

GAO

Testimony

Before the Subcommittee on Health,  
Committee on Ways and Means, House of  
Representatives

---

For Release on Delivery  
Expected at 2:00 p.m. EDT  
Thursday, June 21, 2007

## MEDICARE PART D

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

Statement of Kathleen M. King  
Director, Health Care





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](http://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](mailto:kingk@gao.gov).

# MEDICARE PART D

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

### 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.<sup>1</sup> 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),<sup>2</sup> 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)<sup>3</sup> 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*.<sup>4</sup> 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.

---

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

<sup>2</sup>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).

<sup>3</sup>CMS is the agency that administers the Medicare program on behalf of the Secretary of Health and Human Services.

<sup>4</sup>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,<sup>5</sup> 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.<sup>6</sup> 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.

---

<sup>5</sup>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.

<sup>6</sup>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.<sup>7</sup> 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

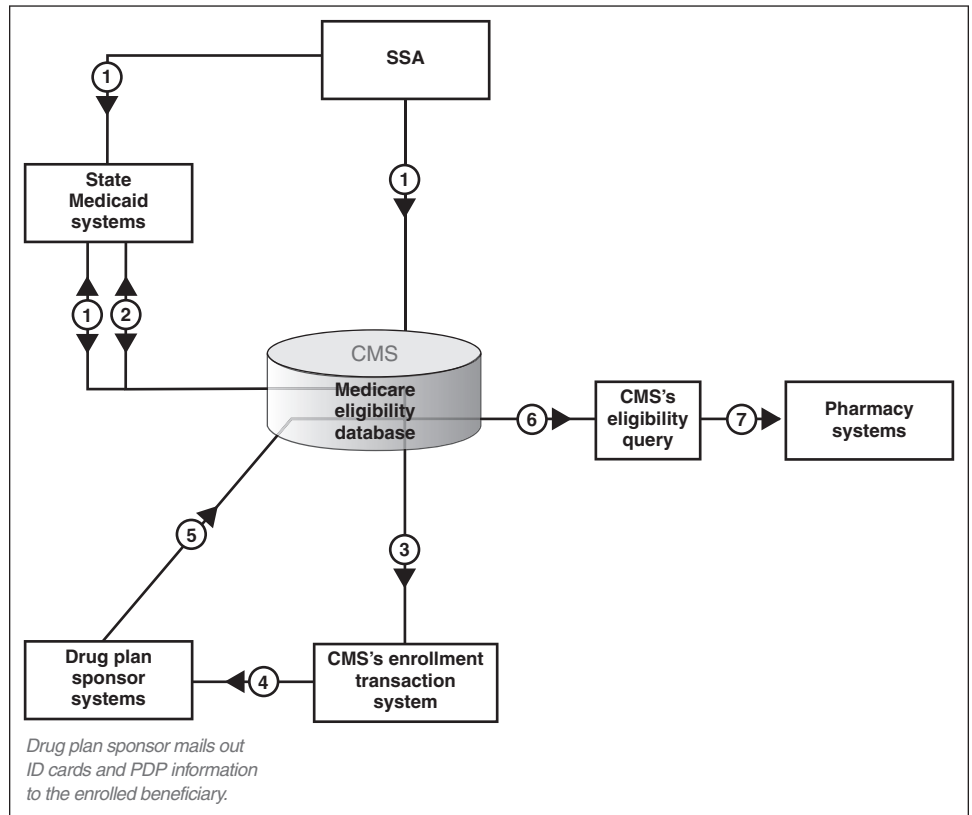
Given the number of entities, information systems, and administrative steps involved, it takes a minimum of 5 weeks for CMS to identify and enroll a new dual-eligible beneficiary in a PDP. As a result, two out of three new dual-eligible beneficiaries—generally those who are Medicare eligible and then 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.

---

<sup>7</sup>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.