2,000.) For example, the House's version of the low-income subsidy program would not cover any of a dual eligible's prescription drug costs in excess of $2,000 until his or her out-of-pocket expenses reached a catastrophic level. Thus, Medicaid would be required to pay dual eligibles' out-of-pocket costs as needed to ensure their cost-sharing obligations did not exceed allowable Medicaid levels. Conferees are still discussing the structure of the low-income subsidy program, as well as the role that Medicaid would play in helping dual eligibles meet their Part D cost-sharing obligations.

Wrap-Around for Coverage

Additionally, under the House bill, state Medicaid agencies would be expected to provide dual eligibles with any prescription drugs not covered by their Part D Medicare plans as long as they were medically necessary and otherwise covered by the state's Medicaid program.

As of the October 26, 2003 focus group, it appeared that conferees were considering prohibiting states from wrapping around the Medicare drug benefit to raise coverage to Medicaid standards. As a result, HMA asked participants to address both the implications of a prohibition on state Medicaid programs supplementing the Medicare prescription drug benefit, as well as the tools they would need to make a "wrap-around" work effectively if it were required as under the original House bill.

### *PARTICIPANTS' OBSERVATIONS ABOUT POSSIBILITY THAT MEDICAID WILL NOT BE ALLOWED TO SUPPLEMENT MEDICARE PRESCRIPTION DRUG COVERAGE*

A number of the participants expressed concerns about the possibility that states might not be allowed to wrap the Medicaid drug benefit around the Medicare Part D benefit, a scenario that they suggested could harm beneficiaries and impose new fiscal burdens on states. Those raising this issue indicated that advocacy groups and policymakers in their states would not likely accept a decline in the quality of drug coverage for dual eligibles as a result of enactment of the Medicare bill. Thus, to maintain the same coverage, states that historically have provided a comprehensive prescription drug benefit to dual eligibles under Medicaid would be forced to use their general revenue funds to finance at least some of the wrap-around on their own. To the extent they cannot find ways to supplement the Medicare coverage, many dual eligibles could end up with worse drug coverage than they currently receive from Medicaid.

***If Medicaid is prohibited from wrapping…***

***"Medicaid recipients will get fewer drug benefits than they get now. They won't care where it comes from, Medicaid or Medicare."***

On the other hand, a couple of the Medicaid directors from states with more limited Medicaid drug benefits (i.e., states that have limits on the number of prescriptions that Medicaid will pay for each month) were supportive of the possibility that Medicaid would not be required to wrap-around. They pointed out that if they did not have to

***"Because of the management issues that we have imbedded in our pharmacy program, where some drugs have preference over others, it seems like you will lose that. It's not just multiple companies – it's multiple drugs, benefit structures and cost sharing."***

wrap-around, it would minimize state expenditures and eliminate many of their coordination concerns (described below).

Overall, it seemed that states with a comprehensive Medicaid drug benefit expressed strong concerns that they might be prohibited from supplementing the Part D coverage of dual eligibles with Medicaid funds, while states with a more limited Medicaid drug benefit were more open to the prospect that they would not need to coordinate Medicare and Medicaid prescription drug coverage.

### *PARTICIPANTS' OBSERVATIONS ABOUT THE POSSIBILITY THAT MEDICAID WILL BE REQUIRED TO SUPPLEMENT MEDICARE PRESCRIPTION DRUG COVERAGE*

Although many of the participants were concerned that Medicaid might not be allowed to supplement the Medicare Part D benefit as needed, they also were concerned that it would be extremely difficult for them to do so. One participant noted, "It's not, do you wrap-around, but how do you wrap and what do you wrap?" Many challenges would arise because states would likely need to wrap-around a number of different Part D plans, each with a different formulary and, potentially, a different cost-sharing structure.

> ***" Let's use Zocor and Lipitor, as an example… We might decide Zocor was the drug of choice [in Medicaid]. And let's say the PBM that won the contract from the Feds covers Lipitor. What do we do?"***

On the cost-sharing issues, they noted that even though it seemed conferees had decided to provide a comprehensive low-income subsidy to individuals with income below 135 percent of poverty, states still have a number of dual eligibles, who would not qualify for the low-income subsidy program. For example, most states provide Medicaid to "medically needy" seniors and disabled individuals whose available net income, after medical expenses are taken into account, falls below the poverty level even though their gross income might exceed 135 percent of poverty. As a result, states will still need to help some dual eligibles meet their Part D cost-sharing obligations, including the costs that a dual eligible might incur if he or she ends up "in the doughnut hole."

When we asked the group to assume for discussion purposes that a wrap-around would be required and to offer specific suggestions to streamline the process, participants mentioned the following:

- **Provide states with timely information on dual eligibles' enrollment in Part D plans and low-income subsidy status**. States need timely information from the federal government / Part D plans about who is eligible for a low-income subsidy and the Part D plan in which each dual eligible is enrolled.

- **Ensure states have updated information on Part D plan formularies.** States need information on the formularies of the plans in which dual eligibles are enrolled to determine when Medicaid, rather than Part D, might be the appropriate source of drug coverage. The information needs to be up-to-date, reflecting the current status of each Part D plan's

formulary. It would not be sufficient simply to refer states to a variety of Part D web sites to gather such information on their own. In addition, states will need a standardized record format to transmit each Part D plan's formulary provisions into their Medicaid payment systems.

- **Provide states with information on dual eligibles' Part D drug expenditures and utilization patterns.** States need information on the drug expenditures of dual eligibles to ensure they are wrapping for cost-sharing obligations appropriately (e.g., they need to know if a dual eligible has reached the doughnut hole or not). It would help states if such data were available in a real-time, online fashion so that they could support their own online claim adjudication systems. As with the information on each Part D plan's formulary, it is important such data be shared with states in a standardized record format.

  Several participants also expressed interest in obtaining data from the Pharmacy Benefit Managers on dual eligibles' utilization of medications under their Part D plans. These data are used now by Medicaid for disease management initiatives and drug utilization review systems that are designed to reduce prescription drug adverse interactions, reduce hospital stays and emergency room visits, monitor the appropriateness of physician prescribing patterns, and control spending. In the absence of such data, states may not be able to continue to effectively include dual eligibles in these programs.

> ***"We need that information [that we use for DUR –Drug Utilization Review] in our reports. It's very important."***

## VI. Other Issues

### *TREATMENT OF INSTITUTIONALIZED POPULATIONS*

Medicaid officials indicated they were daunted by the prospect of wrapping around the Medicare benefit for dual eligibles residing in the community, but that it would be an even greater challenge to make such a wrap-around work for institutionalized individuals.

Several issues were mentioned. One was that nursing homes conventionally work with a single pharmacy. By contracting with a single pharmacy, a nursing home can improve the quality of care provided to its residents by standardizing drug administration protocols and training of nursing home staff on the use of pharmaceuticals. The use of a single pharmacy also streamlines controls for utilization and clinical reviews appropriate to an institutionalized setting. Centralization allows the chosen pharmacy to negotiate better prices based on increased volume. If nursing home pharmacies must work with multiple Part D plans to provide prescription drugs to their Medicaid residents, it could significantly undermine their prices, quality, and utilization control initiatives. Participants also noted that some states have folded prescription drugs into the per diem rate paid to nursing homes.

> ***"In some states, the pharmacy benefit is part of the nursing home benefit. It is a required service of the nursing home benefit."***

Overall, participants noted that the coordination of prescription drug coverage for dual eligibles residing in nursing homes was an area that requires far more attention.

### *MANUFACTURER REBATES*

Since 1991, federal law has provided states with manufacturer rebates on all Medicaid prescriptions, significantly reducing the cost of providing prescription drugs to Medicaid beneficiaries. Under the Medicaid rebate law, states receive federal rebates on most prescriptions paid for in all or in part by Medicaid – even though Medicaid may have paid for only a small share of the cost of the drug (e.g., Medicaid might make a copayment on behalf of a beneficiary with another source of prescription drug coverage). Rebate collections vary by state, but according to a report from the National Pharmaceutical Council they amount to an average of about 20 percent of Medicaid expenditures on prescription drugs.

> ***"Is this a way of saying that if we negotiated a supplemental rebate, we won't get it, even though we may be paying a substantial share of a Medicare beneficiary's drug benefit?"***

The House version of the Medicare prescription drug benefit specifies if a State elects to pay a prescription for a dual eligible "based on the prices negotiated by [a Medicare plan]," the section of federal law that established the Medicaid rebate system will not apply. Although unclear, this language raises the possibility that Medicaid programs might not be able to collect rebates on Part D-financed prescriptions for which they pick up some of the cost. For example, can a state secure a Medicaid rebate when it pays a dual eligible's Part D cost-sharing obligations up to the initial limit? Or when it pays for the full cost of a prescription for a dual eligible because he or she has yet to meet the deductible for the Part D benefit? Although these are technical issues, discussion participants indicated the answers to these questions could have very significant fiscal implications for states.

More generally, participants raised the concern that Part D plans might not be as effective as state Medicaid agencies at keeping the price of prescription drugs down. (States currently rely on the federal Medicaid rebate program, as well as a wide array of additional tools to control drug costs, including supplemental rebates.) If so, states could find themselves being asked to pay for Part D prescription drugs on behalf of dual eligibles using prices that are higher than would have applied if Medicaid alone purchased a prescription.

Moreover, to the extent that Part D plans pay higher prices for drugs than necessary, it means the "clawback" provision (discussed above) might cause even more fiscal harm to states than expected. In the House's original version of the clawback, the amount of money states must return to the federal government is a function of the amount that Medicare spends providing a low-income subsidy to dual eligibles. Thus, if Medicare spends more than necessary on its low-income subsidy program due to high prescription drug prices, the amount of money that states must return to the federal government increases. Participants were concerned they would have no control over this amount.

While many questions remain unanswered, participants agreed that they would need to make complex modifications to both their payment and manufacturer rebate software if a Medicare bill is enacted. Prescriptions for certain individuals in certain circumstances would have to be

excluded from their rebate billing systems. For example, Part B outpatient drugs would always be included in the manufacturer rebate program under federal authority, but the new Part D drugs might be included in the deductible and doughnut hole periods only.

Finally, one participant raised an issue regarding state supplemental rebate initiatives. Would states that have been able to negotiate supplemental rebates lose that rebate revenue as well with implementation of the Part D pharmacy benefit?

### *MEDICARE DISCOUNT PRESCRIPTION DRUG CARD*

***"One of the biggest concerns being expressed is the discount card, and having to do that by January or April, without the necessary systems support."***

Participants discussed the proposed Medicare prescription drug card. Information available at the time of the discussion suggested that states might be expected to determine eligibility and assist in implementation in a very short timeframe (possibly three or four months after enactment). Participants expressed strong reservations about their administrative capacity to take on these responsibilities, especially within the proposed timeframe.

### *FEDERAL MATCHING FUNDS FOR ADMINISTRATIVE ACTIVITIES*

As of the focus group on October 26, 2003, conferees had not finalized provisions regarding reimbursement for state administrative functions related to the proposed Medicare prescription drug benefit. The focus group participants noted that it appears Congress is considering providing enhanced federal funds only for the costs states incur as a result of conducting eligibility determinations for low-income subsidies. The participants, however, were very concerned that they would incur substantial new administrative costs for a much broader array of functions. These would include services, staffing, and systems related to (1) dual eligibles' enrollment in Part D plans, (2) Medicaid reimbursement system changes for coordination of benefits, and (3) manufacturer rebate contracts and billing processes.

### *NEED FOR ONGOING PROCESS TO ADDRESS COORDINATION & DATA EXCHANGE*

A number of participants suggested that it would be vital in the years ahead for states and the federal government to have a system or process in place for addressing coordination issues as they arise (e.g., a commission or task force). They noted that such a system is particularly important because many issues that significantly affect the ability of states and the federal government to coordinate prescription drug coverage for dual eligibles may not even be fully identified until well after the bill is enacted. In addition, they noted the importance of a decision-making and policy promulgation process on coordination issues that is formal, rather than one that simply relies on "Dear State Medicaid Director" letter or other informal mechanisms to resolve issues.

### *CHALLENGES IN UNDERSTANDING & EXPLAINING THE IMPLICATIONS OF THE BILL*

A few participants noted that the complexity of the Medicare drug benefit will make it challenging for them to explain it to other policymakers within their state, as well as to beneficiaries. Indeed, it already has been challenging for them to explain the proposed Medicare

bills to concerned policymakers given the complex nature of these bills, as well as the lack of details on many issues of great import to states. For example, the Medicaid directors fully expect that they will be asked to assess the fiscal impact of any final bill on their states within days of it being enacted, but that they will have a limited ability to prepare accurate estimates. Moreover, some of the participants noted that dual eligibles are likely to contact the Medicaid agency when they have questions about the new Medicare prescription drug plan, particularly if states are given responsibility for administering the Medicare low-income subsidy program. In other words, the Medicaid directors expect that they will find themselves in the challenging position of being approached by political leaders and beneficiaries for assistance in untangling the proposal's complexity and its financial impact, but without the resources or answers to respond.

## Conclusion

In general, while acknowledging the real value of a Medicare drug benefit, the Medicaid directors who participated in the focus group expressed serious concerns about their capacity to address many of the coordination and administrative issues they expect will arise if a Medicare drug bill is adopted without significant changes. Their key concerns included that: 1) They would not be in a position to take on responsibility for determining eligibility for low-income subsidies by 2006 due to staffing shortages and computer system issues, particularly if federal financing is not adequate; 2) States and beneficiaries could be worse off if the drug bill is enacted with a provision prohibiting states from wrapping around the Medicare Part D benefits (a view expressed by some, but not all participants); and 3) to the extent a wrap-around is required or allowed, states will need tools not currently included in the bills under discussion to administer it effectively. Finally, they noted the importance of establishing a specific, concrete process for addressing coordination issues as they arise in the years ahead. They maintained that it is vital for states to be included in this decision-making process, particularly given a long history of difficult collaboration between the federal Medicare program and the states.

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