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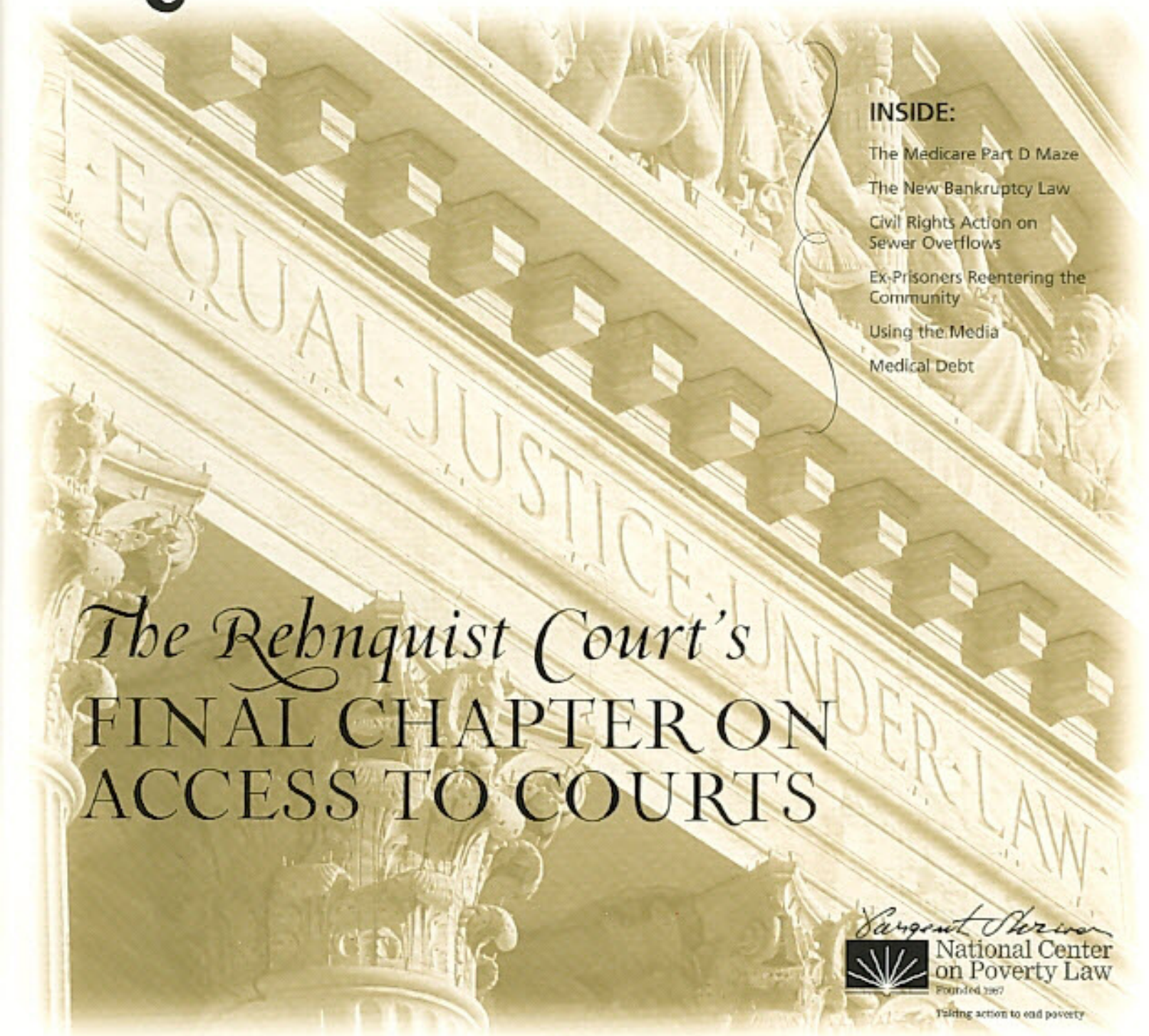

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Goodbye Medicaid, Hello Medicare: Helping Dual Eligibles Navigate the Medicare Part D Maze

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December 31, 2005, signifies the end of Medicaid prescription drug coverage for the more than six million Medicaid beneficiaries who are also eligible for Medicare. Beginning on January 1, 2006, such dually eligible beneficiaries will get their drugs covered through Medicare's new prescription drug benefit, known as Part D, which was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[1] Generally speaking, Part D provides Medicare beneficiaries with limited assistance in paying for prescription drugs through a new benefit operated through private plans.[2] For those dually eligible for Medicare and Medicaid, the assistance is more substantial, but its salutary aspects may be mitigated by the loss of Medicaid coverage.[3]

Note that Medicaid coverage ends whether or not the dually eligible individual chooses to be in a Part D plan and whether or not the plan in which she is enrolled covers the drug she needs.[4] The ending of Medicaid coverage is achieved through the law's prohibition against payment of federal financial participation to state Medicaid programs for such services.[5]

The significance of this loss of Medicaid coverage cannot be overstated: Part D requires fewer beneficiary protection provisions than does Medicaid. As a result, dually eligible beneficiaries may find that they have access to fewer drugs, higher copayments, no assurance of access to prescription drugs if they are unable to afford the copayment, and no assurance of coverage pending appeal.

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[1] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

[2] *Id.* §101, adding §§ 1860D-1 *et seq.* to the Social Security Act of 1935, 42 U.S.C.A. §§ 1395w-101 *et seq.* (West 2005 Supp.).

[3] This elimination of coverage for an otherwise covered Medicaid service represents a substantial departure from the common Medicare-Medicaid relationship for dual eligibles, under which Medicaid pays Medicare's cost sharing and provides "wraparound coverage" for services where, as with home health, Medicare coverage is more limited than Medicaid's or where, as with prescription drugs and long-term care, Medicare coverage is nearly nonexistent. The significance of this situation cannot be overstated. Because of the design of the Medicare drug benefit, many dual eligibles will find themselves with less and more costly prescription drug coverage than they had under Medicaid and potentially less protection during appeals to challenge denials or other barriers to coverage.

[4] More specifically, coverage is eliminated for all prescription drugs that are required to be covered by Medicaid; indeed, Part D–covered drugs are defined by reference to Medicaid law. Those drugs that are optional in Medicaid are not covered by Part D and may continue to be paid for with Medicaid dollars including federal financial participation. 42 U.S.C.A.§ 1396u-5(d)(2) (West Supp. 2005).

[5] 42 U.S.C.A. § 1396u-5(d)(1) (West Supp. 2005); 42 C.F.R. § 423.906 (2005); 70 Fed. Reg. 4420 (Jan. 28, 2005) (preamble).

Moreover, the Act requires states to pay back to the federal government—through a mechanism popularly referred to as "the clawback"—much of the savings that they would otherwise realize from their reduced Medicaid obligation to those individuals and includes other provisions affecting state budgets. Because the clawback is based on the number of dual eligibles in a state's Medicaid program in any given month, it is a strong incentive for states to cut their rolls of such individuals.[6]

An earlier article on Part D familiarized advocates with the prescription drug benefit and proposed implementing regulations, identified emerging issues of particular significance to low-income beneficiaries and to states, and proposed guidance and strategies for advocates to use in advising their clients as well as in engaging their states to prepare for Part D implementation in January 2006.[7] Since that writing, final regulations and countless guidance documents have emerged from the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services.[8]

In this article I focus on issues specific to dual eligibles whose treatment under the law is special in several respects: in addition to losing their current Medicaid coverage effective January 1, 2006, they receive the Part D full low-income subsidy regardless of their income or resources, and, to minimize gaps in coverage at the transition from Medicaid to Medicare, they will be randomly assigned to Part D programs serving their geographic area. They also are entitled to an ongoing special enrollment period, allowing them to change Part D plans at any time. I examine the law, regulations, and guidance concerning treatment of dual eligibles and identify issues to which advocates should pay attention and strategies for assuring that dual eligibles do not experience coverage gaps under Part D.

Dual Eligibles: Who Are They and How Does the Law Define Them?

Dual eligibles are the poorest, sickest, and most expensive consumers of health care resources of the Medicare population. They are high users of prescription drugs.

Demographics and Health Profile. Dual eligibles are impoverished: over 60 percent live below the poverty level, and 94 percent live below 200 percent of the poverty level. Compared to the rest of the Medicare population, dual eligibles are more likely to be Hispanic or African American, disproportionately women, more likely never to have been married, and much more likely to be in an institution. They are less likely to have graduated from high school, more often live in rural areas, and more often live alone. [9] Dual eligibles are more likely than nondual eligibles to be under 65 and disabled or over 85 years old.[10]

Dual eligibles are twice as likely as other Medicare beneficiaries to report fair to poor health status, more likely to have diabetes and stroke, and more than twice as likely to have Alzheimer's disease.[11] They

[6]The clawback requirement has been cited by one Mississippi state legislator as a reason for completely eliminating Medicaid coverage for 65,000 state residents. Mississippi State Sen. Tommy Moffatt is paraphrased as saying that the federal government mandates that persons dually enrolled in Medicaid and Medicare would have to come off Medicaid or the state has to repay the federal government. Natalie Chambers, *Minister: Medicaid Cuts Cruel, Inhuman*, Mississippi Press, July 2, 2004, www.gulflive.com/news/mississippipress/index.ssf?/base/news/108876333882670.xml. (on file with Patricia B. Nemore).

[7]Alfred Chiplin et al., *Dazed and Confused: Navigating the Abyss of the Medicare Act of 2003 for Low-Income Beneficiaries*, 38 Clearinghouse Review 443 (Nov.–Dec. 2004).

[8]Medicare Program; Medicare Prescription Drug Benefits: Final Rule, 70 Fed. Reg. 4194 (Jan. 28, 2005) (codified at 42 C.F.R. pt. 423).

[9]Medicare Payment Advisory Commission, A Data Book: Healthcare Spending and the Medicare Program, www.medpac.gov/publications/congressional_reports/Jun04DatabookSec2.pdf.

[10]Over one-third of dual eligibles qualify for Medicare due to disability (under 65) and 14 percent are 85 or older. *Id.*, chart 2-2.

[11]Kaiser Commission on Medicaid and the Uninsured, Medicaid Facts: Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries (2005).

use, on average, at least ten more prescription drugs than nondually eligible Medicare beneficiaries.[12] Antipsychotic and antidepressant drugs accounted for 18 percent of all Medicaid expenditures for dual eligibles in one recent year.[13]

Both Medicare and Medicaid spend disproportionate amounts of money on dually eligible beneficiaries. Dual eligibles comprise only 14 percent of the total Medicaid population, but they account for about 40 percent of total Medicaid spending.[14] They comprise only 15 percent to 17 percent of Medicare beneficiaries, but their care accounts for approximately 22 percent to 26 percent of Medicare spending.[15]

Dual Eligibles Defined. Part D uses the term "full-benefit dual eligible" to refer to those individuals who are the subject of this article. "Full-benefit dual eligibles" are defined for purposes of Part D as individuals who have coverage under a Part D plan and who are eligible for *full* Medicaid benefits under any category of a state plan, including the elderly and disabled in Section 209(b) states and the medically needy.[16] The apparent contradiction between this definition and the statement made earlier that coverage is eliminated for dual eligibles whether or not they are enrolled in a plan is resolved by reference to a related section of the law; the section describes the elimination of federal financial participation for those with full Medicaid coverage *without reference to* whether they are enrolled in a Part D plan.[17]

Individuals entitled to the Qualified Medicare Beneficiary and Specified Low-Income Beneficiary Programs may be "full-benefit dual eligibles" if they also get full Medicaid services.[18] Dual eligibles include those with full coverage under a research and demonstration or home-based and community-based services waiver, but not individuals receiving only prescription drug coverage under a Section 1115 Pharmacy Plus waiver.[19]

Low-Income Subsidy for Dual Eligibles

Dual eligibility, as defined by Part D, entitles the beneficiary to the best subsidies available to low-income individuals. All dual eligibles, regardless of their income or resources, are entitled to the full low-income subsidy:[20]

- No premium if they choose a plan at the benchmark level or lower (national average standard premium is $32.20 for 2006).[21]

[12] Kaiser Family Foundation, Medicare Chart Book 2005, www.kff.org/Medicare/7284.cfm (tbl. 5.4: Average Number of Prescriptions Filled by Noninstitutionalized Medicare Beneficiaries by Primary Source of Supplemental Coverage 2002).

[13] James M. Verdier & Myoung Kim, *Medicaid Drug Use Data Show High Costs and Wide Variation for Dual Eligibles*, Mathematica Policy Research Issue Brief No. 5 (Aug. 2005).

[14] Medicare Payment Advisory Commission, *supra* note 9.

[15] *Id.*

[16] 42 U.S.C.A. § 1396u-5(c)(6) (West Supp. 2005); 42 C.F.R. §§ 423.772, 423.902; 70 Fed. Reg. 4370 (Jan. 28, 2005) (preamble).

[17] *Id.* at. § 1396u-5(d)(1) (West Supp. 2005); 42 C.F.R. § 423.906(b). Note that states are not prohibited from using their own dollars to cover their residents, regardless of their status as Medicaid beneficiaries. The federal portion of Medicaid dollars is what will end on January 1, 2006.

[18] Qualified individuals, entitled to have Medicaid pay their Medicare Part B premiums, may not be dual eligibles under the Part D definition because the statute defines them as individuals who are *not* receiving full Medicaid services.

[19] *Id.* At this writing, only four states have approved Pharmacy Plus waivers: Illinois, Wisconsin, South Carolina, and Florida. In addition to those four states, Maryland and Vermont have amended existing waivers to include only pharmacy coverage for certain individuals. What, if any, role Pharmacy Plus waivers will play under Part D is unclear.

[20] 42 U.S.C.A. 1395w-114(a)(1), (3)(B)(v)(I) (West Supp. 2005); 42 C.F.R. § 423.773(c)(1)(i) (2005); 70 Fed. Reg. 4368 (Jan. 28, 2005) (preamble).

[21] Because the benchmark premium is the average weighted premium within an area, the premium will differ from one part of the country to another. 42 U.S.C.A. § 1395w-114(b)(2) (West Supp. 2005); 42 C.F.R. § 423.780; 70 Fed. Reg. 4386 (Jan. 28, 2005) (preamble). Regional benchmarks range from $25.41 in the region comprising only California to $36.85 in the region comprising only Louisiana.

- No deductible (standard deductible is $250).
- No gap in coverage (the so-called Doughnut hole) (standard coverage gap is $2,850).

Set dollar copayments depending on income or institutional status or both (Standard benefit has 25 percent coinsurance): $0 copayment for dual eligibles who are institutionalized; $1 (generic/preferred)/$3 (nonpreferred) for dual eligibles with incomes up to 100 percent of the federal poverty level; $2 (generic/preferred)/$5 (nonpreferred) for all other dual eligibles.[22]

Dual eligibles are deemed eligible for the full subsidy without having to apply for it.[23] Beginning in the summer of 2005, they are being notified of this status by CMS, at the same time that others eligible for the low-income subsidy are being notified by the Social Security Administration that they should apply for that subsidy. An individual deemed eligible for the subsidy at any point during a year remains eligible for the subsidy for the duration of that year, regardless of a change in the status that resulted in the deeming.[24] Thus, while a medically needy individual is not a dual eligible for purposes of Part D until she has met her spend-down, she retains, once the spend-down is met for the first time in a year, a full subsidy eligibility throughout that calendar year.[25] If at the end of the year, she is no longer eligible for Medicaid, she will have to apply separately for, and have her eligibility determined according to the income and resource rules that apply to, the low-income subsidy.

However, a dually eligible individual who loses Medicaid eligibility may still qualify as deemed eligible for the full low-income subsidy (and thus bypass the requirement of separate application for the subsidy) if she remains eligible for one of the three Medicare Savings Programs that allow for deemed subsidy eligibility. State Medicaid agencies are required, before terminating Medicaid coverage of any beneficiary, to determine if that individual is eligible for any other category of Medicaid offered by the state.[26]

A Medicare beneficiary who is later found eligible for Medicaid and who thus becomes dually eligible and eligible for the low-income subsidy is subsidy-eligible for the first month for which she is eligible for Medicaid. Thus, if she is entitled to retroactive Medicaid benefits for three months before her application for Medicaid, her subsidy would also be effective during those three months, but only if she was enrolled in a Part D plan during that three-month period.[27] Plans are required to refund any payments that are made by such an individual and covered by the subsidy.[28] Advocates would want to ensure that their dually eligible clients get any retroactive subsidy for which they might be eligible.

Autoenrollment

Presumably because of the loss of Medicaid drug coverage, Congress required that dual

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[22] 42 U.S.C.A.§ 1395w-114(a) (West Supp. 2005); 42 C.F.R. § 423.780, 782 (2005); 70 Fed. Reg. 4384 (Jan. 28, 2005) (preamble).

[23] 42 C.F.R. § 423.773(c)(1)(i) (2005); 70 Fed. Reg. 4368 (Jan. 28, 2005) (preamble).

[24] 42 C.F.R. § 423.773(c)(2).

[25] *Id.*; 70 Fed. Reg. 4376 (Jan. 28, 2005) (preamble to final regulations).

[26] 42 C.F.R. § 435.930(b) (2005) (the agency must continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible); § 435.916(c)(1) (The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility.). See, e.g., *Crippen v Kheder,* 741 F.2d 102 (6th Cir. 1984), rev'g *Crippen v. Dempsey,* 549 F. Supp. 643 (W.D. Mich. 1982); *Massachusetts Association of Older Americans v. Sharp,* 700 F.2d 749 (1st Cir. 1983); *Massachusetts Association of Older Americans v. Commissioner of Public Welfare,* 803 F.2d 35 (1st Cir. 1986) (same case).

[27] See 70 Fed. Reg. 4380 (Jan. 28, 2005) (preamble to final regulations) for a discussion of retroactive eligibility for low-income subsidy by virtue of retroactive eligibility for Medicaid.

[28] 42 C.F.R. § 423.800(c) (2005).

eligibles who had not enrolled in a Part D plan should be automatically enrolled in one.[29] The secretary of health and human services determined that CMS was responsible for autoenrollment and that autoenrollment should be accomplished to be effective January 1, 2006.[30] All dual eligibles were to be informed by CMS, beginning in October 2005, of the plan to which they had been assigned and of their right to choose a different plan.[31] All individuals not enrolled in a Medicare Advantage plan will be randomly assigned among those plans serving their geographic region for which the premium is at or below the benchmark for the region. Random assignment means no effort to match individuals to plans that best serve their needs. Thus a dual eligible could be assigned to a plan whose formulary does not include some or all of her drugs or whose pharmacy network does not include her pharmacy. To avoid being enrolled in such an ill-fitting plan, a dual eligible may choose a different plan before December 31, 2005. Even if she does not make a choice by that time, she may still disenroll from the plan to which she has been assigned and choose another at any time. This is because dual eligibles, unlike most other Medicare beneficiaries, have an ongoing special enrollment period that allows them to change plans at any time.[32]

Be advised that the Medicare & You 2006 handbook sent to all Medicare beneficiaries in October 2005 contains incorrect information: the handbook states that the low-income premium subsidy pays the full premium for all plans in all regions. In fact, the subsidy pays the full premium only for those plans with premiums at or below the benchmark. At this writing, CMS has issued errata information and distributed it to various agencies but does not have plans to resend the handbook. While this error has no impact on autoenrollment—except as described below, dual eligibles are autoenrolled *only* into plans for which they pay no premium—it matters to the extent that they choose a different plan for themselves. Correct plan premium information is available at www.Medicare.gov.

Only plans providing standard or actuarially equivalent to standard coverage is included in the pool for random assignment, even if plans offering enhanced benefits do so with a premium at or below the benchmark.[33]

Individuals enrolled in a Medicare Advantage plan are autoenrolled in a Medicare Advantage Prescription Drug plan (MA-PD) offered by their MA plan, even if the only MA-PD offered has a premium above the benchmark (i.e., subsidized) amount. CMS does not address the question of how a person who is dually eligible can pay for the unsubsidized premium amount; one strategy is to avoid the payment by disenrolling from the MA plan altogether, thus returning to Original Medicare Parts A and B, and then enrolling in a freestanding Prescription Drug Plan.[34]

Nursing Facility Residents and Other Institutionalized Individuals

About one in five dual eligibles resides in a nursing facility or other institution.[35] These individuals have additional challenges and benefits with respect to Part

[29] 42 U.S.C.A. § 1395w-101(b)(1)(C) (West Supp. 2005).

[30] 42 C.F.R. § 423.34(d) (2005).

[31] Centers for Medicare and Medicaid Services, Medicare Managed Care Manual: Prescription Drug Program Guidance, Eligibility, Enrollment and Disenrollment 30.1.4 (Aug. 30, 2005) (final).

[32] 42 U.S.C.A. § 1395w-101(b)(3)(D) (West Supp. 2005); 42 C.F.R. § 423.38(c)(4) (2005); Centers for Medicare and Medicaid Services, *supra* note 31, at 20.3.2. Beneficiaries of the three Medicare Savings Programs, Qualified Medicare Beneficiary, and Specified Low-Income Beneficiary and Qualified Individual, also have an ongoing special enrollment period.

[33] Centers for Medicare and Medicaid Services, *supra* note 31, at 30.1.4.A.

[34] Centers for Medicare and Medicaid Services, Medicare Managed Care Manual ch. 2, sec. 40.1.6. Dual eligibles also have ongoing special enrollment periods with respect to enrollment in Medicare Advantage plans.

[35] Kaiser Family Foundation, *supra* note 12. (chart 1.12: Comparison of Dual Eligible and Other Medicare Beneficiaries 2002)

D. For example, when they are randomly assigned to a Part D plan, they have no assurance that the plan includes in its network the long-term care pharmacy that is used by the facility in which they reside, although all plans are required to include long-term pharmacies in their networks.[36] Residents, many of whom have cognitive impairments, may not have the ability to review their assigned plan or to choose another, yet may not have a designated authorized representative or even a family member to assist them. Advocates may want to work with local long-term care ombudsmen to identify facility residents who might need assistance in connection with Part D decisions.

Dually eligible nursing facility residents have no copayment for drugs included on their plan's formulary.[37] For drugs not on the formulary, they may seek an exception through the required plan process, and, *unlike noninstitutionalized Medicare beneficiaries, including other dual eligibles,* they are entitled to have the plan provide them with nonformulary drugs during the exceptions process.[38] Such a temporary supply of drugs is not, however, available to those who do not seek an exception. Dually eligible residents who are unsuccessful in appealing the noncoverage of their drug may also pay for it through the incurred medical expense deduction allowed for them before they pay to the nursing home their share of cost under Medicaid.[39] Nursing home residents, regardless of their status as dually eligible, are protected from being denied prescription drugs by provisions of the nursing home reform law; the law mandates that facilities provide all services required by the resident's comprehensive assessment, regardless of the availability of Medicare or Medicaid payment.[40]

The protection provisions described above for residents of long-term care facilities generally do not apply to residents of board-and-care or assisted-living facilities, even though such residents may be virtually identical in their needs to long-term care facility residents.[41] The incurred medical expenses deduction for noncovered drugs may be available to such residents if they are required by Medicaid to pay a share of cost.

Transitions

Every plan must have a process to address the needs of new enrollees who are using medications not included on the plan's formulary; dual eligibles who are autoenrolled into a plan are explicitly identified as a population needing attention.[42] The plans have flexibility to design their processes; most of CMS' guidance is suggestive rather than prescriptive. For example, CMS recommends, but does not require, that plans consider filling a tem-

[36] 42 C.F.R. § 423.120(a)(5) (2005); Centers for Medicare and Medicaid Services Long Term Care Guidance (March 16, 2005), www.cms.hhs.gov/pdps/LTC_guidance.pdf.

[37] 42 U.S.C.A. § 1395w-114(a)(1)(D) (West 2005 Supp.); 42 C.F.R. § 423.782(a)(2)(ii) (2005).

[38] See First Fill, What Is [Centers for Medicare and Medicaid Services'] Policy Regarding Emergency Supply of Medications for Long-Term Care Residents? Are Plans Required to Cover a Temporary/Emergency Supply of Nonformulary Part D drugs While an Exception Request Is Being Processed?, www.cms.hhs.gov/pdps/qafirstfillforltcresidents-final.pdf. The protection applies to all residents of long-term care facilities, not just to dual eligibles.

[39] 42 U.S.C.A. § 1396a(r)(1) (West 2005 Supp.); e.g., 42 C.F.R. § 435.832(c)(4) (2005). CMS acknowledges that the excess premium cost may count as an incurred medical expense for the purpose of meeting a medically needy spend-down. 70 Fed. Reg. 4208 (Jan. 28, 2005) (preamble to final regulations). While these two separate concepts of incurred medical expense are not identical, they are quite similar. In view of CMS' interpretation and the plain statutory language authorizing the incurred medical expense deduction, a reasonable assumption is that the latter might be used both for excess premium costs and for paying for nonformulary drugs.

[40] 42 U.S.C.A. §§ 1395i-3(a)-(h) (Medicare), 1396r(a)-(h) (Medicaid) (West Supp. 2005). See also 56 Fed. Reg. 48850 (Sept. 26, 1991) (Preamble to Final Requirements of Participation for Skilled Nursing Facilities and Nursing Facilities).

[41] 42 U.S.C.A. § 1395w-114(a0(1)(D)(i), referring to § 1396a(q)(1)(B) (West Supp. 2005); 42 C.F.R. § 423.772; 70 Fed. Reg. 4372 (Jan. 28, 2005) (preamble to final regulations); 42 U.S.C.A. § 1395w-104(b)(1)(C)(iv) (West Supp. 2005); 42 C.F.R. § 423.100 (2005); 70 Fed. Reg. 4236 (Jan. 28, 2005) (preamble to final regulations); Centers for Medicare and Medicaid Services, *supra* note 36.

[42] Centers for Medicare and Medicaid Services, Information for Part D Sponsors on Requirements for a Transition Process (March 16, 2005), www.cms.hhs.gov/pdps/transition_process.pdf.

porary onetime supply of the nonformulary medication: 30 days for those in the community, 90–180 days for residents of long-term care facilities taking multiple medications.[43] As noted above, the guidance does *require* that plans provide nonformulary drugs to long-term care facility residents during the exceptions process.

During the initial transition from Medicaid to Medicare, dual eligibles can also be protected by having their state Medicaid program provide them with a ninety-day supply of drugs for the period January through March. CMS assured states that they could receive federal financial participation for such coverage, but states are not required to provide it.[44]

Formulary Issues

While issues related to plan formulary do not have a unique impact on dual eligibles, they do have a special relevance for a number of reasons.[45] Dual eligibles are higher users of prescription drugs than other Medicare beneficiaries.[46] In some states, under Medicaid they currently have no copayments, and, where copayments are required, Medicaid beneficiaries may not be denied prescription drugs for failure to meet the copayment.[47] Dual eligibles are entitled to a temporary supply pending a request for prior authorization.[48] They are also entitled to aid paid pending appeal of a cutoff in services.[49]

These protection provisions are generally not available under Part D. Plan formularies under Part D can be considerably more restrictive than Medicaid.[50] Oversight of the generally broad discretion left to the plans is limited to the secretary of health and human services' role in disapproving a plan that may likely "substantially discourage enrollment by certain Part D eligible individuals…."[51] A dually eligible beneficiary might be taking a drug or drugs for which she was able to get Medicaid coverage, but that might not appear on any of the formularies of plans having the benchmark-level premium that gives her a full subsidy or that may be removed from the plan's formulary after she has joined. Plans must have an exceptions process to allow enrollees to seek coverage of a nonformulary drug, reinstated coverage of a drug removed from the formulary, and reduction of the drug's cost sharing from a higher tier to a lower tier, but, with the exception of institutionalized individuals, beneficiaries are generally not entitled to an emergency supply of the drug pending the outcome of the process.[52]

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[43] *Id.*

[44] Centers for Medicare and Medicaid Services, A Strategy for Transitioning Dual Eligibles from Medicaid to Medicare Prescription Drug Coverage—May 2, 2005, www.cms.hhs.gov/medicarereform/strategyforduals.pdf.

[45] For an excellent discussion of prescription drug issues that may particularly affect dual eligibles, see JEFFREY S. CROWLEY, KAISER COMMISSION ON MEDICAID AND THE UNINSURED 2004, THE NEW MEDICARE PRESCRIPTION DRUG LAW: ISSUES FOR DUAL ELIGIBLES WITH DISABILITIES AND SERIOUS CONDITIONS, www.kff.org./Medicaid/7119.cfm.

[46] See KAISER FAMILY FOUNDATION, *supra* note 12.

[47] 42 C.F.R. § 447.53(e) (2005).

[48] 42 U.S.C.A. § 1396r-8(d)(5)(B) (West Supp. 2005)

[49] *Goldberg v. Kelly,* 397 U.S. 254 (1970). CMS, in implementing Part D, has generally not taken into account the application of due process standards contemplated by *Goldberg* for individuals in "brutal need"; determining *Goldberg's* relevance will surely be part of the ongoing agenda of the advocacy community as the law takes effect. See also Nancy Morawetz, A *Due Process Primer: Litigating Government Benefit Cases in the Block Grant Era,* 30 CLEARINGHOUSE REVIEW 97 (June 1996).

[50] Formularies of prescription drug plans must cover at least two drugs in each therapeutic category and class. However, prescription drug plans may define therapeutic categories and classes, 42 U.S.C.A. § 1395w-104(b)(3)(C) (West Supp. 2005); 42 C.F.R. § 423.120(b)(2) (2005).

[51] 42 U.S.C.A. § 1395w-111(e)(2)(D) (West Supp. 2005); 42 C.F.R. § 423.272(b)(2) (2005). Pursuant to 42 U.S.C.A. § 1395w-104(b)(3)(c) (West Supp. 2005), the U.S. Pharmacopeia issued draft Model Guidelines for prescription drug plans to follow in establishing therapeutic categories and classes (www.usp.org). Prescription drug plans that adopt the model will be deemed to meet nondiscrimination requirements with respect to categories and classes. 42 C.F.R. § 423.272(b)(2)(ii) (2005).

[52] 42 U.S.C.A. sec 1395w-104(g), (h) (West Supp. 2005); 42 C.F.R. § 423.578 (2005)

While plans have broad discretion in formulary design, CMS has required them to include "all or substantially all" of the drugs in the categories of antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant, and HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome); CMS states that, through review of current practices in the other federal drug coverage programs, "we learned that formulary inclusion rather than an exceptions process is an appropriate standard in certain circumstances."[53] For some of these drugs, plans will still be permitted to use "utilization management tools" such as step therapy and prior authorization for individuals starting on such drugs, but not on those who are stabilized on them at enrollment.[54]

Drugs Not Covered by Part D

Medicaid may continue to cover, for dual eligibles, those drugs that it may but is not required by law to cover for any Medicaid beneficiary and that are not, by definition, Part D–covered drugs; states will receive federal financial participation for such coverage. Such drugs include benzodiazepines, barbiturates, prescription vitamins, cough and cold relief drugs, and nonprescription drugs, among others.[55] Advocates will want to determine if their states cover such drugs and to assure continued coverage of them for dual eligibles after January 1, 2006.

In addition to drugs for which coverage is excluded from Part D, certain drugs will not be paid for by Part D if they are covered by Part A or B (such as drugs generally administered in a physician's office), whether or not the individual beneficiary is enrolled in that part of Medicare.[56] Since some states do not automatically pay Part A premiums for very low-income dual eligibles who are not entitled to premium-free Part A, even though they are required by law to do so, advocates will want to ensure that their dually eligible clients are enrolled in both Parts A and B.[57]

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Navigating Part D will be challenging for all Medicare beneficiaries and for those helping them. The moment of transition from Medicaid to Medicare on January 1, 2006, will be especially challenging for dual eligibles. To be informed and prepared to assist their clients, advocates can take a number of steps:

1. Find out the state's plans for identifying and assisting dual eligibles in understanding their Part D options.
2. Find out the state's plans for additional coverage assistance through a State Pharmaceutical Assistance Program or through continued coverage of Part D–excluded drugs under its Medicaid program.
3. Learn about how the state administers its incurred medical expense deduction for dual eligibles in long-term care facilities.
4. Work with state and local long-term care ombudsmen to assure that facilities governed by the nursing home reform law honor their legal obligation to provide all drugs required by a resident's plan of care.
5. Assist dually eligible clients in understanding what is available to them in the state and in evaluating the Part D plan to which they are assigned by CMS.

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[53]Centers for Medicare and Medicaid Services Q&A: Why Is CMS Requiring "All or Substantially All" of the Drugs in the Antidepressant, Antipsychotic, Anticonvulsant, Anticancer, Immunosuppressant, and HIV/AIDS Categories?, www.cms.hhs.gov/pdps/formularyqufinalmmrevised.pdf.

[54]*Id.*

[55]42 U.S.C.A. §§ 1395w-103(e)(2), 1396u-5(d)(2) (West Supp. 2005).

[56]*Id.* § 1395w-102(e)(2)(B)); 42 C.F.R. § 423.100 (2005); 70 Fed. Reg. 4233 (Jan. 28, 2005) (preamble to the final regulations).

[57]Memorandum from the Director, Disabled and Elderly Health Programs Group, to Associate Regional Administrators, on Medicaid Obligations to Pay Medicare Health Maintenance Organizations or Competitive Medical Plans or Medicare Plus Choice Organizations (June 30, 2000). This document includes a chart identifying all aspects of Medicare cost sharing for which states are required to pay. See Medicare Handbook, Complexities of Enrolling in Medicare Part A for Eligibility for Qualified Medicare Beneficiary Benefits app 10C (Judith A. Stein & Alfred J. Chiplin Jr. eds., 2005) (unpublished manuscript); for a detailed discussion of the issues related to states purchasing Part A for certain Medicaid beneficiaries, including the process through which clients may be put, see id. § 10.05[C].