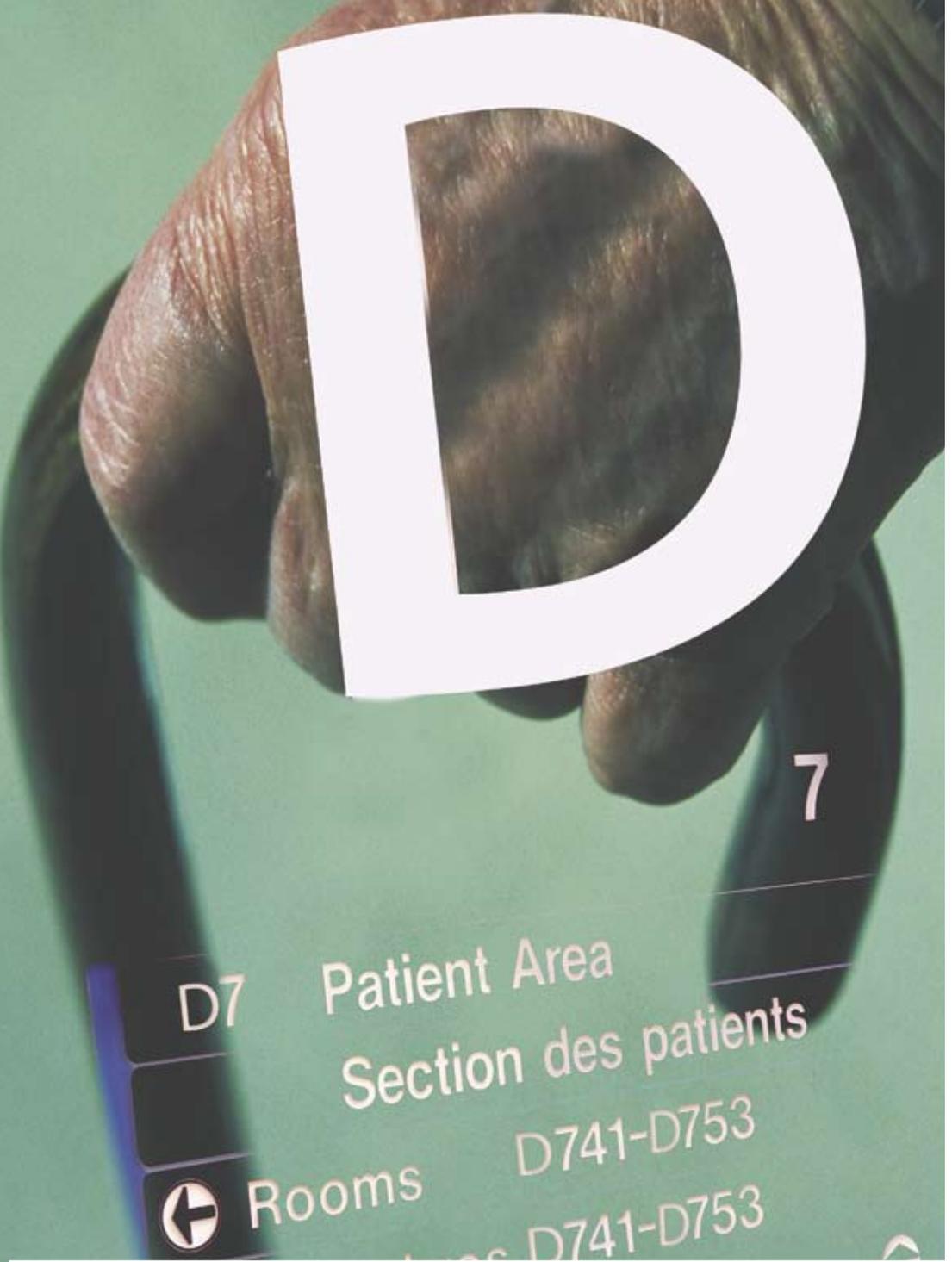


Part D-lemma



Implementing Medicare prescription drug plan a costly proposition for states

by Mary Branham Dusenberry

January was a costly month for California. The state dipped into its reserve fund and allocated more than one-fourth of it for prescription drugs for poor elderly Californians. It was an unexpected expense, and one the state—like more than 30 others—hopes to recoup.

“We are certainly looking to the federal government for reimbursement,” said Stan Rosenstein, deputy director of medical care services for the California Department of Health Services. “We can’t afford to spend this kind of money and not be reimbursed.”

The state is also balking at paying the so-called “clawback,” a reimbursement to the federal government for drugs provided to low-income seniors and disabled people. California State Controller Steve Westly said his office will refuse to send the Medicare payment due each month. And the state—along with several others—is appealing directly to the U.S. Supreme Court to block the federal government from billing it for the drug costs.

The Part D mess

California spent \$14 million in January to cover the prescription drug costs for many senior citizens that should have been covered by Medicare Part D. The state has allocated \$150 million from reserves to cover ongoing problems with the federal program. Many states started as early as Jan. 1 to pay for medicine that should have been covered by prescription drug plans (PDPs) as part of Medicare Part D. But many poor seniors—known as dual eligibles because they qualify for both federal Medicare and state Medicaid coverage—left pharmacies in frustration because of massive confusion. Some weren’t listed in the system or, if they were, weren’t marked as a dual eligible, an oversight that could cost them higher co-pays and deductibles.

While the Center for Medicare Services (CMS) has worked from day one to repair the system, it’s been costly for the states up front. The long-term effects on state budgets, says Scott Pattison, executive director of the National Association of State Budget Officers, should be minimal.

“The Medicaid budget is extremely high (for states),” Pattison said. “From a cash flow standpoint, they usually have sufficient funds at that moment to cover those charges. The end of the fiscal year is the most important.”

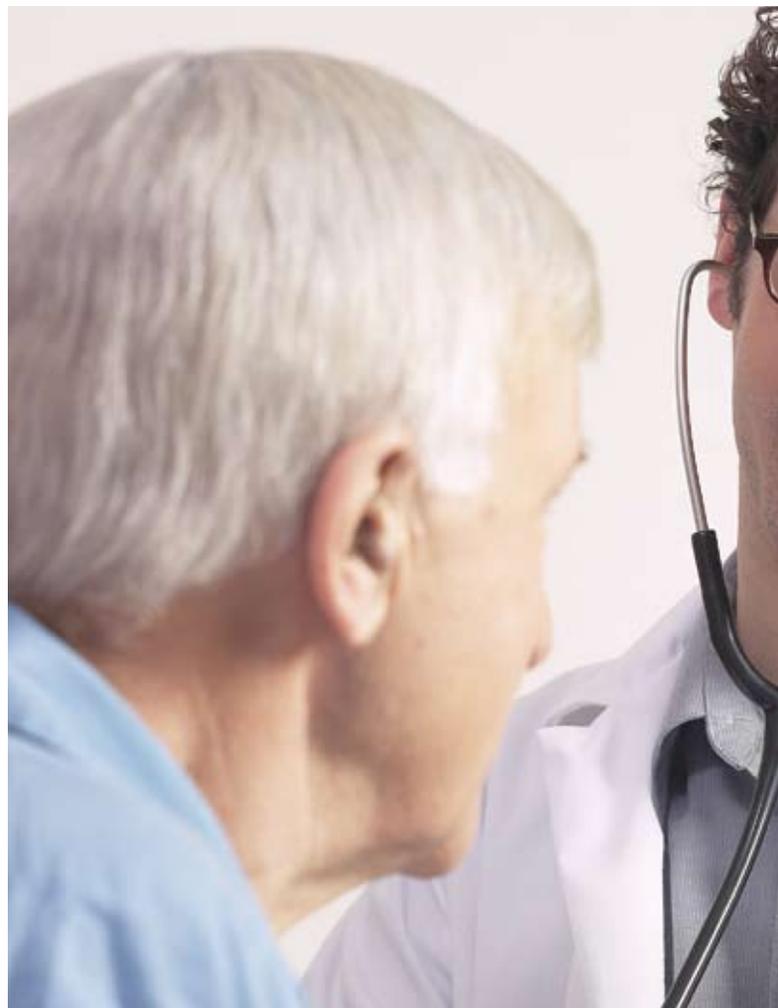
Pattison believes as long as states are reimbursed—which CMS is working on—things will even out in the end.

But reimbursement would have to come before the end of the fiscal year for states to avoid problems. Martha Roherty, director of the National Association of State Medicaid Directors (NASMD), said that could be a problem as states work their way through the reimbursement maze. “The unfortunate thing is the timing may take more than the states can afford,” she said.

Under the CMS plan, Roherty said, states must submit reimbursement plans by May. Then CMS will match patient data with the PDP to which they’re assigned to determine eligibility. In California alone, she said, there are 1 million dual eligibles. “There’s no computer system designed to do this,” she said of scanning the drug plans to match charges for reimbursement. Developing a system, she said, will take time.

“It’s not going to happen overnight,” Roherty said. “If we’re waiting for PDPs to pay the state, how long do they have to reimburse the states? We don’t know.” In some states, she said, Medicare patients can choose from more than 50 PDPs.

Some states have already felt the squeeze of using money earmarked for other programs, or for reserves, to cover the Part D costs. “We’ve taken away the ability of the governor to spend on his priorities because we’ve used this money to cover a federal program,” Rosenstein said of the California expenses.



A rough transition

Most people agree that problems during the transition phase to Part D were expected. “The states anticipated there was going to be some upheaval,” Roherty said. State Medicaid directors, she said, had called for additional safety measures to insure patients would get the medications they need.

“In general,” Roherty said, “the system was just not ready to accommodate the number of duals making a transition to the Medicare system. As those individuals would show up at the pharmacy, there were so many glitches that people were leav-

Medicare Part D

ing pharmacies without medicine.” Mark McClellan, the Bush administration’s top Medicare official, acknowledged that tens of thousands of recipients probably didn’t get medicine due to the confusion in the early days of implementation.

The glitches in the system included everything from wrong eligibility information to inadequate in-



formation on the PDP to which patients were assigned. Pharmacies were unable to get through to the insurers, which didn’t have enough staff to handle the complaints made by phone. And, Roherty said, many PDPs were not honoring the transition plans required by CMS.

Many states anticipated problems and took extra steps to help dual eligibles through the transition. Roherty said some states gave patients “additional fills” on their December prescriptions. Others, like New Jersey, stepped up hotlines “to make sure consumers and providers could contact us,” according to

The Centers for Medicare & Medicaid Services has established a state reimbursement plan that enables states to be fully reimbursed for ensuring their “dual eligibles” received needed medication during the early implementation of the Part D prescription drug plan. For more information and downloadable materials, visit http://www.cms.hhs.gov/States/031_Repayment2States.asp#TopOfPage

For a downloadable fact sheet on the transition program, check out <http://www.cms.hhs.gov/States/Downloads/StateReimbursementFactSheet.pdf>

For more on the history of Medicare, check out Dr. Jon Oberlander’s books on the politics of the program, *Fractured Consensus: Medicare and American Politics, 1965–2001* (University of Chicago Press), and reform, tentatively titled *False Promises: Why the Market Can’t Cure Medicare*.

Sue Esterman, a spokeswoman for the state’s Department of Human Services.

“We did not expect anything that approached this degree,” she said. Her state is glad it made the preparations it did. “I don’t think you’re ever prepared for something as sweeping as this. If we hadn’t made those preparations, the situation would be worse tenfold.”

New Jersey officials turned off filters in the computer system so that every dual eligible claim would be covered by Medicaid, at least until Medicare Part D started working the way it should. The CMS “demonstration program” to reimburse state Medicaid programs was expected to end Feb. 15, and the agency directed participating states to discontinue prescription payments through Medicaid systems on or before that date.

The costs of prescription drugs aren’t the only ones associated with the problems many states faced in January. There were additional administrative costs. “It’s put a major drain on the resources of the department and the local community workers,” Rosenstein said. Some believe that many seniors faced additional physician and hospital visits as a result of not getting their medications. Those costs, Roherty said, will shift to the states.

A “broader war”

The initial problems with Part D implementation may have decreased, but many people expect more problems for states down the road.

Jon Oberlander, an assistant professor of social medicine at the University of North Carolina-Chapel Hill and author of two books on Medicare, says Part D is “a front in the broader war over Medicare—the war over the present and future of Medicare.”

The Part D prescription plan is the first major change since Medicare was enacted in 1965. Several previous attempts to provide prescription drug coverage for seniors failed. The plan that finally passed is not to the liking of either the Democrats, who consider it a giveaway to the drug industry, or the Republicans, who consider it an entitlement program that costs too much money, Oberlander said. States are caught in the middle. “They’re sort of innocent bystanders,” he said.

Part D also removes states’ abilities for disease management, according to Roherty. “The really active or innovative ways states have been involved in to decrease costs and increase wellness, states are concerned are not going to work as well because they’ve lost that capacity (to monitor whether participants are taking their medicine).”

In addition, she said, states—no longer deemed purchasers of medicine—have lost the ability to negotiate for the best rates.

Oberlander expects the states to play a larger-than-expected role in servicing the Part D participants, particularly the dual eligibles. “I think the thing is CMS and the federal government aren’t really set up in Medicare to have one-on-one counseling at the local and regional level,” he said. States can expect to continue “a huge role in administering the program because they do have more resources on the ground.”

Stacey Mazer, a senior staff associate for NASBO who deals with Medicaid issues, also expects more effects on states down the road. “I think it’s going to be tricky to figure out the impact,” she said, “There are going to be some unexpected things, possible costs, possibly changes in expected cost. You can at least predict things will be unpredictable.”

Oberlander said states “unfortunately (are) not going to be able to hide from this. It’s going to be there.”

State officials are well aware of that. With every new month comes new people considered dual eligibles. In California alone, that adds up to 10,000 new people in the program each month. And there’s no limit on the number of times patients can switch drug plans. Roherty, of NASMD, said the federal government has no deadline for switching plans each month. That’s a problem, and one the states hope to change. “The switch is instant,” Rosenstein of California said, “but the data takes several weeks to catch up.” He, like Roherty, believes that could create problems similar to the ones in January because of inaccurate or old information.

There’s also the opposition some states have with “clawbacks,” those payments states must make to the federal government for the Part D program. At least five states intend to appeal to the

U.S. Supreme Court to block the clawback payments the Part D legislation requires states to pay CMS. Oberlander calls the clawbacks “a federal government cost-shifting.” He says the dual eligibles are “a population the feds should take care of, but they’re not.”

The states say the clawback formula is unfair, and will cost some states more than the old funding formula. Kentucky, for instance, estimates it will pay \$20 million more annually for prescription drugs for dual eligibles with the clawback than it would have paid under Medicaid, according to Jennifer Hans, a

Kentucky assistant attorney general who is working with other states on a lawsuit challenging the clawback provision.

“What that (provision) did was come up with a formula for each state to pay back to the federal government a certain sum of money that was supposed to represent what the state would have paid for had they continued to cover dual eligibles,” Hans said. “The formula they used is inherently unfair. Some states may be on the plus side. Many states, including Kentucky, are going to lose state money through clawback.”

Hans said the plan also “violates some fundamental constitutional principles in requiring states to pay for a federal program.” The federalism issue will be included in the lawsuit, but Hans declined to discuss specifics before the lawsuit was filed.

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— Jennifer Hans,
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Better off

Despite the past and expected problems, many people in Medicaid circles think Medicare Part D is a good thing. “The majority of people who sign up for this are going to benefit from it,” said Ross Mason, public information officer for the Idaho Department of Health and Welfare.

Indeed, throughout a month of criticism for the confusion in implementing the program, McClellan, the Medicare official, touted the fact that 1 million prescriptions were being filled each day. Rosenstein said CMS and the states are working hard to make the program work. “For the large majority of people, the program is working very well,” he said. “It is a good program that, when these problems are resolved, will provide a very much-needed program to senior citizens.

While states are working with CMS to resolve the problems, Rosenstein said, “ultimately, this is a problem the states can’t solve. It’s got to be solved by the federal government.”

—Mary Branham Dusenberry is managing editor of *State News magazine*.