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MEDICARE PART D

CMS's Process and Policy for Enrolling New Dual-Eligible Beneficiaries

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June 21, 2007

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Highlights

Highlights of GAO-07-1022T, a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), dual-eligible beneficiaries—individuals with both Medicare and Medicaid coverage—have their drug costs covered under Medicare Part D rather than under state Medicaid programs. The MMA requires the Centers for Medicare & Medicaid Services (CMS) to enroll these beneficiaries in a Medicare prescription drug plan (PDP) if they do not select a plan on their own. CMS enrolled about 5.5 million dual-eligible beneficiaries in late 2005 and about 634,000 who became dually eligible during 2006.

GAO was asked to testify on (1) CMS's process for enrolling new dual-eligible beneficiaries into PDPs and its effect on access to drugs and (2) how CMS set the effective coverage date for certain dual-eligible beneficiaries and its implementation of this policy. This testimony is based on the GAO report, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries* (GAO-07-272).

What GAO Recommends

GAO's report contains several recommendations, including that CMS require PDPs to modify beneficiary notices and that CMS monitor the implementation of its payment policy. CMS did not agree with all of the recommendations, but it has taken steps to implement some.

www.gao.gov/cgi-bin/getrpt?GAO-07-1022T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

CMS's process for enrolling new dual-eligible beneficiaries who have not yet signed up for a PDP involves many parties, information systems, and administrative steps, and takes a minimum of 5 weeks to complete. For about two-thirds of these individuals—generally Medicare beneficiaries who subsequently qualify for Medicaid—pharmacies may not have up-to-date PDP enrollment information needed to bill PDPs appropriately until the beneficiaries' data are completely processed. As a result, these beneficiaries may have difficulty obtaining their Part D-covered prescription drugs during this interval. CMS has created contingency measures to help individuals obtain their new Medicare benefit, but these measures have not always worked effectively. For the other one-third of new dual-eligible beneficiaries—Medicaid enrollees who become Medicare-eligible because of age or disability—CMS eliminated the impact of processing time by enrolling them in PDPs just prior to their attaining Medicare eligibility. This prospective enrollment, implemented in late 2006, offers these dual-eligible beneficiaries a seamless transition to Medicare Part D coverage.

CMS set the effective Part D coverage date for Medicare eligible beneficiaries who subsequently become eligible for Medicaid to coincide with the date their Medicaid coverage becomes effective. Under this policy, which was designed to provide drug coverage for dual-eligible beneficiaries as soon as they attain dual-eligible status, the start of the Part D coverage can extend retroactively for several months before the date beneficiaries are notified of their PDP enrollment. GAO found that CMS did not fully implement or monitor the impact of this policy. Although beneficiaries are entitled to reimbursement for covered drug costs incurred during this retroactive period, CMS did not begin informing them of this right until March 2007. Given their vulnerability, it is unlikely that these beneficiaries would have sought reimbursement or retained proof of their drug purchases if they were not informed for their right to do so. Also, CMS made monthly payments to PDPs for providing drug coverage during retroactive periods, but did not monitor PDPs' reimbursements to beneficiaries during that period. GAO estimated that in 2006, Medicare paid PDPs millions of dollars for coverage during periods for which dual-eligible beneficiaries may not have sought reimbursement for their drugs.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the Medicare Part D prescription drug benefit. Implementation of this new drug benefit has raised particular concerns for individuals eligible for both Medicare and full Medicaid benefits—known as dual-eligible beneficiaries.[1] These individuals account for about 15 percent of all Medicare beneficiaries and 15 percent of all Medicaid enrollees. As a group, they are generally poorer and tend to have more extensive health care needs than other Medicare beneficiaries. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),[2] dual-eligible beneficiaries—who previously received drug benefits under Medicaid—have had their prescription drug costs paid under Medicare Part D since January 1, 2006. In addition, the MMA requires the Centers for Medicare & Medicaid Services (CMS)[3] to assist dual-eligible beneficiaries by enrolling them in a private Medicare prescription drug plan (PDP) if they do not select a plan on their own. CMS enrolled about 5.5 million dual-eligible beneficiaries in late 2005 for the initial implementation of Part D and about 634,000 beneficiaries who became dual-eligible during 2006.

My testimony today will summarize selected findings from the previously released GAO report, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries*.[4] Specifically, my remarks today will focus on (1) CMS's process for enrolling new dual-eligible beneficiaries into PDPs and its effect on beneficiary access to drugs and (2) how CMS set the effective Part D coverage date for certain dual-eligible beneficiaries and its implementation of this policy.

[1]We use the term dual-eligible beneficiaries to refer to individuals who qualify for a state's full package of Medicaid benefits.

[2]MMA, Pub. L. No. 108-173, tit. I, § 101, et seq., 117 stat. 2066, 2071-2152 (2003) (to be codified at 42 U.S.C. § 1395w-101, et seq. and 42 U.S.C. § 1396u-5).

[3]CMS is the agency that administers the Medicare program on behalf of the Secretary of Health and Human Services.

[4]GAO, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries*, GAO-07-272 (Washington, D.C.: May 4, 2007).

To address these issues, we conducted site visits in six states—California, Maine, Maryland, Michigan, New Jersey, and Texas—to learn about dual-eligible beneficiaries' enrollment in Part D from the perspective of state Medicaid agencies, pharmacies, and long-term care providers. We also interviewed officials from CMS and representatives of PDPs about issues that pertain to dual-eligible beneficiaries. We conducted the work for our report from March 2006 through April 2007 in accordance with generally accepted government auditing standards.

In summary, we found that CMS's process for enrolling new dual-eligible beneficiaries involves many parties, information systems, and administrative steps, and takes a minimum of 5 weeks to complete. For the majority of these individuals—generally Medicare beneficiaries not yet enrolled in Part D who subsequently qualify for Medicaid—this processing interval can create difficulties in obtaining Part D-covered drugs at their pharmacies. For other new dual-eligible beneficiaries—Medicaid enrollees who become Medicare eligible because of age or disability—CMS took steps to eliminate the impact of the processing interval by enrolling them in PDPs just prior to their attaining Medicare eligibility. In addition, for the Medicare first, Medicaid second group of new dual-eligible beneficiaries, CMS set the effective date of Part D coverage to coincide with the first date of their Medicaid eligibility. Under this policy, which was designed to provide drug coverage for dual-eligible beneficiaries as soon as they attain dual-eligible status, the start of their Part D coverage can be retroactively set to several months before the date of their actual PDP enrollment. We found that CMS did not fully implement or monitor the impact of this coverage date policy. Although beneficiaries are entitled to reimbursement for covered drug costs incurred during this retroactive period, CMS and PDPs did not begin informing them of this right until March 2007. Also, CMS did not track Medicare payments made to PDPs to provide retroactive coverage or monitor PDPs' reimbursements to beneficiaries for that period. We estimate that in 2006, Medicare paid PDPs about $100 million for coverage during periods for which dual-eligible beneficiaries may not have sought reimbursement for their drug costs. In the report, we recommend that CMS require PDPs to notify beneficiaries about their right to reimbursement, monitor implementation of its retroactive payment policy, and take other steps to improve the operational efficiency of the program.

Background

Dual-eligible beneficiaries are a particularly vulnerable population. These individuals are typically poorer, tend to have far more extensive health care needs, have higher rates of cognitive impairments, and are more likely to be disabled than other Medicare beneficiaries. About three out of four dual-eligible beneficiaries live in the community and typically obtain drugs through retail pharmacies. Other dual-eligible beneficiaries reside in long-term care facilities and obtain drugs through pharmacies that specifically serve these facilities.

In general, individuals become dual-eligible beneficiaries in two ways. One way is when Medicare-eligible individuals subsequently become Medicaid eligible. This typically occurs when income and resources of beneficiaries fall below certain levels and they enroll in the Supplemental Security Income (SSI) program,[5] or they incur medical costs that reduce their income below Medicaid eligibility thresholds. If these Medicare beneficiaries did not sign up for a Part D plan on their own, they have no drug coverage until they are enrolled in a PDP by CMS. CMS data show that this group represented about two-thirds of new dual-eligible beneficiaries the agency enrolled in PDPs in 2006. According to CMS, it is not possible for it to predict which Medicare beneficiaries will become Medicaid eligible in any given month because Medicaid eligibility determinations are a state function.

Another way individuals become dually eligible is when Medicaid beneficiaries subsequently become eligible for Medicare by reaching 65 years of age or by completing the 24-month disability waiting period.[6] Once they become dual-eligible beneficiaries, they can no longer receive coverage from state Medicaid agencies for their Part D-covered prescription drugs. In 2006, this group represented approximately one-third of the new dual-eligible beneficiaries enrolled in PDPs by CMS. CMS can generally learn from states when these individuals will become dually eligible.

[5]In most states, beneficiaries who qualify for cash assistance from SSI—a cash assistance program for aged, blind, and disabled individuals with limited income and resources—automatically qualify for full Medicaid benefits.

[6]Under Social Security Disability Insurance (DI), which assists people who worked but became disabled before their retirement age, individuals are eligible for Medicare coverage after they have received DI cash benefits for 24 months.

For dual-eligible beneficiaries, Medicare provides a low-income subsidy that covers most of their out-of-pocket costs for Part D drug coverage. This subsidy covers the full amount of the monthly premium that non-subsidy-eligible beneficiaries normally pay, up to the low-income benchmark premium.[7] The subsidy also covers most or all of a dual-eligible beneficiary's prescription copayments. In 2007, these beneficiaries are responsible for copayments that range from $1 to $5.35 per prescription, depending on their income and asset levels, with the exception of those in long-term care facilities, who pay no copayments.

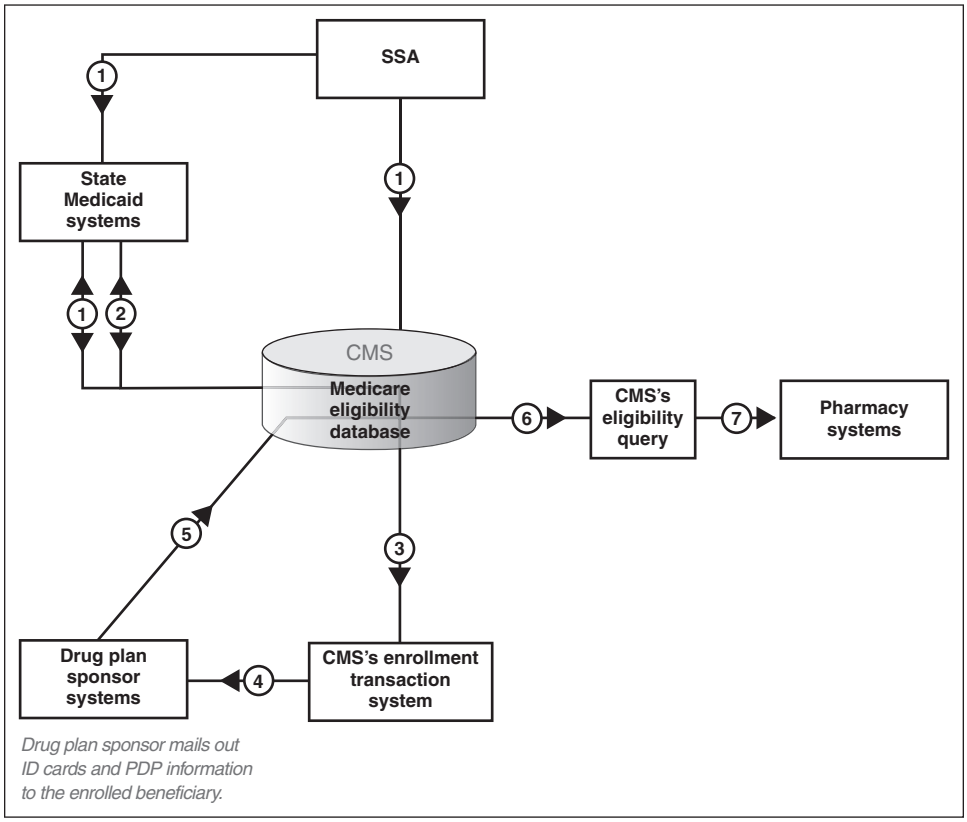
CMS's Enrollment Process Takes Time and Can Create Difficulties for Some Dual-Eligible Beneficiaries

Given the number of entities, information systems, and administrative steps involved, it takes a minimum of 5 weeks for CMS to identify and enroll a new dual-eligible beneficiary in a PDP. As a result, two out of three new dual-eligible beneficiaries—generally those who are Medicare eligible and then become Medicaid eligible—may experience difficulties obtaining their prescription drugs under Part D during this interval. For other new dual-eligible beneficiaries—those switching from Medicaid to Medicare drug coverage—CMS instituted a prospective enrollment process in late 2006 that enrolls these individuals before their date of Medicare eligibility and offers a seamless transition to Part D coverage.

Multiple parties and information systems are involved in identifying and enrolling dual-eligible beneficiaries in PDPs. As shown in figure 1, CMS, the Social Security Administration (SSA), state Medicaid agencies, and PDP sponsors play key roles in providing information needed to ensure that new dual-eligible beneficiaries are identified and enrolled properly. SSA maintains information on Medicare eligibility that is used by CMS and some states. State Medicaid agencies are responsible for forwarding to CMS lists of beneficiaries whom the state believes to be eligible for both Medicare and Medicaid. CMS is then responsible for making plan assignments and processing enrollments. PDP sponsors maintain information systems that are responsible for exchanging enrollment and billing information with CMS.

[7]The low-income benchmark is the average monthly beneficiary premium for all PDPs in a region, weighted by each plan's enrollment.

Figure 1: Overview of the Major Systems and Steps Used to Enroll Dual-Eligible Beneficiaries in PDPs

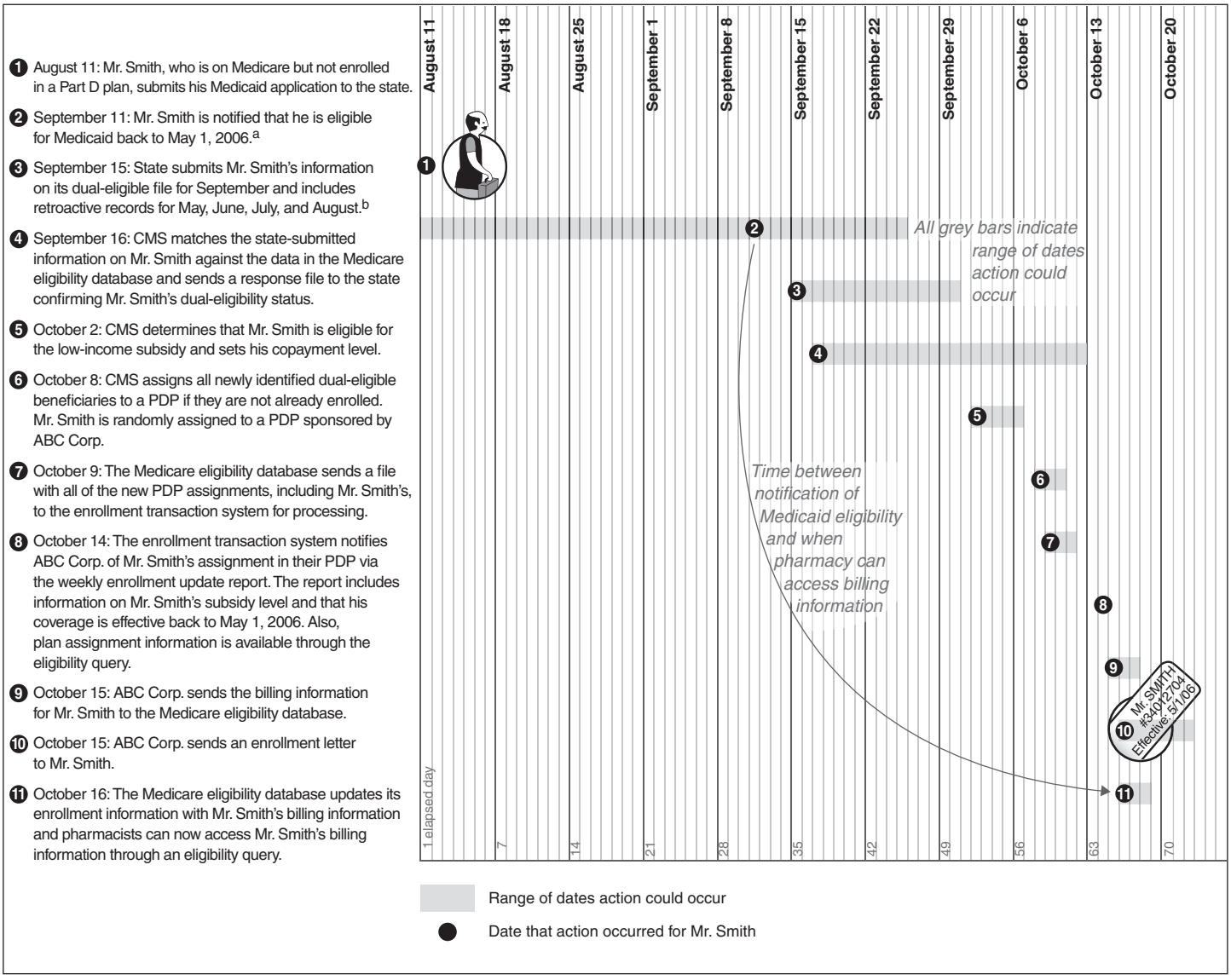


Source: GAO.

Notes: CMS adapted existing information systems used in the administration of other parts of the Medicare program to perform specific functions required under Part D. The Medicare eligibility database serves as a repository for Medicare beneficiary entitlement, eligibility, and demographic data. The database is used by CMS to provide up-to-date information to verify the status of dual-eligible beneficiaries, as well as determine subsidy status and make assignments to PDPs. The enrollment transaction system is used to enroll beneficiaries in PDPs. The eligibility query is used by pharmacies to obtain Part D enrollment information from the Medicare eligibility database.

The process of enrolling dual-eligible beneficiaries requires several steps. It begins when state Medicaid agencies identify new dual-eligible beneficiaries and ends when PDPs make billing information available to pharmacies and send enrollment information to dual-eligible beneficiaries. We estimate that it takes at least 5 weeks to complete the process under current procedures. During this interval, pharmacies may not have up-to-date PDP enrollment information on new dual-eligible individuals. This may result in beneficiaries having difficulty obtaining Part D-covered drugs at their pharmacies. To illustrate why this occurs, we present the hypothetical example of Mr. Smith, who as a Medicare beneficiary did not sign up for the Part D drug benefit and, therefore, upon becoming Medicaid eligible, was enrolled in a PDP by CMS. (Fig. 2 shows the steps in Mr. Smith's enrollment process.)

Figure 2: Mr. Smith, a Hypothetical Example of the Enrollment Process for a Newly Identified Dual-Eligible Beneficiary Who Was Medicare Eligible but without Previous Part D Coverage



Source: GAO.

Notes: The dates presented in this example of enrollment for Mr. Smith generally represent the best-case scenario. The range of dates represent the minimum and maximum length of elapsed time allowed for processing and notification, based on information provided by CMS. GAO makes no assurances that the events described would occur on the dates provided for any specific dual-eligible beneficiary.

[a]The scenario presented reflects an application to Medicaid based on a reason other than disability. State Medicaid agencies have 45 days to make eligibility determinations not based on disability and 90 days for eligibility determinations based on disability, subject to extensions in certain circumstances.

[b]If the state Medicaid agency did not determine that Mr. Smith was eligible for Medicaid before it submitted its September dual-eligible file, his information could not be submitted until October. This scenario is not presented in this figure.

From the time Mr. Smith applies for his state's Medicaid program on August 11, it takes about 1 month for him to receive notification from the state that he is eligible for Medicaid, thus beginning the enrollment process. From there, Mr. Smith's new status is submitted by his state to CMS in a monthly file transmittal. Once CMS receives the lists of dual-eligible beneficiaries from all of the states, it verifies eligibility for Medicare and sets each beneficiary's cost-sharing level. Then, around October 8, CMS assigns Mr. Smith to a PDP randomly, based on the premium level and the geographic area served by the PDP.[8] CMS next notifies the PDP sponsor, which then has to enroll him in its plan and assign the necessary billing information. This billing information, such as a member identification number, is necessary for pharmacies to correctly bill the PDP for Mr. Smith's prescriptions. The PDP also has to inform Mr. Smith of his enrollment information. By the time this process is completed, it is the middle of October.

CMS has developed some contingency measures to help individuals like Mr. Smith during the processing interval. However, we found that these measures have not always worked effectively. For instance, CMS designed an enrollment contingency option to ensure that dual-eligible beneficiaries who were not yet enrolled in a PDP could get their medications covered under Part D, while also providing assurance that the pharmacy would be reimbursed for those medications. However, representatives of pharmacy associations we spoke with reported problems with reimbursements after using this option, which has led some pharmacies to stop using it.

[8]Some states have assisted dual-eligible beneficiaries by using other methods to select a PDP for enrollment, including methods that also consider drug utilization information. For example, the State of Maine used beneficiary-specific data to reassign nearly half of the state's dual-eligible beneficiaries to PDPs that covered more of their prescriptions. After reassignment, the number of beneficiaries whose PDP covered nearly all of their prescription drugs increased significantly.

To avoid a gap in coverage for beneficiaries transitioning from Medicaid to Medicare prescription drug coverage, CMS has implemented a prospective enrollment process. Because states can predict and notify CMS which Medicaid beneficiaries will become new dual-eligible beneficiaries and when, CMS begins the enrollment process for these individuals 2 months before the their anticipated dual-eligible status is attained. By conducting the processing steps early, the prospective enrollment used for this group of new dual-eligible beneficiaries should ensure a seamless transition from Medicaid drug coverage to Medicare Part D coverage. Fully implemented in November 2006, prospective enrollment applies to about one-third of the new dual-eligible beneficiaries enrolled in PDPs by CMS.

CMS Made Drug Coverage Retroactive, but Did Not Inform Beneficiaries of Their Right to Reimbursement

For the majority of new dual-eligible beneficiaries, CMS requires PDPs to provide drug coverage retroactively, typically by several months. During 2006, Medicare paid PDPs millions of dollars to provide coverage to dual-eligible beneficiaries for drug costs that may have been incurred during the retroactive coverage period. However, we found that CMS did not fully implement or monitor the impact of this policy.

CMS made the effective date of Part D drug coverage for Medicare beneficiaries who become Medicaid eligible coincide with the effective date of their Medicaid eligibility. Under this policy, Part D coverage for these beneficiaries is effective the first day of the month that Medicaid eligibility is effective, which generally occurs 3 months prior to the date an individual's Medicaid application was submitted to the state, if the individual was eligible for Medicaid during this time. Thus, the Part D coverage period can extend retroactively back several months from when the actual PDP enrollment takes place.

Medicare makes payments to the PDPs for providing drug coverage retroactively. Specifically, PDPs are paid approximately $90 per month for the retroactive coverage period.[9] PDPs, in turn, are responsible for reimbursing their members (or another payer) for Part D drug costs incurred during the retroactive months. For instance, in the case of Mr. Smith, while he applied for Medicaid in August and learned of his PDP assignment for Part D in October, his coverage was effective May 1. If

[9]The $90 per month includes the direct subsidy Medicare pays PDPs for providing the Medicare drug benefit to any Medicare beneficiary and the low-income premium subsidy CMS pays PDPs to cover the cost of premiums dual-eligible beneficiaries would pay if they were not receiving the low-income subsidy.

Mr. Smith incurred any costs for Part D-covered prescription drugs from May—when he became eligible for Medicaid—through October, he could submit his receipts to his assigned PDP and be reimbursed by the PDP, less the copayments he would pay as a dual-eligible beneficiary.

We found that CMS's implementation of this policy in 2006 was incomplete. While dual-eligible beneficiaries were entitled to reimbursement by their PDPs in 2006, neither CMS nor PDPs notified dual-eligible beneficiaries of this right. The model letters used until March 2007 to inform dual-eligible beneficiaries of their PDP enrollment did not include any language concerning reimbursement of out-of-pocket costs incurred during retroactive coverage periods. In response to a recommendation in our report, CMS modified the model letters that the agency and PDPs use to notify dual-eligible beneficiaries about their PDP enrollment. The revised letters let beneficiaries know that they may be eligible for reimbursement of some prescription costs incurred during retroactive coverage periods.

Given the vulnerability of this population, it seems unlikely that many dual-eligible beneficiaries would have contacted their PDPs for reimbursement if they were not clearly informed of their right to do so and given information about how to file for reimbursement, neither would they likely have retained proof of their drug expenditures. Mr. Smith, for example, would need receipts for drug purchases made during a 5-month period preceding the date he was notified of his PDP enrollment—at a time when he could not foresee the need for doing so.

Further, CMS did not monitor how many months of retroactive coverage PDPs provided, nor did it monitor PDP reimbursements to beneficiaries for costs incurred during retroactive coverage periods. Based on data provided by CMS, we estimate that Medicare paid about $100 million to PDP sponsors in 2006 for retroactive coverage. CMS does not know what portion of this $100 million PDPs paid to dual-eligible beneficiaries to reimburse them for drug costs. If Mr. Smith's PDP did not reimburse Mr. Smith for any prescription drugs purchased during the retroactive coverage period, the PDP retained Medicare's payments for that period.

Conclusions

Given the time it takes to complete the enrollment process, CMS has taken action to ensure ready access to Part D for some new dual-eligible beneficiaries, but difficulties remain for others. For the one-third of new dual-eligible beneficiaries whose eligibility can be predicted, CMS's decision to implement prospective enrollment should eliminate the

coverage gap in transitioning from Medicaid to Medicare drug coverage. However, because of inherent processing lags, most new dual-eligible beneficiaries may continue to experience difficulties obtaining their drugs for at least 5 weeks after being notified of their dual-eligible status. In addition, CMS's incomplete implementation of its retroactive coverage policy in 2006 means that CMS paid PDPs millions of dollars for coverage during periods for which dual-eligible beneficiaries may not have sought reimbursement for their drug costs. Without routine monitoring of this policy, the agency remains unaware of what portion of these funds was subsequently reimbursed to beneficiaries and, therefore, cannot ensure the efficient use of program funds.

Our report contains several recommendations. We recommend that CMS require PDPs to notify beneficiaries of their right to reimbursement and monitor implementation of its retroactive payment policy. We also recommend that CMS take other steps to improve the operational efficiency of the program. Although the agency did not agree with all of them, it has already taken steps to implement some of our recommendations. As of March 2007, CMS has modified its letters to dual-eligible beneficiaries to include language informing them of their right to reimbursement for drug costs incurred during retroactive coverage periods and required PDP sponsors to do the same. In addition, CMS officials told us that they plan to analyze data to determine the magnitude of payments made to PDPs for retroactive coverage and the amounts PDPs have paid to beneficiaries. We hope that CMS will use this information to evaluate the effectiveness of its retroactive coverage policy. If, after conducting the analysis, CMS determines that it is paying PDPs substantial amounts of money and dual-eligible beneficiaries are not requesting reimbursements, the agency may want to rethink its policy in light of pursuing the most efficient use of Medicare funds.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to respond to any questions that you or other members of the subcommittee may have at this time.

Contacts and Acknowledgments

For further information regarding this testimony, please contact Kathleen King at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Contributors to this testimony include Rosamond Katz, Assistant Director; Lori Achman; and Samantha Poppe.

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