

MMA and Dual Eligibles: A Transition in Crisis

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Acknowledgements

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Medicare Rights Center

Medicare Rights Center (MRC) is the nation's largest independent source of health care information and assistance for people with Medicare. Founded in 1989, MRC helps older adults and people with disabilities get high-quality, affordable health care. MRC provides telephone hotline services to individuals who need answers to Medicare questions or help securing coverage and getting the health care they need. MRC brings the consumer voice to the national debate on Medicare reform.

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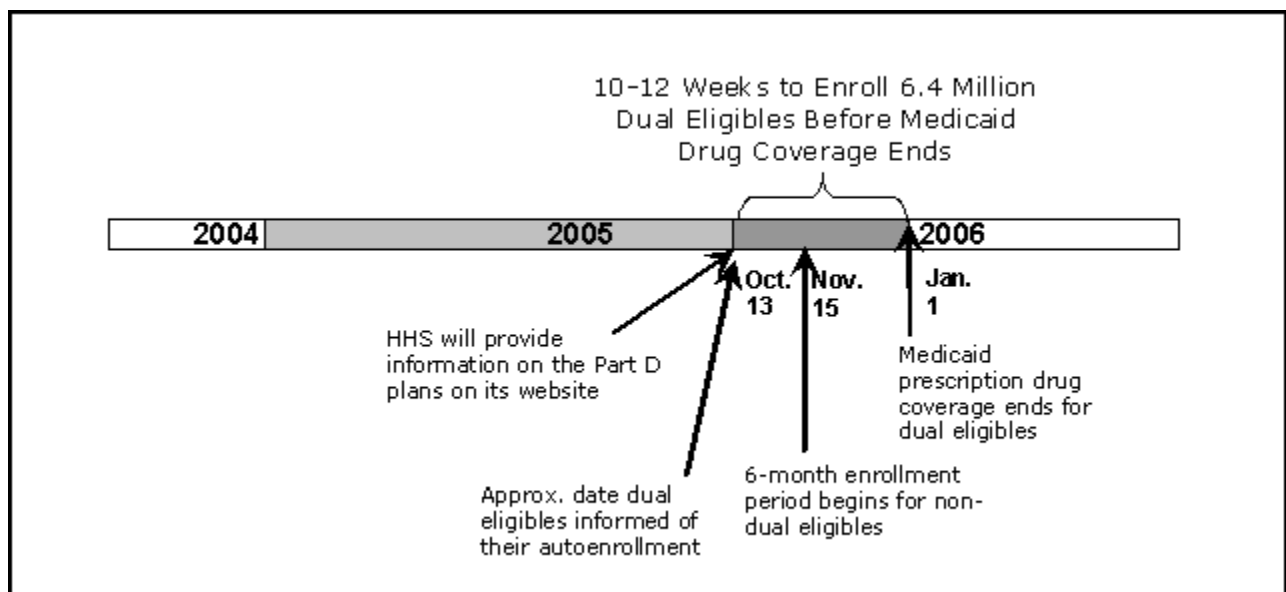
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Overview: The Medicare Modernization Act (MMA) eliminates Medicaid drug coverage for 6.4 million dual eligibles (those enrolled in both Medicare and Medicaid) and moves them into Medicare drug coverage on January 1, 2006. Because Medicaid coverage ends on the first day that Medicare coverage is effective, the transition leaves literally no margin for computer error, system failures, postal delays, or inevitable disruptions and confusion involved in moving millions of the frailest older and disabled adults out of one program and into a very different one.

- Under the current timetable, millions of dual eligibles could experience gaps in treatment during the first months of the Medicare prescription drug benefit. Such gaps would have catastrophic consequences, including increased hospitalizations, disruptive behaviors, disease progression, drug resistance, and premature death, and result in a failed rollout of the MMA for the first group required to enroll in Part D.
- In final rules implementing the MMA, CMS recognized special concern for dual eligibles. But the CMS approach – adding a few more weeks on the front end of the enrollment timetable – is inadequate. While helpful, it will not avert a transition crisis.
- Avoiding a crisis will require enough time to implement a comprehensive education and transition plan involving states, CMS, health advocates, providers and drug plans. The plan must include a limited period in which Medicaid serves as back-up drug coverage for dual eligibles.

Timeline for Dual Eligibles' Loss of Medicaid Drug Coverage and Transition to Part D



Key Transition Challenges For Dual Eligibles:

1. Data/System Barriers: Full coverage for dual eligibles on January 1, 2006 will require perfect data and perfect data transfers between states, CMS, and multiple drug plans. CMS must:

Example: Ms. R

Ms. R is 33 years old and has severe physical disabilities. She is well aware of the changes in Medicaid drug coverage and has been informed that she will be automatically assigned to an appropriate plan in time to refill her prescriptions in January, 2006. On December 15, she still hasn't received a new Part D card. She calls her state Medicaid office and is told not to worry, she will be assigned to a plan and cards will be sent at the end of the week. On January 5, she still hasn't received a card and her prescriptions are running out. She calls again and is told that they don't have a record of her as a dual eligible, and therefore haven't assigned her to a plan. She will have to go to the Medicaid office with her card to straighten it out. She arranges a ride and goes to the office the next day, where she waits in line for 5 painful hours. At the end of the day, she is told that she must wait for her new plan to process her enrollment and to send her a Part D plan card before she can fill her prescriptions.

- obtain and maintain complete, up-to-date names and addresses of dual eligibles from 51 Medicaid programs;
- match the 6.4 million individuals with appropriate plans in their regions;
- ensure that all assignments are accurately communicated to the plans and to beneficiaries;
- accommodate changes within the 10-12 week period from individuals who move or change their mailing address, whose Medicaid eligibility varies month-to-month, and those who elect to switch plans during the enrollment period.

2. Education and Access Barriers: The biggest challenge to autoenrollment is educating dual eligibles how to navigate a complex new world of competing plans, formularies, and pharmacy networks. In order for dual eligibles to fill prescriptions using their new Medicare coverage, CMS will have to ensure that by January 1, 2006, each dual eligible knows and understands:

- her Medicaid card will not work at a drugstore anymore,
- which Part D plan she is assigned to;
- which pharmacies she can use to fill prescriptions;
- which of her drugs are on the new plan formulary;
- what to do if a drug she takes is not on the plan formulary;
- what her copayments will be at the pharmacy (and that she must pay or not get her drugs).

Example: Mr. H

Mr. H is 75 years old, lives on his small Social Security check in a small town in Eastern Montana, and takes medication to control his high blood pressure and diabetes. He learns that he has been automatically enrolled in a Part D plan when he receives a Part D plan card in December 2005. In late January, he brings the card with him when a neighbor drives him to the nearby pharmacy he has used for 40 years to refill his prescriptions. His pharmacist tells him that the pharmacy is not part of his new plan's network and he can't use his Medicaid card to buy his drugs any longer. Several days after that, he confides in his son that he has run out of his medications and doesn't know where to turn. His son calls 1-800-Medicare and determines which pharmacy his father can use. Because the pharmacy is 15 miles away in the next town, he must wait until the weekend to refill his prescription when his son can drive him there. By the time his prescriptions are refilled, he has been off his medication for 6 days and is at high risk for complications.

Experience with the discount card shows that the most aggressive outreach and education campaign cannot effectively reach this vulnerable population in such a short time.¹ According to a recent report from the Kaiser Family Foundation, “[t]he experience of states that have successfully enrolled dual eligibles [into managed care] is that this is a very challenging population to contact and engage.”² **Even if 80 percent of dual eligibles can be educated about program changes during the ten to twelve week transition period, more than one million of the frailest Medicare beneficiaries will lack access to needed medications on January 1, 2006.**

Example: Mr. P

Mr. P is 84 years old, living alone, with early stage Alzheimer’s disease and glaucoma. He receives a new drug card in the mail in November 2005, but he throws it out, thinking that it is an unsolicited credit card. On January 4, 2006, he walks to his corner pharmacy and presents his Medicaid card. The pharmacist tells him that he can’t accept it anymore, and asks Mr. P if he has a new card. Mr. P is angry, because his Medicaid card has always worked before. The pharmacist has no way to determine what plan Mr. P is enrolled in or where to refer him. He suggests that Mr. P call 1-800-Medicare, and Mr. P goes home empty-handed. Mr. P can’t remember the number when he gets home. He doesn’t refill his prescriptions until his daughter takes him to the doctor in March, where she discovers that he has been off his medications for two months and his eyesight has deteriorated significantly.

3. Health System/Infrastructure Barriers: Changing procedures for millions of individuals on one day can be expected to result in short-term disruptions to the entire care delivery system:

Example: Ms. B

Ms. B has schizophrenia and a dependent personality disorder and takes 8 prescription drugs per month, including an atypical antipsychotic called Risperdal. She receives a new Part D plan card in the mail in November 2005. When she brings the card to her pharmacy to refill her prescriptions on January 10, 2006, her pharmacist tells her that three of her prescriptions, including Risperdal, are not on the new plan’s formulary. Ms. B is frightened and confused. The pharmacist suggests that she call her physician. Ms. B’s doctor has been seeing patients like Ms. B to address new formulary restrictions round-the-clock since January 1. His receptionist tells Ms. B that her doctor’s first available appointment is in three days. Ms. B runs out of Risperdal while waiting for her appointment, and on January 12 she is hospitalized after a suicide attempt.

- Part D plans must prepare for hundreds of thousands of coverage requests and appeals;
- pharmacist workload will increase dramatically, as confused dual eligibles seek personal assistance from front-line providers to explain the new benefit;³
- the risk of medication errors at pharmacies will increase;⁴
- physician workloads will spike, as physicians will have to review new formularies, provide new prescriptions, and help patients appeal so current medications can be continued.

Under the existing MMA timeframe, CMS will have **ten to twelve weeks** to accomplish transition tasks that the Medicare Payment Advisory Commission (MedPAC) suggests require at least **six months**.⁵

¹ For example, CMS officials confirmed that of the 1.1 million people enrolled in Medicare Savings Program who received Medicare discount cards in the mail with a \$600 credit attached, less than 6% had actually used their cards 8 weeks after they were mailed.

² Kaiser Commission on Medicaid and the Uninsured, *The New Medicare Prescription Drug Law: Issues for Enrolling Dual Eligibles into Drug Plans*, (Jensen, R.), January 2005.

³ 30% of seniors are likely to turn to a pharmacist, and 38% to a doctor, for help navigating the new Medicare benefit. Kaiser Family Foundation, *Health Poll Report Survey: Selected Findings on the Medicare Drug Law*, 2005.

⁴ Phillips, D., Jarvinen, J., and Phillips, R, “A Spike in Fatal Medication Errors at the Beginning of Each Month,” *Pharmacotherapy* 2005; 25(1).

⁵ Medicare Payment Advisory Commission (MedPAC), Report to the Congress: *New Approaches in Medicare*, Ch. 1, June, 2004.

Characteristics of Dual Eligibles

The characteristics of the dual eligible population will complicate transition efforts and make it particularly difficult for dual eligibles to navigate the Part D transition. Dual eligibles are/have:⁶

- **Sick.** More than 50 percent are limited in activities of daily living, and they have higher rates of Alzheimers disease, diabetes, pulmonary disease and stroke than other people with Medicare.
- **Cognitive impairments.** Nearly 4 in 10 have a mental or cognitive impairment. That means that 2.5 million dual eligibles may not be able to navigate program changes even if education and communication efforts are appropriate for an elderly population.
- **Underserved.** More than 40 percent of dual eligibles are racial/ethnic minorities, and dual eligibles are more likely to live in rural areas than other Medicare beneficiaries.
- **Dependence on Prescription Drugs.** Dual eligibles are expected to fill 20 million prescriptions in January 2006.
- **Institutionalized.** One in four dual eligibles lives in a nursing home or other long-term care facility.
- **Poor.** More than 60 percent live below the poverty level.

Example: Mrs. L

Mrs. L is a 94 year-old widow living in a nursing home. She is randomly assigned to a Part D plan that does not have a contract with the long-term care pharmacy that services her nursing home. Her roommate is automatically assigned to a different Part D plan, and her neighbors down the hall have chosen a third Part D plan to enroll in. The nursing home social worker has set aside two hours every day to develop a chart indicating the plans that residents are assigned to, the plan rules and formularies, the pharmacies in the networks, and which of the pharmacies delivers 24 hours a day and keeps intravenous versions of certain medications in stock. On January 5, before the social worker had completed her chart, Mrs. L begins showing signs of a low-grade pneumonia. The doctor prescribes antibiotics before he leaves the facility that night. The nurse on duty spends several hours juggling her workload while determining which pharmacies in Mrs. L's plan stock the IV solution. Mrs. L's condition deteriorates while she waits for the medication, and at midnight the nurse calls for an ambulance to take Mrs. L to the hospital.

Potential Solutions

To ensure the successful implementation of the MMA and the safe and smooth transition of dual eligibles, Congress should extend the availability of Medicaid as backup drug coverage during a reasonable transition period to Part D. The backup coverage would be used for: (1) dual eligibles not enrolled in a Part D plan on January 1, 2006; (2) dual eligibles who have not received notice of their plan assignment or do not yet know how to obtain medications using their Part D plan; and (3) dual eligibles who must be evaluated and for, and stabilized on, new drug regimens to comply with their Part D plan formularies.

⁶ Id., Ch. 3. The statistics cited in the MedPAC report apply to full dual eligibles and those enrolled in the Medicare Savings Programs.