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IMPLICATIONS OF THE MEDICARE MODERNIZATION ACT FOR STATES:

Observations from a Focus Group Discussion with Medicaid Directors

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HEALTH MANAGEMENT ASSOCIATES

January 2005

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

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ACKNOWLEDGEMENTS

This paper is based entirely on discussions with a group of Medicaid officials who gathered to discuss the impact of the Medicare prescription drug benefit on state Medicaid programs. We acknowledge and thank the Medicaid directors and other state officials who took the time to participate in this discussion, and who reviewed and offered feedback on an earlier version of this report. Especially, we thank Medicaid officials from California, Indiana, Iowa, Kansas, Missouri, New Jersey, New York, Ohio, Oklahoma, Utah, Washington and West Virginia.

The authors thank the Kaiser Commission on Medicaid and the Uninsured for commissioning this report. Special thanks go to Diane Rowland and Barbara Lyons for their counsel and personal interest in this effort, as well as Jocelyn Guyer, Linda Elam, Michelle Kitchman, and Andy Schneider who offered their expertise in preparing for the focus group and provided insightful comments and assistance in writing the final report. We also thank Cliff Binder and Kathy Kotula of the American Public Human Services Association for their assistance with this project.

The observations presented in this report are those of the authors. They are not intended to represent the views of the National Association of State Medicaid Directors or the Kaiser Commission on Medicaid and the Uninsured.

EXECUTIVE SUMMARY

Adopted in December 2003, the Medicare Modernization Act (MMA) added a new "Part D" to the Medicare program to provide coverage for prescription drugs through private plans, beginning in 2006. Within ground rules set by the federal government, each private plan will design its own prescription drug coverage and plans will be expected to use tools (such as formularies and tiered copayments) to control costs. The MMA also includes low-income subsidies that reduce the cost-sharing requirements under Part D so that low-income beneficiaries will be better able to take advantage of the new benefit.

Even though the MMA is most widely known for creating the new federal Medicare drug benefit, states have a surprisingly large stake in the successful implementation of the MMA. Since the beginning of each program, Medicaid has provided drug coverage for low-income Medicare beneficiaries, and the transition to Medicare coverage has important implications both for Medicaid programs and for these beneficiaries.

Background on the Focus Group

At the request of the Kaiser Commission on Medicaid and the Uninsured, Health Management Associates convened a focus group on November 16, 2004 with fourteen Medicaid officials, including Medicaid directors from twelve states. As state officials with extensive experience administering the Medicaid program, the participants were asked to provide a practical, implementation perspective on a number of Medicaid-related elements of the MMA, including:

- **Treatment of dual eligibles.** The law moves "dual eligibles" (i.e., low-income seniors and people with disabilities who are enrolled in both Medicare and Medicaid) from Medicaid to Medicare prescription drug coverage. Under the law, Medicaid drug coverage ends January 1, 2006 when the Medicare drug plans first begin providing a benefit.
- **Clawback payments.** The law requires states to make monthly payments, often referred to as "clawback" payments, to the federal government to finance a share of the new Medicare drug benefit for dual eligibles.
- **States' role in the low-income subsidy program.** The law includes special benefits for low-income beneficiaries and requires state Medicaid programs to take applications for the low-income subsidy program that accompanies the new Medicare drug benefit. When people apply for the subsidy at a Medicaid office, they must be offered the opportunity to enroll in Medicaid if they appear eligible.

At the time of the focus group discussion, the Department of Health and Human Services (HHS) had released a proposed rule on the implementation of the MMA, but the rule did not fully resolve some issues relating to states' role in MMA implementation. For purposes of the conversation, participants were asked to consider the implications for states and Medicaid beneficiaries if such issues were resolved in a variety of ways.

Key Themes Identified by Medicaid Officials

For Medicaid officials, the addition of a prescription drug benefit for Medicare beneficiaries was recognized as a most positive change. Medicaid officials participating in the focus group discussion were quick to recognize the positive aspects of the MMA, particularly for persons on Medicare currently without drug coverage. The expertise of Medicaid officials is on the specific impacts of the MMA on state Medicaid programs and beneficiaries, and the purpose of the focus group was to draw on this expertise. In general, the Medicaid officials participating in the discussion expressed substantial concerns about the likely impact of the law on state Medicaid programs and Medicare beneficiaries who now receive their drug coverage through Medicaid (the "dual eligibles.) While any transition can prove difficult, the Medicaid officials noted the movement of dual eligibles to Medicare drug coverage is likely to be particularly hard given the low-income, cognitive limitations, and other health issues that characterize the dual eligible population. In discussing the issues, they identified a number of key themes, including the following:

- **States have much at stake in MMA implementation.** Most participants expressed substantial concern that their states would fare poorly as a result of the MMA, because they expect the law may require new state resources and because it may jeopardize continued access to prescription drugs that dual eligibles are taking. State policymakers also expect they may be held responsible if dual eligibles have problems securing medications as a result of the MMA.
- **The MMA will help many low-income Medicare beneficiaries.** A number of the participants noted that the MMA would provide valuable benefits to Medicare beneficiaries who currently have no drug coverage, particularly those who qualify for the low-income subsidy. However, as discussed below, they expressed concern that the MMA likely will not improve drug coverage for dual eligibles and, in fact, may prove to be less beneficial than the drug coverage they currently receive through Medicaid.
- **Medicaid provides a full and comprehensive prescription drug benefit; dual eligibles may have more limited coverage in private Medicare drug plans.** The focus group participants maintained that their Medicaid programs now provide dual eligibles with a comprehensive, affordable prescription drug benefit, even taking into account long-standing benefit limits and recent cost containment efforts. A number of them expressed concern that dual eligibles will encounter problems securing necessary medications under Medicare drug plans, because the drugs they need may not be covered and because of copayment requirements. Given that dual eligibles by definition are very low-income and often have serious health problems, the Medicaid officials were concerned that this population would find it difficult to navigate the complexity of the new Medicare drug benefit, with potentially serious consequences for their health.
- **The timeframe for moving dual eligibles into Medicare drug plans poses major challenges.** Nearly all of the participants suggested that the current timeframe for moving dual eligibles from Medicaid to Medicare drug coverage poses major challenges. Some used the term "disaster" to describe the ambitious timetable and the likely outcome of its implementation. They noted that detailed information on the private plans is scheduled to become available in the fall of 2005, leaving as little as a month or two to

enroll dual eligibles before their Medicaid drug coverage ends on January 1, 2006. From their perspective as program administrators, participants indicated that the time allotted to get dual eligibles into private Medicare drug plans is not sufficient, even without accounting for the time dual eligibles would need to learn how to use them. As such, the transition is likely to present challenges in all states.

- **Implementation of the MMA may require new state resources.** Although it is widely assumed that states will be better off financially as a result of the MMA, most focus group participants said that the law could actually end up costing their state Medicaid programs money. States will no longer be responsible for providing drug coverage under Medicaid for dual eligibles, but a number of the participants estimate that the savings they realize as a result will be offset by new MMA costs. New costs will result from clawback payments, higher Medicaid caseloads, diminished ability to do disease management for dual eligibles and to control the prescription drug cost of Medicaid beneficiaries who remain eligible for drug coverage, and administrative costs associated with taking applications for the Part D low-income subsidy. Some states may also incur costs as a result of supplementing the Part D benefit for dual eligibles. Overall, most of the participants expected no Medicaid savings and indicated the MMA may actually add new state costs.
- **The "clawback" requirement raises a number of concerns.** The requirement to send clawback payments to the federal government was a particular concern to the Medicaid officials in the focus group. They objected on the grounds that requiring states to help pay for a federal Medicare benefit sets a troubling precedent. Beyond objecting to the concept, state officials regarded the clawback formula as flawed. Officials pointed out that the clawback formula does not take into account actions states have taken in recent years to slow Medicaid prescription drug spending growth. A few participants also pointed out that they are being required to send clawback payments to the federal government based on their costs for a comprehensive Medicaid drug benefit for dual eligibles, but they do not expect dual eligibles will receive as comprehensive a benefit from the Medicare Part D plans.
- **Despite much work by CMS staff, states need more information and time to prepare for MMA implementation.** Medicaid officials praised the efforts of CMS staff who are working to implement the MMA. Nevertheless, in light of the far-reaching impact of the MMA on Medicaid beneficiaries and budgets, Medicaid participants also are trying to prepare for MMA implementation, but they are missing key information needed to do so. For example, some are debating whether they should supplement the Medicare drug benefit for dual eligibles, but they will not know until the fall of 2005 – just a few months before Medicaid drug coverage ends and long after their state legislators have gone home – what the Medicare Part D plans available to the dual eligibles in their state will look like. As a result, they cannot readily decide whether or how to supplement the Medicare drug benefit since they are missing information on what they would be supplementing. In identifying MMA implementation issues, participants generally cited problems caused by the underlying structure of the law and its tight timeframes rather than by CMS staff. Indeed, a number complimented CMS staff efforts to work with states to make implementation more successful.

Conclusion

Successful implementation of the new Medicare drug benefit is critically important, particularly for the low-income dual eligibles who have relied on Medicaid for drug coverage up to this time. Medicaid officials in this focus group discussion highlighted significant challenges that states and the federal government will face in the months ahead in implementing the new Medicare prescription drug benefit. State officials were especially concerned that dual eligibles have a smooth transition to Medicare drug coverage, and that these beneficiaries not be denied access to drugs that are important to their health. If problems arise, state officials were concerned they might bear much of the burden. State officials also were concerned about the fiscal impacts of the new law on states. They expressed reservations about the clawback formula and the concept of states financing a part of a federal benefit. The state officials participating in this discussion made clear they are committed to ensuring a smooth and successful implementation. At the same time, they raised issues that they believe need to be addressed to accomplish this goal.

IMPLICATIONS OF THE MEDICARE MODERNIZATION ACT FOR STATES:

Observations from a Focus Group Discussion with Medicaid Directors

I. Introduction

Adopted in December 2003, the Medicare Modernization Act (MMA)[1] added a new "Part D" to the Medicare program to provide coverage for prescription drugs through private plans, beginning in 2006. Within ground rules set by the federal government, each private plan will design its own prescription drug coverage and plans will be expected to use tools (such as formularies and tiered copayments) to control costs. The MMA also includes low-income subsidies that reduce the cost-sharing requirements under Part D so that low-income beneficiaries will be better able to take advantage of the new benefit. Even though the MMA is most widely known for creating the new federal Medicare drug benefit, states have a surprisingly large stake in the successful implementation of the MMA.

First, states currently provide drug coverage through Medicaid for the roughly 6.4 million low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. These individuals are often referred to as "dual eligibles." For states, it is important that the new drug benefit meets the needs of these individuals, who often have significant medical and prescription drug needs. As of January 1, 2006, the MMA ends Medicaid drug coverage for dual eligibles and requires that they instead secure their medications through private Medicare drug plans. Although states no longer will be providing drug coverage to dual eligibiles through Medicaid, they will likely have a major role to play in helping them make the transition to new Medicare prescription drug plans. In the longer-term, states may face considerable pressure to supplement the coverage provided to dual eligibles by Medicare drug plans.

Second, the law also requires states to finance much of the cost of providing drug coverage to dual eligibles through private Medicare drug plans. Indeed, for the indefinite future states are expected to send payments (often referred to as "clawback" payments) to the federal government on behalf of dual eligibles enrolled in a Medicare prescription drug plan on a monthly basis.

Third, states are expected to play a role in helping Medicare beneficiaries sign up for the low-income subsidies available under Part D. They will face new administrative expenses and responsibilities as a result of this new role, as well as the prospect that Medicaid caseloads will increase as people who apply for the Part D low-income subsidy find out about and enroll in Medicaid.

[1] The formal title of this legislation is "The Medicare Prescription Drug, Improvement, and Modernization Act of 2003" (Public Law 108-173).

To explore these, as well as other implications of the MMA for dual eligibles and states, the Kaiser Commission on Medicaid and the Uninsured asked Health Management Associates (HMA) to conduct a focus group with state Medicaid directors.

II. Background on the Focus Group

The focus group consisted of fourteen Medicaid officials, including Medicaid directors from twelve states, who were asked to discuss the implications of the MMA for Medicaid beneficiaries and state Medicaid programs. When selecting participants for the meeting, HMA sought to include a diverse group of states from across the country. The fourteen participants represented states in different geographic regions, states with a wide range of Medicaid prescription drug programs, and states involved with working groups convened by the Centers for Medicare and Medicaid Services (CMS) and the National Association of State Medicaid Directors in August of 2004 to address implications of the MMA for states. Officials from California, Indiana, Iowa, Kansas, Missouri, New Jersey, New York, Ohio, Oklahoma, Utah, Washington and West Virginia participated in the focus group.

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

The focus group discussion was held on November 16, 2004, a date made possible because Medicaid directors were convening for their annual conference in Washington, D.C. the following day. At the time of the discussion, the Department of Health and Human Services (HHS) had released a proposed rule on the implementation of the MMA, but had not indicated how HHS was planning to deal with a number of key issues relating to the states' role in the implementation of the MMA. For purposes of the conversation, participants were asked to consider the implications for states and Medicaid beneficiaries if these and other issues were resolved in a variety of ways. To facilitate the group discussion, state participants were also asked to complete a brief one-page survey. (A copy of the survey is included in this report as Appendix A).

The remainder of this report provides a detailed review of the Medicaid officials comments on several topics, including: the transition of dual eligibles from Medicaid to Medicare prescription drug Coverage (Section III); the longer-term implications of moving dual eligibles into private Medicare drug plans (Section IV); states' role in the low-income subsidy program (Section V); the fiscal impact of the law on state Medicaid programs (Section VI); the status of states' implementation efforts (Section VII); and an array of other, more discrete issues of relevance to Medicaid beneficiaries and states (Section VIII).

III. Moving Dual Eligibles from Medicaid to Medicare Prescription Drug Coverage

Background

Dual Eligibles' Enrollment in Medicare Drug Plans

The MMA mandates a fundamental shift in prescription drug coverage for dual eligibles. These individuals must transition from Medicaid drug coverage to the new Medicare prescription drug plans. Specifically, states will no longer be able eligible for federal Medicaid matching funds for the cost of providing prescription medications to dual eligibles as of January 1, 2006. Instead, dual eligibles are to enroll in one of the new private Medicare drug plans to secure their medications. If they do not enroll, they may have no drug coverage on January 1, 2006.

Like other Medicare beneficiaries, dual eligibles will begin receiving information about the private Medicare drug plans being offered in their region in October of 2005. They can begin voluntarily signing up for private Medicare drug plans on November 15, 2005. If dual eligibles do not sign up for a private plan on their own, the law calls for them to be auto-enrolled on a random basis into a basic plan (i.e., a plan with an average or below-average monthly premium). The proposed rule suggested auto-enrollment for dual eligibles would not begin until May 15, 2006. This is the date on which the six-month initial enrollment period for all Medicare beneficiaries in the new Medicare drug benefit ends. In a number of public forums, however, HHS officials subsequently have indicated that dual eligibles will be auto-assigned to a Part D plan before their Medicaid drug coverage ends on January 1, 2006. Once enrolled in a private Medicare plan, dual eligibles can decide they want to disenroll. Unlike most other Medicare beneficiaries, they also have the option to decide that they want to switch to a different plan at any point in a year.

At the time of the focus group, many details of how the auto-enrollment process would work remained unclear. For example, the proposed rule left unresolved the question of whether the federal government or the states will be responsible for conducting auto-enrollment. As noted above, it now appears clear that HHS intends to try to auto-enroll all dual eligibles before January 1, 2006 when they lose Medicaid drug coverage, but it is not clear whether the process would begin in November or December of 2005.

Observations of Focus Group Participants

Across the board, the focus group participants were concerned that the movement of dual eligibles from Medicaid to Medicare drug coverage had the potential to create significant problems (some used the term "disaster"), particularly given the complexity of the task and the short timeframe in which it is slated to occur. Prescription drug coverage is so important for this group that Medicaid officials were concerned that any slip-up, however small, could be a major issue. Largely for this reason, some officials felt that states should avoid playing any role in enrolling dual eligibles into Part D plans. In the longer-run, they also had concerns that dual eligibles would find their new Part D coverage to be worse than their Medicaid drug coverage, but that it would be difficult for states to supplement Medicare drug plans. Their specific observations and suggestions for implementation included the following:

- **The timeframe for moving dual eligibles from Medicaid prescription drug coverage into Medicare drug plans poses challenges.**
  Nearly all of the Medicaid officials said that the current timeframe in which the dual eligibles must move from Medicaid to Medicare drug coverage may not be realistic. Indeed, a number of them described their concerns in quite strong terms, noting that the short timeframe had the potential to be a "disaster" or, in one case, a "trainwreck waiting to happen." They noted that detailed information on the private plans would not become available until the fall of 2005, leaving as little as a month or two to enroll dual eligibles before their Medicaid drug coverage ends on January 1, 2006. The short timeframe will make it difficult to enroll all dual eligibles into private Medicare plans before Medicaid ends, as well as to help them adjust to their new private Medicare plans. In making their comments, the Medicaid directors cited the practical, implementation challenges associated with making a fundamental change in the care of a low-income population that relies heavily on medications and often has limited capacity to navigate complicated systems. From their perspective as program administrators, the time allotted to get dual eligibles into private Medicare drug plans and accustomed to using them is simply not sufficient. As such, the transition is likely to present challenges in all states. As one participant noted, "This [the timeframe] is an issue for every state. It is a bi-partisan issue."

- **People could face serious harm if the transition does not go smoothly; state policymakers may be held responsible if problems arise.**
  Many of the Medicaid directors noted that the stakes are high for dual eligibles if the transition does not go smoothly since they rely on medications to maintain their health and often even to stay alive. As one participant framed it, "People's health and life are in jeopardy if it doesn't go right". Currently, dual eligibles secure the medications that they need from Medicaid. If they face gaps in coverage as a result of the MMA, they may have little or no capacity to purchase drugs on their own. When people find themselves unable to fill their prescriptions, a number of the state Medicaid officials noted that state legislators and other state policymakers are likely to be held responsible. "We have tens of thousands of people on Medicaid, in nursing homes, who will call their state legislators. It will be Medicaid that will be blamed. State legislative leaders on both sides of the aisle have a firm interest in [a better transition plan]" one participant said.

- **With some exceptions, states do not want to conduct auto-enrollment because they are concerned problems will arise.**
  Focus group participants were certain the only way to ensure enrollment of dual eligibles by the January 1, 2006 and to avoid a break in coverage was to use an auto-enrollment process. As discussed above, many focus group participants suggested that the time available to transition dual eligibles from Medicaid to Part D plans may not be realistic. One Medicaid official said that if her state were required to conduct autoenrollment, "It would be physically impossible, even if we started getting ready now" to be ready to do so by the fall of 2005. Further, if HHS were to give states responsibility for auto-enrollment, a number of the Medicaid officials said that it would be impossible for their states to complete the task by January 1, 2006, even if they had the necessary information and could begin preparing now.

Many of the Medicaid directors felt that they might be in the best position to help dual eligibles sign up for a private Medicare drug plan since they have a long history of working with this population and are well-versed in their unique needs. At the same time, a number thought the process was not likely go well and so, as one Medicaid official framed it, "we want to stay as far away from this as possible." Of particular concern to some of the participants was that the random assignment provision of the MMA precludes them from selecting a plan for dual eligibles that matches their needs. "If I can't pick the plan, I don't want to do the auto-assignment," said one Medicaid official.

In a few cases, Medicaid officials indicated they wanted the option to conduct auto-enrollment. These officials noted that they know the dual eligible population better than the federal government and so may be better able to get them enrolled in appropriate plans. Also, they will continue to be involved in providing care to dual eligibles because they provide them with many services not covered by Medicare. In these cases, however, the state officials noted they would need some discretion to guide people to appropriate plans and to be reimbursed by the federal government for the costs created by auto-enrollment.

- **Auto-enrollment is essential, but does not solve all of the problems**.
  The participants agreed that auto-enrollment was essential because dual eligibles otherwise would end up without any prescription drug coverage. At the same time, some pointed out that they did not think it would solve the transition problems. Instead, it moves the issue from being whether or not someone has coverage to whether or not they are aware of their coverage and able to secure the medications that they need. As one participant said, "Auto-enrollment is absolutely essential, but the sooner it arrives, the sooner our problems arise. Once they auto-enroll, we'll have to explain to every single dual eligible why they will lose Medicaid."

- **Even if auto-enrollment occurs by January 1, 2006, dual eligibles will need time to transition to their new private Medicare drug plans.**
  Even after dual eligibles are enrolled in Part D plans, the Medicaid officials noted they are likely to face a number of transition issues. First, people who are auto-enrolled into a plan may not even be aware that the source of their drug coverage has changed until they go to fill a prescription and their Medicaid card no longer works or they learn that their pharmacy does not participate with their new Medicare plan. One official from a state that recently auto-enrolled people from its state pharmacy assistance program into a temporary discount card noted that half of them never used the card, suggesting they were not aware of their auto-enrollment even after receiving their discount card in the mail.

  A number of the participants also cited clinical reasons for why dual eligibles would face transition issues even after auto-enrollment. One noted that the current implementation schedule means that there is physically not enough time before Medicaid ends for dual eligibles to get their new plans to cover drugs that are medically necessary for them, but not on their formularies or subject to prior authorization requirements. The participant noted, "my major concern obviously is from [the] medical side . . . When I ask about what you are going to do when someone [enrolls in a Part D Plan], you can't just stop a

medication that day – you have to [allow] a period of time to transition to something else. What will you do about medications that need to be continued contingent on a period of time for a patient to see a physician?" Another Medicaid director pointed out that states have case histories that Medicare drug plans should have when making decisions about which drugs they will cover for dual eligibles, but the current schedule does not give states the time to transfer them to the plans.

- **A transition period for dual eligibles would be beneficial.**
  In terms of specific suggestions, the participants suggested that more time was needed for dual eligibles to make the transition to Medicare drug plans before their Medicaid ends. Many suggested a one-year transition period. During such a period, they noted it would be critical for the federal government to work actively with states and the dual eligible population to address problems. In the absence of active work, a transition period would simply delay by one year the onset of the problems. A few of the participants noted that states would be hard pressed to provide Medicaid during a transition period if they also were faced with the obligations to make full clawback payments. (Clawback payments are discussed in greater detail in Section VI, Fiscal Impact of the MMA on State Medicaid Budgets.)

IV. Long-Term Issues for Dual Eligibles in Private Medicare Drug Plans

Background

Subsidies for Dual Eligibles

Once enrolled in a plan, dual eligibles will need to secure their medications through a private Medicare drug plan. To make it more affordable to access the Part D coverage, the MMA provides dual eligibles (and other low-income Medicare beneficiaries) with a low-income subsidy that covers almost all out-of-pocket costs under Part D. All dual eligibles will receive a full premium subsidy for the cost of enrolling in a low or average-cost plan. The exact level of the cost-sharing subsidy will depend on a dual eligible's income level and institutional status, but, in general, dual eligibles living in the community can expect to pay $1 to $5 in 2006 for each prescription covered by their Medicare drug plan. (If the drug is not covered by their plan, they must pay for the drug on their own unless they can secure an exception.) In later years, their copayment obligations will increase with inflation. Unlike other low-income Medicare beneficiaries, dual eligibles do not need to apply for the low-income subsidy. They are deemed automatically eligible by virtue of their status as Medicaid beneficiaries, although it still will be necessary to determine which level of subsidy they are entitled to based on their income and institutional status.

Access to Drugs for Dual Eligibles

Like other Medicare beneficiaries, dual eligibles will be enrolled in private Medicare drug plans that have the flexibility to decide which medications are included on their formularies. If they need medications that are not included on their plans' formularies, dual eligibles can attempt to secure them by using the exceptions and appeals process established by the MMA. The law itself did not include any special provisions aimed at creating a simplified, expedited appeals process for dual eligibles, nor any that would allow dual eligibles to continue to get their current

medications filled by their Part D plans for a transitional period as they move from Medicaid to Medicare drug coverage on January 1, 2006. In public comments, however, the Administrator of CMS has indicated the agency may consider requiring drug plans to fill the prescriptions of dual eligibles who currently are stabilized on medications for a transitional period.[2]

State Options to Supplement

The MMA prohibits states from receiving federal Medicaid matching funds if they supplement the drug coverage provided by private Medicare plans. Thus, states choosing to do so would have to fund the supplemental coverage entirely from state funds. The one exception is that states can secure federal Medicaid matching funds for covering drugs that cannot be covered by Part D plans. These classes and drugs are listed on Table 1.

Table 1: Examples of Part D Excluded Drugs

Part B Drugs	Optional Classes Under Medicaid Not Covered by Part D
• Immunosuppressants: Sandimmune • Nebulization Drugs: Alupent, Atrovent, Intal, etc. • Oral Anti-Cancer Agents: Cytoxan • Diabetic Supplies: Blood glucose monitors, blood glucose test strips, etc • Anti-Emetics: Kytril, Zofan, etc. • Dialysis Drugs: Epogen, Procrit, etc. • Antihemophilic Drugs: Hemophil-M, Feiba, etc. • Multiple Scelrosis Drugs: Avenox	• Agents when used for anorexia, weight loss, or weight gain. • Agents when used to promote fertility. • Agents when used for cosmetic purposes or hair growth. • Agents when used for the symptomatic relief of cough and colds. • Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations. • Nonprescription drugs. • Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee. • Barbiturates, e.g., Phenobarbital, etc. • Benzodiazepines, e.g., Valium, Ativan, Librium, etc.

Observations of Focus Group Participants

- **Medicaid is a full and comprehensive benefit; dual eligibles may have more limited coverage under private Medicare drug plans.**
  Many of the focus group participants were from states that recently have undertaken efforts to control prescription drug spending using tools such as prior authorization requirements, preferred drug lists and supplemental rebates. Even with these recent cost containment efforts, the participants emphasized that their Medicaid programs continue to provide comprehensive prescription drug coverage, covering all necessary medications at little or no cost to beneficiaries. One participant in the group who represented a state with a monthly limit on the number of prescriptions explained that the limit does not apply to the nursing home population and some other groups with extensive medication needs. In the end, the official indicated the state provides all necessary medications. In

[2] Mark McClellan, MD PhD. Administrator, Centers for Medicare and Medicaid Services, presentation to the National Association of State Medicaid Directors, November 18, 2004, Washington DC.

light of their comprehensive prescription drug coverage, many of the participants were concerned that dual eligibles might not fare as well in private Medicare drug plans. A few of the participants recounted stories of encounters with federal policymakers who maintain that dual eligibles will be better off in private Medicare drugs plans. The participants disagreed with this assessment and were surprised that some federal policymakers did not understand the quality of the drug coverage currently provided by states under Medicaid.

- **State officials are concerned about the ability of dual eligibles to secure needed medications and make copayments.**
  In expressing concerns that dual eligibles may be worse off after losing Medicaid, the participants specifically noted that the private drug plans might have formularies that do not include medications needed by their dual eligible population. One participant pointed out that it is particularly likely that dual eligibles will end up in Medicare drug plans with the most restrictive formularies since they receive a full subsidy only for an average or low-cost plan. (This participant also questioned whether the average and low-cost plans could remain actuarially sound if all of the dual eligibles – who have higher drug costs than the general Medicare population – were enrolled only in these plans and not spread more generally across all of the plans.)

  Although they were aware of the opportunities for dual eligibles to ask for exceptions to a Medicare plan's formulary list, the participants expressed skepticism that the dual eligible population would be able to navigate an exception or appeals process to secure needed medications. A number of the participants also pointed out that even nominal copayments of $1 to $5 in 2006 will be greater than dual eligibles currently pay in many states.

- **With some exceptions, states are unlikely to supplement Medicare drug plans.**
  When pressed, most participants suggested that their states likely would not supplement the Part D benefit, even though they anticipated that it would fall short of Medicaid drug coverage standards. The reasons they cited include:

  - **States lack information needed to allow them to decide whether or not to supplement**. A few of the participants pointed out that it is extremely difficult to assess whether or not to supplement at this point because it is not yet clear what the private Medicare drug plans will cover. As one Medicaid director put it: *"How are we going to deal with the issues to wrap-around benefits, when nobody will know what Medicare will cover until October 15th of next year – two and half months before we implement?*"
  - **Too expensive.** The cost of supplementing could be prohibitively expensive since states must do so without the assistance of federal Medicaid matching funds.[3] Also, the administrative tasks associated with wrapping around the

[3] MMA allows FMAP for State coinsurance on Part B covered drugs and for drugs and classes specified at Section 1927 (d)(2) and (3) of the Social Security Act. Part B drugs include immuosuppresants, nebulization drugs, oral anti-cancer agents, diabetic supplies, antihemophilic drugs, etc. Section 1927(d) drugs include products for weight loss, fertility products, cosmetic or hair growth products, cough/cold preparations, prescription vitamins and minerals, over-the-counter drugs, barbiturates, benzodiazepines, etc. See Table 1 for details.

Part D benefit would be complex and perhaps costly, given that a state's dual eligibles could be enrolled in multiple Medicare prescription drug plans – each with its own unique formulary. An official from one state indicated that she had been assuming her state would supplement until her agency ran an informal cost estimate of the expense. The Medicaid director from another state suggested that she could not afford to supplement unless her state cut back on coverage for children and parents or else dropped some optional categories of drugs from Medicaid coverage for non-dual eligibles.

- **No control over drug benefit for dual eligibles.** A number of the participants suggested that it would be difficult to supplement because they have no control over the underlying Part D benefit, which may vary widely from plan-to-plan. As a result, they might have limited control over the nature of the supplemental coverage that they would be expected to provide. "It's not as if we don't want to do it [supplement], but we absolutely lose control," said one Medicaid director.

- **Supplementing could create incentives for Medicare drug plans to provide narrower coverage.** Participants pointed out that if they were to supplement, it would make it easier for Medicare drug plans to provide a narrower benefit. Over time, this could create a troubling dynamic where states step forward to address shortcomings in the Medicare drug benefit for dual eligibles and plans respond by scaling back their coverage of drugs that are used heavily by the dual eligible population. As one participant framed it, "If we step forward early, we're dead."

In a few states, however, Medicaid officials indicated that they expected they would end up supplementing because they operate in an environment where it simply would be unacceptable for dual eligibles to lose access to necessary medications as a result of the MMA. One of these officials explained, "It could have some significant financial impacts for us because I can't imagine that if we don't get everyone these [drugs] we're going to let these people lie on the floor. That [supplementation] could cost us $100 million a month to just continue [coverage] and there's no FFP." A number of states also indicated that they might take the option in the law to provide through Medicaid discrete classes of drugs to dual eligibles that cannot be covered by Part D plans, such as over-the-counter medications and benzodiazepines (see Table 1).

V. The Role of States in the New Part D Low-Income Subsidy Program

Background

The MMA provides low-income subsidies to make the Medicare drug benefit more affordable for Medicare beneficiaries with limited income and assets. Some 14 million Medicare beneficiaries are expected to be eligible for these subsidies. The law requires both the Social Security Administration and state Medicaid agencies to accept and process low-income subsidy applications. It also provides for the federal government to pick up half of the cost to states of processing these new applications. In its proposed Part D regulations, HHS indicated that states would be required to begin processing low-income subsidy applications on July 1, 2005.

The MMA also requires states to screen the applications of people applying for low-income subsidies to see if they are eligible for Medicaid.[4] If they appear to be eligible, states need to offer them the opportunity to enroll in Medicaid.

The federal agencies responsible for administering the MMA have indicated that they are seeking ways to minimize the burden on states of processing low-income subsidy applications. For example, the Social Security Administration has indicated states can forward the applications that they receive to its staff for processing. But, it is not yet clear the extent to which the statute itself requires states to have at least a minimal capacity to process applications.

Observations of Focus Group Participants

- **Many states will not be ready to process low-income subsidy applications for some time.** A number of the state officials indicated that they are not yet preparing to process low-income subsidy applications, since federal regulations or other guidance has not been provided to the states. Instead, they are expecting to take advantage of the process proposed by SSA under which states would take applications for the low-income subsidy program, but then forward them to SSA for processing. Even if it becomes clear in the next several months that states must have an independent capacity to process low-income subsidy applications, many states are unlikely to be able to comply. They do not have the staff capacity within their agencies, nor have they begun to make the time consuming computer programming changes that would be required.
- **Even if states can forward all applications to SSA for processing, the low-income subsidy program will increase the workload of Medicaid agencies.** Participants noted that they are likely to experience a significant workload increase as a result of the low-income subsidy program even if they do not end up processing applications. One Medicaid director noted, Medicare beneficiaries as a group tend to have lots of questions about health care issues and to want to talk to someone in person about them. He expects that his staff will have to spend a lot of time helping people fill out applications and answering their questions. He and other state officials also explained that they expect their workloads to increase when low-income subsidy applicants find out that they might be eligible for Medicaid and then require assistance to secure enrollment.
- **There is significant risk that it will be difficult to coordinate eligibility for the Part D subsidy and Medicaid.** The state officials indicated they are expecting Medicaid caseload increases as a result of the low-income subsidy program. However, a few of them indicated that they thought the low-income subsidy application being developed by SSA would make it difficult to coordinate enrollment in the low-income subsidy and Medicaid. For example, the

[4] The new Part D Section 1860D-14(a)(3)(B) stipulates that the states or the Social Security Administration shall determine eligibility for the low-income subsidies. Further, the MMA amended the federal Medicaid statute (found at Title XIX of the Social Security Act) to require states, as part of the process of determining eligibility for the subsidies, to also screen applicants for eligibility under the various "Medicare Savings Program" categories. These include the QMB, SLMB, and QI-1 eligibility categories. For details, see Section 1935(a)(2)(3) of Social Security Act.

application that SSA is developing does not gather enough information for states to evaluate whether someone is eligible for Medicaid, making it necessary for states to develop a separate process to determine if someone also can qualify for Medicaid.

VI. Fiscal Impact of the MMA on State Medicaid Budgets

Background

To help finance the Medicare drug benefit, the MMA requires states to send a monthly payment, often referred to as the "clawback" payment, to the federal government. The size of these payments is determined under a formula specified in the MMA statute (Figure 2). In theory, the formula generates an estimate of the amount a state's Medicaid program would have spent on dual eligibles' drug coverage if the MMA had not been enacted. The federal government then "takes back" a share of this spending, with the take back share set at 90 percent in 2006 and tapering down to 75 percent for 2015 and thereafter. To estimate the amount a state would have spent on drug coverage for dual eligibles in the absence of the MMA, the formula considers a state's per capita drug spending on dual eligibles in 2003. This amount is trended forward at a national growth rate. It then is multiplied by the number of dual eligibles in a Medicare drug plan for the month in question. Many of the details of the clawback formula are complex and are still being finalized by CMS.[5]

Figure 2
Clawback Formula

MULTIPLY:

– 1 –
Monthly Adjusted Per Capita Expenditures

TIMES

– 2 –
Monthly Count of Full-Benefit Duals

TIMES

– 3 –
Phased-Down Percentage

- A -
1/12th of CY03 Rx Payments[6]
÷
CY03 Full-Benefit Duals

X

- B -
CY03 Mfg Rebate Revenue
÷
CY03 Rx Payments

X

- C -
State Match [1 – FMAP] for the Clawback Month

X

- D -
Growth Factor for the Clawback Month

Full-Benefit Duals are individuals with one or more Medicaid benefits (including pharmacy) and enrolled in both Medicare and Medicaid. Duals receiving Medicaid coverage for only Medicare cost-sharing (buy-in programs) are excluded.[7] Duals are counted whether eligible "one" day or "every" day of the month.

2006	2007	2008	2009	2010	2015 +
90%	88⅓%	86⅔%	85%	83⅓%	75%

The phased-down percentage decreases 1⅔ percent each year – until 2015 when it remains constant at 75 percent.

As discussed further below, states also have other new expenses, as well as opportunities to reduce costs, under the MMA.

Observations of Focus Group Participants

- **The clawback payments establish a troubling precedent.**
  The focus group participants felt strongly that the very notion of requiring states to send money to the federal government to help finance a federal Medicare benefit was highly problematic. They noted that it establishes a troubling precedent and a few questioned whether it was even legal. There was a certain level of resentment related to the fact that many states had expected a measure of fiscal relief from the adoption of the Medicaid prescription drug benefit, and the inclusion of clawback negated the hoped-for relief. The participants also were particularly concerned that they must send money to the federal government to help finance a prescription drug benefit over which they have no control. A few of the states that are considering supplementing the Medicare drug benefit for dual eligibles noted they will face a double hit: First, they must send money to the federal government to finance a benefit that they believe will not be as good as Medicaid (and the amount that they send is based on the cost of providing comprehensive Medicaid drug coverage), and second they will spend more money to supplement the Medicare drug benefit to the extent it proves inadequate. As one of these participants asked, "When you look at what we're paying for the clawback, why should we have to pay 90 percent of what we spent and get something substantially less in value back [and] then have to wrap-around?"

- **The clawback formula is flawed and may largely eliminate any Medicaid savings from the MMA.**
  The focus group participants had a number of specific concerns about the formula used to calculate clawback payments, including that it is based on their spending in 2003. As a result, states that have made significant progress in reducing Medicaid drug expenditures for dual eligibles will lose the benefit of those savings. Instead, they must send money to the federal government based on their outdated -- and artificially high -- Medicaid spending levels in 2003. A few of the states also indicated that the growth rate used to trend forward their 2003 spending level is higher than the actual rate of growth they are experiencing in Medicaid prescription drug spending. The flaws in the formula are of such significance that even though the percent reduction (i.e., the take back percentage) is below 100 percent, some participants believe that they will actually end up spending more on clawback payments than they would have spent on drug coverage for dual eligibles if the MMA had never been adopted. Every Medicaid official in the focus group expressed pointed concerns about the clawback formula, using terms such as "simply outrageous."

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[5] For an extensive discussion of the issue, see Andy Schneider, *The "Clawback": State Financing of Medicare Drug Coverage*, prepared for the Kaiser Commission on Medicaid and the Uninsured, available at www.kff.org/medicaid/7118a.cfm.

[6] Rx payments include both ingredient and dispensing fee payments for Part D covered drugs.

[7] This exclusion includes the following "Medicare Buy-in" eligibility categories: Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs) and Qualifying Individuals (QIs). Pharmacy Plus Medicaid waiver enrollees are also excluded from the definition of a full-benefit dual. CMS is considering exclusion for enrollees in Section 1115 waivers with pharmacy coverage, but to date no final guidance has been provided.

- **In light of the clawback requirement, states face new incentives to scale back coverage of seniors and people with disabilities.**
  One state official noted that the clawback requirement has fundamentally re-shaped his states' thinking about the extent to which it is willing to provide Medicaid to seniors and people with disabilities. While the state had been considering expanding its medically needy program, it decided not to pursue the expansion after considering that doing so would increase the size of its dual eligible population and, thus, its clawback payment. Now the state is considering ways to scale back the size of its medically needy program.
- **Overall, the MMA could have a negative fiscal impact on state Medicaid budgets.**
  Many of the participants said that they thought the MMA would actually end up as a net cost to their state Medicaid programs. Although states will no longer be responsible for directly providing and paying for drug coverage to the dual eligibles, a number of participants said their analysis showed a net higher cost to Medicaid programs. The higher costs would be due to the clawback payments, higher Medicaid caseloads, the cost of providing Medicaid to people who arrive in state offices to apply for the Part D low-income subsidy, and the potential cost of supplementing the Part D benefit for dual eligibles. In addition, there would be higher administrative expenses for taking applications for the low-income subsidy program. Finally, after Medicaid drug coverage for dual eligibles ends, many of the participants expect to have diminished leverage in supplemental rebate negotiations and less ability to use other mechanisms to control the medication costs of Medicaid beneficiaries who remain eligible for drug coverage.
- **Some states may experience fiscal relief in areas outside of their Medicaid budgets.**
  Although it was not the focus of the discussion, a few participants pointed out that other areas of their state budget would expect to have savings as a result of the MMA. Along with providing Medicaid prescription drug coverage to dual eligibles, many states also spend a substantial amount providing prescription drugs to Medicare beneficiaries under their state retiree health systems and, in some cases, a State Pharmacy Assistance Program (SPAP). By creating a drug benefit for Medicare beneficiaries, the MMA has the potential to relieve states of some of the prescription drug costs they now incur under these programs.

    - **State Pharmacy Assistance Programs (SPAPs).** States with SPAPs for seniors may find that they can reduce their costs by relying on Medicare Part D to provide a drug plan that they then supplement, instead of bearing the full cost of providing prescription drug coverage.
    - **State Retiree Health Systems.** States that provide prescription drug coverage to their retirees can take advantage of a subsidy program included in the MMA for employers. The program picks up a share of an employer's drug costs for retirees on Medicare as long as its drug coverage meets certain standards.

  These savings would occur outside of state Medicaid programs and would not accrue to all states. The states expecting savings in these areas were unable to assess the extent these savings might offset their higher costs under Medicaid.

VII. Status of Implementation Efforts

Background

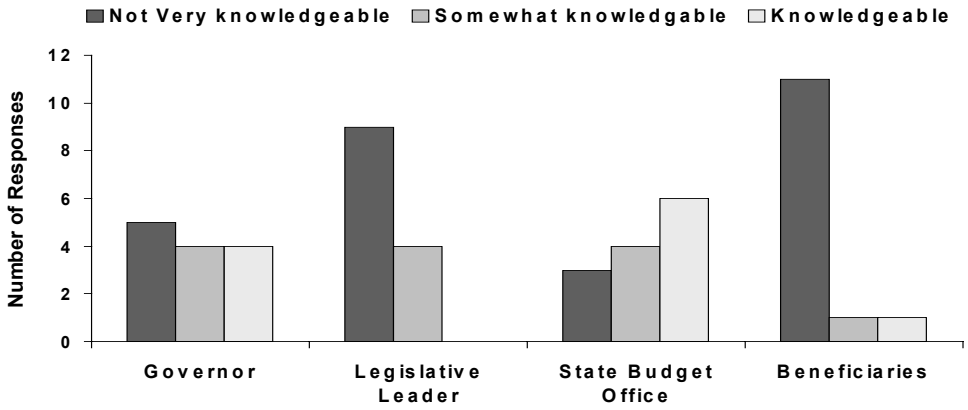
Because the MMA requires states to be ready to process low-income subsidy applications by July 2005 and further provides that Medicaid drug coverage for dual eligibles will end six months later on January 1, 2006, most state legislatures will need to act in the first half of calendar year 2005 to prepare for MMA implementation. Most states operate on a July-to-June fiscal year. Therefore, most state legislatures will be adopting budgets in early or mid calendar year 2005 for the state fiscal year that will begin on July 1, 2005 (SFY 2006) and must take into consideration the potential fiscal impacts on the state in SFY 2006 from MMA implementation.

Observations of Focus Group Participants

- **Many key state policymakers may be caught off guard by the impact of the MMA on their states**
  Most of the participants reported that at least some of the key policymakers in their states are not yet aware of the impending changes to drug coverage for dual eligibles and the potentially significant implications of the MMA for their state. In some cases, the state's Governor, legislators, or fiscal offices have begun to consider the implications of the MMA for the state, but the participants thought it was far more common for them not yet to be prepared. At the same time, as noted above, a number of the participants suggested that state policymakers were most likely to be held responsible by the public for problems that arise for dual eligibles. Many of the focus group participants also believed that the dual eligible population had little or no understanding of the MMA or how they would be impacted. Figure 1 below summarizes responses to the written survey question regarding the level of knowledge of key state decision makers and stakeholders concerning impending Part D changes.

Figure 1

In your opinion, how knowledgeable are the following key decision makers and stakeholders concerning the impending Part D Impacts:
(N=13 responses)



- **States need more information to prepare for MMA implementation.**
  A number of the focus group participants noted that they lack critical information needed to begin work on MMA implementation efforts. Despite rapidly approaching implementation deadlines, states will be hard-pressed to begin making program changes and educating beneficiaries until they get more information. For example, a few of the focus group participants noted it is important to begin telling beneficiaries, particularly dual eligibles, about impending changes long before they occur because they typically must hear messages many times before they will be able to act upon them. Medicaid agencies, however, currently do not have enough information to begin that education process. As one of the participants said, "I anticipate having ten thousands of scared elderly and disabled people who won't [know] whether they're affected and how they're affected. And will I have to tell them they're affected? But I won't be able to tell [them] how. And that's not healthy for this population." Similarly, some participants noted they are considering supplementing the Medicare drug benefit for dual eligibles, but they cannot do so since, as one of them explained, "It is virtually impossible to plan. We don't even know who we're coordinating with."

- **Federal CMS officials are working hard to address state issues, but problems remain.**
  Most focus group participants complimented CMS staff efforts to respond to state MMA implementation concerns, with one saying, "they [CMS staff] are working extremely hard." They cited the effort CMS made to establish workgroups with states to discuss issues (although the groups subsequently suspended their work due to administrative procedure issues) and the calls and meetings that CMS has held with state groups. At the same time, some participants noted that CMS staff has not had enough time to work on issues relating to dual eligibles given the many other responsibilities they have for MMA implementation. Others expressed concerns that the CMS staff working on implementation consists primarily of Medicare experts with little knowledge of how Medicaid works or of the dual eligible population and its special needs.

VIII. Other Issues

- **The Part D enrollment process and auto-assignment of dual eligibles into Part D plans pose significant challenges for the nursing home population.**
  Close to one in four dual eligibles are nursing home residents, the vast majority of whom use a number of medications each day. Due to the complex medication needs of their patients, nursing homes traditionally contract with a single pharmacy. By doing so, they can standardize their inventory controls, staff training for administering drugs, drug product packaging, and distribution systems. Often a nursing home pharmacy maintains a formulary specific to the needs of the facility, ensuring clinical integrity and cost-effectiveness. The focus group participants raised a number of key questions about how dual eligibles residing in nursing homes would be integrated into the Medicare drug benefit, including:

    - How will this population (which sometimes is not competent) make decisions on which Medicare drug plan will meet their medication needs?

- How will a nursing home coordinate with multiple Part D plans, each with potentially different pharmacy networks and drug coverage?
- What will happen if dual eligibles in nursing homes are auto-assigned to Medicare drug plans that do not include the pharmacy serving their facility?

One participant also commented that promising efforts to explore managed care options that integrate nursing home, behavioral and health care services could be negatively impacted by the structure of the Part D benefit.

- **When the dual eligibles migrate to the Part D benefit, states will lose significant prescription volume and market leverage.**
  A few of the participants noted that as the dual eligibles move to the new Medicare prescription drug plans, states will lose purchasing power for their remaining pharmacy programs. For states with supplemental rebate programs, this loss could affect manufacturer negotiations and supplemental rebate levels. Reduced prescription volume could result in higher pharmacy benefit manager (PBM) administrative costs. Also, some of the officials indicated that it may be harder to justify the added development and operational costs associated with new pharmacy cost control measures for a smaller population.

- **States may be required to cover Part D excluded drugs for the duals if these products are covered for other Medicaid recipients.**
  The Part D benefit does not cover certain classes of drugs such as over-the-counter (OTC) drugs, cough and cold preparations, daily vitamins, barbiturates, and benzodiazepines. (See Table 1 above.) These products are often covered by state Medicaid programs because states find them to be clinically beneficial and cost-effective. Unlike *covered* Part D drugs, states may choose to continue providing Medicaid coverage to dual eligibles for these *non-covered* Part D drugs and continue to receive federal Medicaid matching funds after January 1, 2006.

  Some state officials indicated that their states would probably continue Medicaid coverage of these products for dual eligibles. Others could not say whether coverage would continue. However, one participant noted that current Medicaid law may prevent a state from eliminating coverage of non-covered Part D drugs for dual eligibles unless that coverage is also eliminated for all other Medicaid recipients. For this reason, states may feel forced to continue coverage of these products for dual eligibles because of the adverse clinical and fiscal consequences of eliminating coverage for the non-dual eligibles.[8] Continuing coverage for dual eligibles, however, is likely to impose new administrative costs. While the MMA provides for federal matching funds to support the system development and other administrative costs of establishing a separate "limited" dual eligible drug benefit for only the non-covered Part D drugs, systems development would be time consuming, states would still have to pay a portion of the cost and the total development and on-going operational costs could be significant.

[8] Federal regulations mandate that Medicaid benefits be provided in the same amount, scope, and duration to persons within the categorically needy and medically needy groups. 42 CFR 440.240 "Comparability of Services for Groups."

- **The MMA may make it harder for states to carry out disease management programs for dual eligibles.**
  A few of the focus group participants noted that they had been advised by CMS that it would not require private Medicare drug plans to share drug claims data for dual eligibles with Medicaid agencies. These participants expressed concern that ongoing efforts to better manage the care of dual eligibles in disease management and care management programs would be undermined by the inability to access their drug claims data.
- **On an ongoing basis, some low-income seniors and people with disabilities will be faced with the loss of Medicaid prescription drug coverage when they become eligible for Medicare.**
  While the Medicaid officials were focused on the challenges raised by trying to move more than six million dual eligibles from Medicaid to Medicare drug coverage in late 2005, one participant pointed out that there also is a "permanent" transition problem. In future years, Medicaid beneficiaries who become eligible for Medicare will find themselves abruptly losing their Medicaid prescription drug coverage. This will be an issue primarily for people with disabilities who age into Medicare coverage (e.g., a 64-year old disabled man who turns 65) or who reach the end of the waiting period for Medicare disability coverage.

IX. Conclusion

Through the creation of the new Part D Medicare drug benefit, the MMA has brought historic and far-reaching changes to both the Medicare and Medicaid programs. For Medicaid programs, the most significant change is that the prescription drug coverage Medicaid has provided for low-income Medicare beneficiaries is shifted to Medicare. State Medicaid officials participating in the focus group, however, expressed significant concerns about how this shift in coverage may occur, and the implications for Medicaid programs and the dual eligible beneficiaries who are most immediately affected.

A key concern relates to the termination of Medicaid drug coverage for dual eligibles as of January 1, 2006 and the enrollment of these individuals into private Medicare drug plans. While Medicaid currently provides a full and comprehensive drug benefit, state Medicaid officials are concerned that the new private prescription drug plans are likely to have more restrictive formularies and, in some cases, higher cost-sharing. Further, the MMA requires that the complex and difficult task of transitioning dual eligibles from Medicaid to Medicare drug coverage be accomplished in a severely compressed timeframe that provides little or no margin for error. The Medicaid officials in the group also expressed deep concerns about the fiscal impacts of the new law on states. They expressed serious reservations about the clawback formula and the concept of states financing a federal benefit.

Despite the far-reaching implications for beneficiaries, state finances, and state administrative systems, state Medicaid officials continue to lack important information they believe they need to plan for a successful implementation and to inform state policymakers, stakeholders and dual eligible beneficiaries about the changes that are coming. As the

January 1, 2006 deadline approaches, many state Medicaid officials are concerned about the prospects for a successful transition for dual eligibles.

The Medicaid officials were well aware of their need to press forward toward the timely implementation of the Part D benefit for Medicare beneficiaries lacking adequate drug coverage, and expressed commitment to a successful transition for dual eligibles. They emphasized how important it is that there be no gap in coverage for these individuals, and how important prescription drug coverage was for this group of dual Medicaid- Medicare enrollees. At the same time, the focus group participants regarded themselves as well positioned to assess whether there was adequate time to avoid disruptions in drug coverage. With the health and safety of an extremely vulnerable population at stake, they expressed an eagerness to work with federal policymakers to identify ways to make the current implementation process more workable, such as by taking steps to ensure dual eligibles do not face abrupt disruptions in their drug regimes in the transition to Medicare drug coverage.

Appendix A

Medicare Part D: Impact on States

For the Kaiser Commission on Medicaid and the Uninsured

November 16, 2004

Name: _____ State: _____

1. Has their been one or more analyses done regarding how the implementation of Part D will affect your state? ___Yes ___No

   If so, did the analyses address any of the following issues (check all that apply)?

   ____ Clawback
   ____ Supplementation costs for dual eligibles
   ____ Cost of low-income subsidy determinations
   ____ Woodwork effect
   ____ State employee retiree coverage
   ____ State Pharmacy Assistance Program
   ____ Other _____

2. In your opinion, how knowledgeable are the following key state decision makers and stakeholders concerning the impending Part D state impacts:

Governor:	1	2	3	4	5
	Yes, very knowledgeable		Somewhat		No, not at all
Legislative Leaders:	1	2	3	4	5
	Yes, very knowledgeable		Somewhat		No, not at all
State Budget Office:	1	2	3	4	5
	Yes, very knowledgeable		Somewhat		No, not at all
Provider Organizations:	1	2	3	4	5
	Yes, very knowledgeable		Somewhat		No, not at all
Beneficiaries:	1	2	3	4	5
	Yes, very knowledgeable		Somewhat		No, not at all

3. Has your state appropriated funding for Part D implementation? ___Yes ___No

4. Has your state enacted other legislation addressing Part D implementation? ___Yes ___No

5. In your opinion, who should carry out the auto-enrollment function for dual eligibles?

___CMS ____States ____Other _____

6. Is your state planning to process applications for the Part D low-income subsidy? ___Yes ___No

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