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Issue Brief

Impact of the Medicare Prescription Drug Benefit on Home- and Community-Based Services Waiver Programs

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ABSTRACT: “Dual eligibles” is the term for the 6.4 million low-income, elderly, and disabled Americans who are enrolled in both Medicare and Medicaid. With home- and community-based services waivers allowed under Section 1915(c) of the Social Security Act, many of these individuals are able to live in a home or community setting, thereby avoiding institutionalization. Surveying Maryland’s 3,180 dual eligibles who are enrolled in home- and community-based waiver programs, the author finds that the end-of-2005 transfer of prescription drug coverage from Medicaid to Medicare under the Medicare Modernization Act of 2003 could put these beneficiaries in jeopardy. Maryland’s experience is likely to be typical of what other states will face. The author recommends a number of federal policy remedies, among them allowing 90-day prescriptions, using open or shared formularies, and lengthening the enrollment period.

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Overview

The term “dual eligibles” refers to those low-income, elderly people and disabled individuals who are enrolled in both Medicare and Medicaid. In January 2006, responsibility for providing prescription drug coverage for the nation’s 6.4 million dual eligibles will transfer from Medicaid to Medicare, as stipulated by the Medicare Modernization Act of 2003. Those who are nursing-home-certified and participating in home- and community-based services (HCBS) waiver programs face particular challenges with the transition to the new Medicare Part D prescription benefit.

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HCBS waiver participants are receiving an enriched Medicaid benefit package to help them avoid institutionalization and remain in the community. Participants typically receive a full complement of prescription drugs that, together with home-maker services, case management, personal attendant services, and other care, enable these individuals to function in a home or community setting. Without thoughtful planning and the elimination of administrative barriers, the changeover to Medicare Part D poses risks for dual eligibles in HCBS waiver programs.

This issue brief examines the likely impact of the new prescription drug benefit on HCBS dual eligibles in the state of Maryland as these individuals move from Medicaid to Medicare coverage. In Maryland, access to needed medications may be impeded, both in the short and long term; case managers are likely to be overburdened; and a nonalignment of incentives across Medicaid and Medicare may compromise the basic premise of HCBS waiver programs—to enable very sick and disabled people to remain in a community setting. The anticipated scenario in Maryland exemplifies the challenges all states will face in making the transition to Medicare Part D a smooth one.

Dual Eligibles: Health Status and Spending

Of the nation's 6.4 million dual eligibles, two-thirds are age 65 or older and one-third are nonelderly adults with disabilities. Dual eligibles tend to be sicker and more impoverished than other Medicare beneficiaries. Nationally, 71 percent of dual eligibles live on annual incomes of \$10,000 or less. Both elderly and nonelderly dual eligibles require more assistance with activities of daily living (ADLs). Elderly dual eligibles report more chronic disease and are more likely to be in a nursing facility.¹

Because dual eligibles are in many cases disabled and more often suffer from chronic and debilitating health conditions, they consume proportionately more medical care, prescription drugs, and support services. Combined Medicare and Medicaid spending on dual eligibles totaled \$106 billion in 2000. In that same year, while only 16

percent of Medicaid beneficiaries were dual eligibles, they accounted for 42 percent of Medicaid spending. Eighteen percent of Medicare beneficiaries were dual eligibles, with per capita spending of \$18,100, more than twice that for other Medicare beneficiaries. In 2002, 65 percent (\$58 billion) of Medicaid expenditures for dual eligibles went for long-term care. Nationally, prescription drug spending for dual eligibles in 2002 totaled \$13 billion, or 14 percent of total Medicaid spending, while state per capita spending on prescribed drugs for dual eligibles averaged \$918.²

Home- and Community-Based Services Waiver Programs

HCBS programs operate through waivers granted by the U.S. Department of Health and Human Services under Section 1915(c) of the Social Security Act. Certain Medicaid requirements are waived under these programs to enable states to provide a range of home-based services to individuals who might otherwise be institutionalized, while continuing to receive federal matching funds.

To receive waiver approval, states must demonstrate cost neutrality—that is, waiver program costs must be no greater than the cost of institutional care. States are required to limit the number of participant “slots,” and they have the discretion to set medical and financial eligibility criteria, cap spending, and limit availability to certain population groups or geographic areas. In 2001, the most recent year for which aggregate data are available, 49 states were operating 231 HCBS waiver programs with 843,000 participants.³ Of these, 94 waiver programs served 489,000 aged and disabled participants.⁴ No reliable national estimates are available for the number of dual eligibles enrolled in HCBS programs for the elderly and disabled. However, extrapolating Maryland's experience to the national enrollment data that are available suggests that some 425,000 HCBS participants are dual eligibles.

Maryland's HCBS Waiver Programs

In FY2004, 3,180 dual eligibles were enrolled in two 1915(c) waiver programs in Maryland:

- Older Adults Waiver (OAW).** Available to low-income adults who are at least 50 years old and qualify for nursing facility level of care. In operation since 1999, OAW enrolled 3,212 Maryland residents in FY2004. Ninety percent of participants were dual eligibles (Table 1). The benefit package includes case management, personal care, home health care, personal emergency response systems, home-delivered meals, consumer and family training, nutritionist services, home modifications, and assistive devices.
- Living at Home: Maryland Community Choices (LAH).** Available to low-income people with disabilities between the ages of 21 and 59 who qualify for nursing facility level of care. LAH began in 2001 and enrolled 446 individuals in FY2004. Sixty-three percent of participants were dual eligibles. Covered services are similar to those for OAW, with the addition of training and supervision of attendants, occupational therapy, speech and language services, and disposable medical supplies not normally covered by Medicaid or Medicare.

Medicare Drug Benefit’s Effects on Maryland’s Dual Eligibles

Drug Formularies

Access to an extensive formulary of prescription drugs is essential to enabling dual eligibles participating in Maryland’s OAW and LAH programs to remain in the community. In FY2004, prescription drug expenditures for dually eligible OAW and LAH participants totaled \$13.8 million, or 91 percent of total prescription drug expenditures for participants in these waiver programs. More indicative of the importance of prescription drugs to this population is the actual quantity and variety of medications prescribed. Table 2 lists the 10 most prescribed drugs in FY2004 and how many beneficiaries received at least one prescription of each drug. The most widely prescribed drug among dual-eligible waiver participants was Furosemide. This diuretic, which is used to treat hypertension,

Table 1. Dual Eligibles in Maryland’s HCBS Waiver Programs, Fiscal Year 2004

	Total Enrollees	Dual Eligibles	
		Number	Percent
Older Adults Waiver	3,212	2,900	90
Living at Home:			
Maryland Community Choices	446	280	63
Total	3,658	3,180	

Source: UMBC analysis of Maryland Medicaid data.

was prescribed for one-third of waiver participants. Other drugs to lower blood pressure and high cholesterol are frequently prescribed (Lisinopril, Norvasc, Lipitor), as are antibiotics (Cipro, Zithromax), Prevacid (for acid reflux disease), Zoloft (for depression), and Ambien (for sleep disorders).

Overall, Maryland’s 3,180 dual-eligible waiver participants received a total of 220,884 prescriptions in FY2004, for an average of almost 70 prescriptions per beneficiary. Seventy-one percent of dual eligibles required four or more prescriptions per month, and almost 10 percent required 12 or more prescriptions per month (Figure 1).

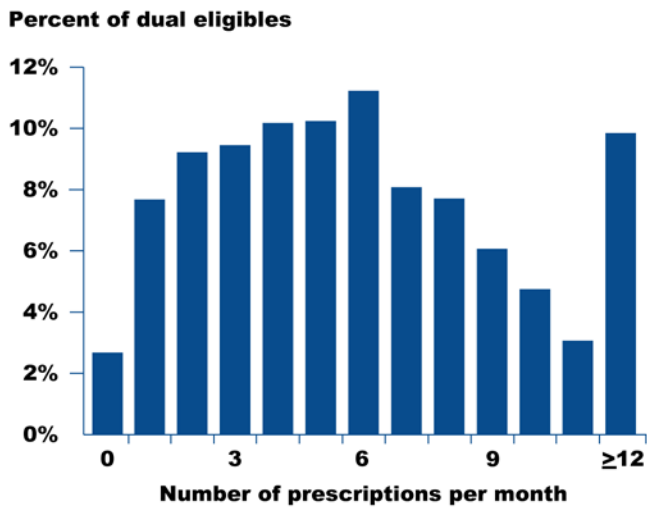
Not only do these beneficiaries require a large number of prescriptions, but the formulary to meet their needs must include a wide range of medications. In FY2004, Maryland’s dually eligible waiver participants required and received 1,645 different (unduplicated) kinds of prescription

Table 2. Top 10 Drugs Prescribed to Maryland’s 3,180 Dual-Eligible Waiver Participants, Fiscal Year 2004

Drug	Beneficiaries	
	Number	Percent
1 Furosemide	999	31
2 Prevacid	764	24
3 Lisinopril	676	21
4 Norvasc	574	18
5 Lipitor	517	16
6 Plavix	470	15
7 Cipro	430	14
8 Zithromax	415	13
9 Zoloft	405	13
10 Ambien	399	13

Source: UMBC analysis of Maryland Medicaid data.

Figure 1. Number of Prescriptions Received Monthly by HCBS Dual Eligibles in Maryland, FY 2004



Source: UMBC analysis of Maryland Medicaid data.

medications. Moreover, 400 of these 1,645 medications were prescribed for one beneficiary only.

To ensure a smooth transition to Medicare Part D prescription drug coverage, Medicare drug plans must be prepared to offer dual eligibles a formulary of drugs that is equivalent to the Medicaid formulary. The Medicare Modernization Act of 2003 anticipates that drug plans will include the use of formularies to manage drug benefits, and Medicare will establish a therapeutic classification system to serve as the basis for plan formularies. The law also requires that the plan and in particular its formulary cannot discourage enrollment of certain beneficiaries.⁵ However, the extent to which drug plan formularies will meet the needs of HCBS waiver participants remains to be seen.

The Centers for Medicare and Medicaid Services now plans to auto-enroll dual eligibles in a drug plan by mid-December 2005. This is intended to give the Medicare drug plans lead time to approve medications by January 1, 2006, and guarantee continuity of coverage. However, given the number of medications required by waiver participants, will this be adequate time? What if an individual is using a drug that is excluded from the drug plan's formulary? Is there

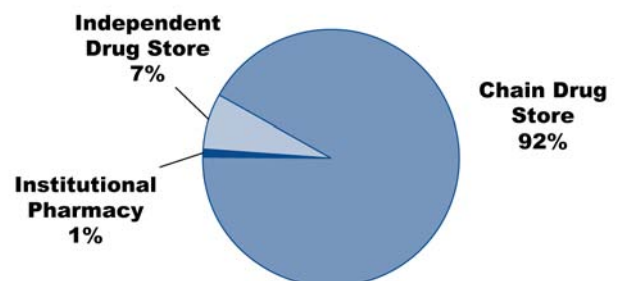
a way to provide access to that drug during the appeal process or until which time the patient's needs can be reassessed by a Medicare-approved physician and alternative, formulary-approved drugs can be prescribed? If not, community-based dual eligibles whose drugs have not been approved may be at risk of medical complications and even hospitalization or institutionalization.

Prescription Drug Distribution Channels

Under Medicare Part D, it is possible that Medicare-approved drug plans will contract with a more limited network of pharmacies than what is currently available to Maryland's dual-eligible waiver participants. This may impede the ability of infirm and disabled dual eligibles to continue obtaining prescription drugs from their neighborhood pharmacy. As shown in Figure 2, Maryland's dual-eligible waiver beneficiaries receive prescriptions from a variety of outlets—chain drug stores, independent drug stores, and institutional pharmacies—and virtually all the pharmacies in the state participate in the Medicaid program. Under a new Medicare prescription drug plan, waiver participants may be forced to establish accounts with new pharmacies, possibly having to travel further from home to obtain prescriptions.

In addition, Medicare drug plans are likely to encourage filling prescriptions by mail because the law allows plans lower cost-sharing for mail-order drugs. Overreliance on mail-order for maintenance medications could prove problematic for

Figure 2. Types of Pharmacies Used by Maryland's Dual-Eligible Waiver Beneficiaries



Source: UMBC analysis of Maryland Medicaid data.

waiver participants. It is well documented that Medicaid beneficiaries move frequently, are more likely to rent than own a home or apartment, and oftentimes are without a permanent mailing address. As a result, automatic monthly drug mailings risk not reaching the beneficiary.

Transportation to the Pharmacy

In Maryland, Medicaid covers beneficiary transportation costs for nonemergency transportation to obtain Medicaid-covered benefits. This means that HCBS waiver participants are currently provided with transportation to the pharmacy to pick up their prescriptions.

Under Medicare Part D, dual-eligible waiver participants will no longer be eligible to receive transportation to the pharmacy because they will no longer be traveling to the drug store to obtain a Medicaid benefit. This may be especially problematic for waiver participants if their Medicare drug-plan-approved pharmacies are farther from home. Consequently, waiver participants may delay picking up prescriptions until they can afford a taxi or arrange for a ride from a family member or friend. State Medicaid programs will have the option of retaining the transportation benefit for dual eligibles, but without federal cost-sharing.

Pressure on HCBS Case Managers

Case managers who arrange for and monitor services received by HCBS waiver participants in Maryland generally do not have to coordinate access to prescription drugs across multiple health plans and formularies. During the transition to Medicare Part D, these Medicaid case managers will find themselves dealing not just with Medicaid, but also with a number of Medicare drug plans, each with its own formulary, distribution channels, and cost-sharing requirements. Case managers will be on the front lines, ensuring continuity of prescription drug coverage for their clients during the transition from Medicaid to Medicare. They will be thrust into the role of educating clients and their caregivers about the new Medicare drug benefit,

coordinating benefits among multiple providers and formularies, and negotiating timely receipt of medications from diverse vendors. After the transition to Medicare Part D, case managers will retain responsibility for dual eligibles but no longer have access to dual eligibles' drug records from the Medicare prescription drug provider, making it more difficult for case managers to coordinate long-term supports and services. All of this is likely to significantly increase case manager workloads, putting pressure on HCBS programs to reduce caseload ratios, which would in turn place upward pressure on Medicaid payment rates for HCBS programs.

Incentive Nonalignment Across Payers

Successfully managing very sick individuals at home or in the community as HCBS programs strive to do requires a full complement of prescription drugs. Unlike HCBS programs, however, the Medicare program as currently structured offers few incentives to avoid long-term institutionalization. Medicare pays only for short-term, post-hospital discharge stays in skilled nursing facilities. Private insurance, the patient's own funds, or Medicaid finance other long-term expenditures. Consequently, Medicare prescription drug plans may be less inclined to approve drugs that beneficiaries need to remain in the community, and it is possible that formularies will not even include all of the drugs that HCBS participants require. Even if certain drugs are included in the prescription drug plan's formulary, dosage form restrictions (e.g., a tablet versus a liquid) may limit access for HCBS beneficiaries. Moreover, in addition to prescription drugs, HCBS waiver participants typically require a number of over-the-counter drugs, which are currently covered by Medicaid. The new Medicare Part D prescription drug benefit does not cover over-the-counter drugs.

Conclusion and Recommendations

Clearly, the drug formularies offered by Medicare prescription drug plans will matter if dual eligibles participating in HCBS waiver programs are to

receive the prescription drugs they need to remain at home or in the community. The networks of pharmacies participating in Medicare prescription drug plans must be broad enough to ensure easy access to an approved pharmacy, particularly if waiver participants are to lose their Medicaid transportation benefit after the transition to Medicare. HCBS case managers will require training and other supports to see them through the transition period. Thereafter, caseloads will require careful monitoring to guard against case manager stress and overload.

Recognizing the potential for formulary shortcomings and administrative holdups during the transition period, the Centers for Medicare and Medicaid Services has included in the rules for the new Medicare law “formulary review for certain diseases, medical necessity coverage of nonformulary drugs, and plan-specific transition procedures to further ensure that dual-eligible beneficiaries will get the drugs they need.”⁶

But states and beneficiaries are demanding more. The following interim measures, together or in part, would serve to further ease the transition for dual eligibles as they move from Medicaid to Medicare prescription drug coverage:

- **Allow states to dispense 90-day prescriptions in December 2005 with full federal matching funds.** This would ensure that HCBS waiver participants have the supplies they need to give them a two-month head start into 2006 and the transition to Medicare. Because this authorization would involve Medicaid expenditures for a time frame that is outside Medicaid’s responsibility (January 2006 forward), special rules are required to ensure it is not considered to be fraudulent.
- **Allow Medicaid to share drug information with the Medicare prescription drug plan as soon as auto-enrollment is finalized.** This would allow case managers more time to guide dual eligibles through the transition process and help beneficiaries secure prescription approvals from Medicare.

- **Require Medicare prescription drug plans to offer dual eligibles open formularies or Medicaid-equivalent formularies during the first six months to a year.** This would in essence lengthen the transition period for dual eligibles, allowing more time to consult with an in-network Medicare physician, align prescription needs, and acquire approvals under the beneficiary’s new drug plan.
- **Require Medicare prescription drug plans to honor a beneficiary’s existing pharmacy regimen until an in-network physician develops a new care plan.** In effect, if Medicare is obligated to approve a beneficiary’s drug regimen until the beneficiary is seen by a physician, the beneficiary will be insulated from some of the transition effects. This form of “grandparent” protection is necessary.
- **Allow states to pick up the cost of noncovered drugs with full federal matching funds and be eligible for a credit to the state “clawback.”** The rules issued by the Centers for Medicare and Medicaid Services in January 2005 state that “states may continue to cover drugs for dual eligibles not covered by the Medicare prescription drug benefit and receive Federal Financial Participation under Medicaid.”⁷ At the same time, states are required to contribute a portion of the cost of Medicare coverage for dual eligibles according to a complex formula based on prior per capita drug expenditures for dual eligibles (the “clawback”). The Congressional Budget Office estimates that the new Medicare drug law will actually increase state Medicaid spending by \$1.2 billion between FY2004 and FY2006, primarily due to clawback payments.⁸ Without clawback relief, “wrap around” Medicaid drug coverage may be prohibitively expensive for states.
- **Lengthen the period for auto-enrollment.** Many states have pushed for auto-enrollment of dual eligibles into a Medicare prescription drug plan so that enrollment will not be dependent

on action by individual beneficiaries. The final rules issued by the Centers for Medicare and Medicaid Services on January 21, 2005, do in fact include auto-enrollment. Auto-enrollment is slated to begin in fall 2005, “as soon as eligible Part D plans are known,”⁹ and “those who do not sign up for a drug plan by the middle of December will be auto-enrolled by Medicare.”¹⁰ However, auto-enrollment in mid-December 2005, for a benefit scheduled to begin on January 1, 2006, simply does not allow enough time to ensure that all dual eligibles are enrolled in a plan that matches their needs.

Moreover, for continued coverage of prescription drugs, beneficiaries will have just a few short weeks to (a) see an in-network Medicare physician to have prescriptions written by that in-network provider, and (b) receive prior authorization from the Medicare prescription drug plan for those newly written prescriptions. Finalizing auto-enrollment at least 60 days prior to January 1, 2006, would provide a more reasonable time period for beneficiaries to complete these steps.

HCBS programs have been successful in keeping very sick, frail, and disabled dual eligibles in the community, out of nursing facilities. Many states have long waiting lists for these programs, as enrollment is limited per federal statute. Yet the literature documents overwhelming evidence that beneficiaries and their caretakers are exceedingly more satisfied with community-based care.

The issues Maryland faces in ensuring a smooth transition for HCBS dual eligibles from Medicaid to Medicare drug coverage are typical of what other states will confront. The remedies suggested here should receive careful consideration by policymakers. Otherwise, a turbulent transition stands to hurt most the very people the programs serve, compromise the ability of states to effectively operate and finance HCBS programs, and tarnish the future of public health insurance programs.

NOTES

- ¹ Kaiser Commission on Medicaid and the Uninsured, “Dual Eligibles: Medicaid’s Role in Filling Medicare’s Gaps,” The Henry J. Kaiser Family Foundation, March 2004.
- ² Kaiser Commission on Medicaid and the Uninsured, “Dual Eligibles: Enrollment and Spending, by State, 2002,” The Henry J. Kaiser Family Foundation, February 2004.
- ³ All states except Arizona operate 1915(c) waivers; Arizona operates an 1115 waiver.
- ⁴ Martin Kitchener, Terence Ng, Nancy Miller, and Charlene Harrington, “Medicaid Home and Community-Based Services: National Program Trends,” *Health Affairs* 24 (Jan/Feb 2005): 206–212.
- ⁵ Jack Hoadley, “The Effect of Formularies and Other Cost Management Tools on Access to Medications: An Analysis of the MMA and Proposed Regulations,” The Henry J. Kaiser Family Foundation, September 2004.
- ⁶ Centers for Medicare and Medicaid Services, “Final Rules Implementing the New Medicare Law: A New Prescription Drug Benefit for All Medicare Beneficiaries, Improvements to Medicare Health Plans and Establishing Options for Retirees,” Medicare Fact Sheet, January 21, 2005.
- ⁷ Centers for Medicare and Medicaid Services, “Principal Changes in New Medicare from Proposed Rules to Final Rules: New Rules Establish New Prescription Drug Benefit, Improvements to Medicare Health Plans and Options for Retirees,” Medicare Fact Sheet, January 21, 2005.
- ⁸ Congressional Budget Office, “A Detailed Description of CBO’s Cost Estimate for the Medicare Prescription Drug Benefit,” July 2004.
- ⁹ Centers for Medicare and Medicaid Services, “Overview of the Medicare Prescription Drug Benefit: MMA Title I Summary,” January 21, 2005.
- ¹⁰ Centers for Medicare and Medicaid Services, “Final Rules Implementing the New Medicare Law: A New Prescription Drug Benefit for All Medicare Beneficiaries, Improvements to Medicare Health Plans and Establishing Options for Retirees,” Medicare Fact Sheet, January 21, 2005.

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