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HMS White Paper:

The Good News And Bad News About Medicare Drug Coverage – And What States Can Do About It

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State governments are now grappling with the most dramatic change in the nation's public healthcare system in 40 years: the addition of prescription drug coverage to the federal Medicare program.

Since the Medicare Modernization Act became law in 2003, the drug benefit has made headlines. For states, the news generally has been good: Medicare's new "Part D" benefit now pays for many medications used by seniors, eliminating one of the primary drivers of state spending on Medicaid.

That's because Medicaid recipients who also are eligible for Medicare benefits – the so-called "dual eligible" population – represent a very expensive responsibility for states. In fact, while dual-eligibles number about 7 million, or roughly 16 percent of Medicaid recipients, they accounted for 42 percent of Medicaid costs before the implementation of the drug benefit, according to the Kaiser Commission on Medicaid and the Uninsured.

The Kaiser Commission also estimated that dual-eligibles incurred almost half the costs that Medicaid spends on drugs – costs that grew for years at double-digit rates. States, led by the National Governors Association, sought relief from the federal government. Now that relief is forthcoming. Or is it?

As a result of the benefit, the Congressional Budget Office has projected, the federal government will foot the bill for $115 billion in costs that states would otherwise pay. Good

news, indeed. However, as states are discovering, the story is more complex than it may appear. While lightening the burden of drug coverage, the MMA also creates new fiscal and administrative challenges. As a result, states need to control the cost of caring for dual-eligibles more than ever. This article outlines some of these challenges, as well as practical solutions states can implement to help overcome them.

The clawback

While the MMA may seem like a windfall for states, in reality, they will forego most of their potential savings. The law requires states to make federal payments in proportion to the drug costs they otherwise would have paid. These "clawback" payments start this year at 90 percent of the estimated savings, and decrease over time. Nevertheless, in 2015, states will be returning three-quarters of their savings to Medicare.

What's more, the formula for computing the size of the clawback may unfairly penalize some states. Because it is initially based on each state's prescription drug expenditures in 2003, states with unusually high expenditures in that year will be stuck with an unusually large clawback payment, despite the cost controls many have implemented since then.

Not only does the clawback ignore the controls states have used successfully in the past, it handicaps states from using these measures in the future. States will pay predetermined amounts, with fewer options to reduce their expenditures. For example, many states previously negotiated steep discounts and rebates from pharmaceutical suppliers with which they contract; the MMA eliminated more than half of the states' bargaining power. And there will be no opportunity for states to reduce the cost of drugs – costs the states continue, in effect, to pay – by searching out private insurers and other parties that actually are liable for the cost of a senior's care. It's estimated that five percent of Medicaid expenditures can be recovered through this "coordination of benefits" process.

New responsibilities, unknowns, and the bottom line

States also have incurred a host of new responsibilities and costs under the Medicare law. The law calls for Medicaid agencies to determine who is eligible for Medicare's new low-income

subsidy benefit, a duty the federal government will fund only in part. And while they're at it, states are required to screen every new Medicare applicant for Medicaid eligibility. It's predicted that this will create a "woodwork effect," as previously unidentified individuals are added to the rolls of Medicaid recipients, overwhelming an already overwhelmed benefit system.

Finally, there is the challenge of implementing and coordinating the new Part D benefit in the midst of many unknowns. States already have made progress in addressing prescription drug coverage through their own programs; how will these programs function now? Will they complement the new federal benefit, despite the fact that states need to fund them without federal support? How will states ensure that the maze of benefits is properly coordinated, so that expenditures are shared appropriately at the state and federal level? What will the cost of the benefit really be?

There are no easy answers to these questions. But the Congressional Budget Office put together a bottom-line estimate. The prediction: While ultimately saving money for states, the changes to Medicare first will create net costs. In 2006 alone, these costs will total more than $1.2 billion.

Clearly, the solution to the high cost of seniors' prescription drugs goes beyond the capabilities of Medicare. States need to take action of their own. The experience of Health Management Systems, Inc., a leading cost containment firm for state Medicaid programs, has demonstrated some of the lessons state officials should bear in mind.

Recommendations

1. States need in-depth data to reveal how Medicare can better serve their elderly Medicaid recipients. Since Medicare is the primary alternative to Medicaid in funding the cost of care for dual-eligibles, it is important that state programs understand which Medicaid recipients and which services are covered under the federal program.

That means states must have access to a wide range of data regarding Medicare eligibility, claims that have been paid, and other information that often is not contained in Medicaid records. Maintaining accurate, up-to-date records of Medicaid recipients who are eligible for

Medicare benefits is especially important because the size of the dual-eligible population factors into the amount of the clawbacks states will be paying. States need to understand exactly how this population changes from month to month, as Medicaid recipients die, move to other states, or become ineligible for Medicare.

Unfortunately, the necessary Medicare data isn't easily obtained from a single source. Technology and expertise are required to access and integrate information, and create an accurate depiction of exactly which services should have been billed to Medicare in the past, or can be billed to Medicare in the future.

2. *States should make the most of Medicare's "other" pharmacy benefit.* Amid all the attention to Part D, it's easy to ignore the fact that the benefit does not pay for drugs already covered under Medicare's existing Part B drug benefit. Part B generally covers the cost of immuno-suppressant drugs and chemotherapy, and states often pick up the cost of coinsurance for these – or sometimes, pay more than the amounts for which they are liable. To ensure that Medicaid does not shoulder inappropriate costs, states need to understand the detailed requirements of the Part B benefit. In many cases, additional clinical information is required to complete a Part B claim. Again, information technology and expertise can make or break this effort.

3. *States should not overlook other opportunities to properly coordinate benefits with Medicare.* While prescription drugs are a popular target for containing the cost of seniors' care, there are many other areas where states can control their Medicaid expenditures for this population by improving the way benefits are coordinated with Medicare. For example, Medicaid agencies sometimes do not realize when a member's nursing home care may be eligible for Medicare coverage. (Medicare picks up the cost of skilled nursing facility services after a member has been hospitalized for three days.) Using these opportunities requires an in-depth understanding of both programs, and the information to pinpoint potential overlap between the two.

4. *States should maximize the pharmacy rebates to which they are entitled.* It's true that the Medicare benefit deprives states of much of their purchasing power. It's true they may no longer have the same bargaining leverage to obtain generous rebates from pharmaceutical suppliers. However, states can make the most of existing rebates for their dual-eligibles'

prescription drugs. To do so, state healthcare programs need data to identify overlooked drugs that are eligible for rebates, whether the state has paid for the drugs through a pharmacy assistance program or as part of its Medicare Part B obligation.

5. States should consider the value of a vendor. While states work diligently to recover their Medicaid expenditures from Medicare and other liable payors, the Part D benefit increases the complexity of the task. As they coordinate benefits among Medicaid, their own pharmacy assistance programs, and now two distinct Medicare drug benefits, states will be wise to consider employing a vendor to supplement their efforts. Vendors bring dedicated technology and information expertise, which can be critical in accurately identifying opportunities to recover revenue. Vendors also bring lessons learned from performing similar services in other states, and a fresh perspective that can help states develop successful new strategies to increase recoveries. Most importantly, vendors typically charge only a small contingency fee for their services. As a result, Medicaid agencies can increase their cost recoveries – in a budget-neutral, zero-risk manner.

Conclusion

The start of the Medicare drug benefit has been "good news, bad news" for state government. In the short term, the benefit presents significant challenges for state Medicaid agencies, as they confront new costs and responsibilities. But by better utilizing benefit information and resources that are available today, states can ensure that costs are shared appropriately. And in the long term, the Act *can* lighten the load for state government. Like all good stories, this one has a happy ending.

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