Approved: February 10, 2006
Date

MINUTES OF THE HOUSE APPROPRIATIONS COMMITTEE

The meeting was called to order by Chairman Melvin Neufeld at 9:00 A.M. on February 2, 2006 in Room 514-S of the Capitol.

All members were present except:
Representative Joe McLeland- excused
Representative Kevin Yoder- excused
Representative Tom Sawyer- excused

Committee staff present:
Alan Conroy, Legislative Research Department
J. G. Scott, Legislative Research Department
Becky Krahl, Legislative Research Department
Mike Corrigan, Revisor of Statutes
Nikki Feuerborn, Administrative Assistant
Shirley Jepson, Committee Secretary

Conferees appearing before the committee:
Kathy Greenlee, Acting Secretary, Department on Aging
Scott Brunner, Division of Health Policy and Finance

Others attending:
See attached list.

- Attachment 1 Testimony by Kathy Greenlee
- Attachment 2 Testimony by Scott Brunner
- Attachment 3 Updated List of Payments for Medicare Part D by the State

Representative Light moved to introduce legislation regarding court admissions to the Reception and Diagnostic Center. The motion was seconded by Representative Sharp. Motion carried.

Representative Light moved to introduce legislation regarding claims settlement authority for the Secretary of Corrections.The motion was seconded by Representative Pilcher-Cook.Motion carried.

Continued discussion from February 1st on Medicare Part D Prescription Plan:

Chairman Neufeld recognized Kathy Greenlee, Acting Secretary, Department on Aging, who presented an overview of the implementation of Medicare Part D in Kansas (Attachment 1). Ms. Greenlee noted that the State has been working for three years to put together a team of individuals to respond to problems associated with the implementation of the drug program. She noted that one problem with the training involved the lack of final details and resources. In addition, the Plan Finder, the Center for Medicare and Medicaid Services (CMS) internet tool to find providers, is very complicated and difficult to understand. Even with all the preparation, Ms. Greenlee stated that there were serious problems with the implementation of the drug program on January 1st. Approximately one-quarter of the dual-eligibles were lost in the system because an edit feature was dropped from the computer system.

Of the 400,000 Kansans eligible for the Medicare Part D Prescription Drug coverage, 40,000 are dual-eligibles. Approximately one-quarter of these dual-eligibles live in nursing homes. The plan design indicates that these individuals, who live in nursing homes, do not have to pay a co-pay. The remaining three-quarters of the dual-eligibles, have a co-payment because of the plan design. These individuals who are now being asked to make a co-payment, did not have a co-payment in the past. Ms. Greenlee stated that the problem needs to be analyzed to identify these individuals, the cost of the co-payment and how the State can fix the problem if they choose to do so.

Ms. Greenlee felt it is important to determine jurisdiction, provide on-going assistance, correct the problems with dual-eligibles and eliminate the problems experienced by the pharmacists. She noted it will be necessary to go to Congress to correct the malfunctions in the design plan.

Responding to questions from the Committee, Ms. Greenlee stated that CMS approved the 41 prescription drug plans available to Kansans eligible for Medicare Part D. Ms. Greenlee noted that providers of assistance can answer questions and provide assistance to eligible individuals but they are unable to make a decision for the individual on the choice of an insurance company drug plan. Ms. Greenlee stated that the individual who can make these decisions is left to State law.

With regard to the penalty clause for those eligible individuals who do not enroll in a plan, Ms. Greenlee felt that this provides for a good mix of participants for the insurance companies, providing healthy individuals as well as those in need of prescription drugs. The Committee felt it is important to correct the problems associated with the program and not create a "panic" among eligible citizens. The Committee indicated that it may seek a resolution to extend or eliminate the May 15th deadline when the penalty clause becomes effective.

The Chair recognized Scott Brunner, Division of Health Policy and Finance, who presented testimony on Medicare Part D and Dual Eligibles (Attachment 2). Mr. Brunner felt that the State is taking a positive approach in resolving the problems associated with the implementation of the Medicare Part D program.

Because CMS has created a central electronic point of sale electronic system to take care of all Part D enrollees, plan assignments and benefit coverage, the State, on January 1st, blocked their Medicaid Management Information electronic system to prevent pharmacy payments for Medicare eligible beneficiaries. The CMS system was not responsive or correct during the first week of the Part D program causing the State to reverse their action and allow Medicaid to be billed for these prescription drugs in order for the individual to have their prescriptions filled. As of January 30, the State has expended approximately $2.9 million to correct the problem caused by the malfunction of the CMS system. This temporary measure was offered until February 1st , has been extended to February 6th and will be evaluated to determine if further action is necessary. CMS has indicated that they are working to provide full federal reimbursement for costs incurred by states providing this transitional coverage for dual eligibles. CMS has indicated that this reimbursement will be effective until February 15th. Mr. Brunner noted that the State is "payer of last resort" and pharmacies should be using the CMS system first before turning to the State.

Responding to a Committee question with reference to the fact that dual-eligibles in nursing homes do not have a co-payment on prescription drugs, Mr. Brunner indicated that he felt the individuals have limited income and limited interaction with the pharmacist. He also indicated that this group of individuals were not addressed when the program was designed and there was a lack of understanding with this issue.

Mr. Brunner provided an updated list of payments made by the State (Attachment 3).

The Committee requested additional information:

- If Jayhawk Pharmacy of Topeka, has used the temporary State program; and if so, why they had not received any reimbursement.

The Chairman thanked Mr. Brunner for his testimony.

The Committee requested that a special committee be appointed to address the Medicare Part D Prescription Drug program, review possible state solutions and items to offer the federal government in a resolution.

Chairman Neufeld appointed the following members to a Special Committee on Medicare Part D Prescription Drug to review program issues:
Representative Landwehr, Representative Ballard, Representative Williams, Representative Henry, Representative Bethell, Representative McCreary and Representative Schwartz.

HB 2194 was withdrawn from Appropriations and referred to Economic Development Committee.
HB 2565 was withdrawn from Appropriations and referred to Select Committee on Veterans Affairs.

MINUTES OF THE House Appropriations Committee at 9:00 A.M. on February 2, 2006 in Room 514-S of the Capitol.

The meeting was adjourned at 10:25 a.m. The next meeting will be held at 9:00 a.m. on February 7, 2006.

Melvin Neufeld, Chairman

HOUSE APPROPRIATIONS COMMITTEE

February 2, 2006
9:00 a.m.

NAME	REPRESENTING
Ron Seeber	Hein Law Firm
Deborah Neille	LTC Ombudsman
Tim Maddox	KNOC
Katy Sueltz	CDOA

KANSAS

DEPARTMENT ON AGING
KATHY GREENLEE, ACTING SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

Feb. 1, 2006

TO: House Appropriations Committee

FROM: Kathy Greenlee, Acting Secretary
Kansas Department on Aging

RE: Overview of Kansas Implementation of Medicare Part D

Rep. Neufeld and members of the House Appropriations Committee, thank you for the opportunity to appear before you today.

I would like to focus today on three areas of the program's implementation: an overview of the implementation, the impact on Kansans and the status of enrollment of beneficiaries in Kansas, KDOA's outreach and training efforts and our plans to utilize the additional resources recently allocated by Gov. Sebelius.

Background

Plan Design: KDOA recently provided members of the legislature with a Medicare Prescription Drug program Resource Guide. I brought addition copies of the information should you need them. Attached to my testimony is an At-A-Glance overview of the benefit.

State of Kansas Implementation: An interagency team lead by Scott Brunner, Kansas Medicaid director, has been meeting for the past 18 months on the numerous implementation details for the State of Kansas. The Kansas Insurance Department and KDOA are members of the implementation team.

Outreach and Training: During the past year, 157 people have been newly certified as Senior Health Insurance Counseling of Kansas (SHICK) counselors by completing the 24-hour Initial Training Course. Another 234 people completed training to maintain their SHICK certification. SHICK representatives also trained a variety of government agencies and community-based organizations to provide individual assistance to seniors. Nearly 400 educational programs have been presented across the state and more than 1 million Kansans have received information about Medicare Prescription Drug Coverage through targeted mailings and media events.

Governor's Medicare Part D Committee: Last month, the Governor asked me to convene a group of advocacy organizations, providers and agency staff to share on-the-ground implementation information during this critical time period. From this group, we have been able to learn of important emerging issues and concerns and identify additional training and education needs.

HOUSE APPROPRIATIONS
DATE 2-02-2006
ATTACHMENT 1

Kansas Medicare Population

The Medicare population in Kansas totals approximately 400,000 elderly and persons with disabilities who reside in communities and facilities across the state. Approximately 40,000 of the 400,000 are eligible for both Medicare and Medicaid. These beneficiaries (often called the "dual eligibles") also reside in communities and institutions across the state.

Medicare Part D impacts all 400,000 beneficiaries. Beneficiaries generally fall into one of five main groups, based on an individual's current coverage. The following Kansas-specific information is from Centers for Medicare and Medicaid Services (CMS) and reflect prescription coverage enrollment as of Jan. 20, 2006:

- **Those with Medicare and Medicaid coverage (duel eligibles): 38,297** automatically assigned

This group of approximately 40,000 Kansans began receiving their prescription drug coverage from Medicare Jan. 1, 2006. If they had not joined a plan by Dec. 31, 2005, they were automatically enrolled in a plan, at random. This group may choose to re-enroll in a different plan each month.

- **Those with no prior prescription drug coverage who have enrolled in a stand-alone plan: 42,595**

Persons who formerly had no prescription drug coverage have until May 15, 2006 to enroll in drug plan. If they do not enroll by the deadline, they will pay a premium penalty if they decide to enroll later.

- **Those with employer/union coverage: 27,607** Union or under decision

This group will continue to receive coverage through their employers or unions as Medicare will help the employers and unions continue to provide retiree drug coverage that meets Medicare's standards.

- **Those with Medicare Advantage Plan or other Medicare Health Plan: 13,415**

This group will continue to receive prescription drug coverage.

- **Federal government retirees: 35,626**

This group constitutes an additional group of individuals receiving prescription drug coverage.

As such, the number of Kansans with prescription drug coverage totals 158,170 or 39.8%, of the Medicare population. It should be noted, however, the percentage linked to individuals who have chosen a Medicare Part D appears closer to 14%.

Emerging Issues

Enrollment Assistance: $500,000 Governor's Recommendation.

- Expand the capacity of the SHICK toll-free number.

- Include targeted questions for SHICK volunteers to ask of beneficiaries when they call.

- Fully utilize opportunities for on-line enrollment training and assistance from CMS:

    - Coordinate CMS-sponsored four-hour trainings, specific to on-line enrollment, to Community organizations, Ombudsman staff and volunteers, SRS EES staff, and Sponsoring Organization Coordinators and volunteers. Provide stipends to community organizations and volunteers who participate in the training in concert with their commitment to assist Medicare beneficiaries with on-line enrollment.

    - Promote CMS-sponsored Regional Office tele-training opportunities.

- Refer calls from the SHICK toll-free number for assistance with on-line enrollment and re-enrollment to the appropriate group of staff/volunteers.

- Provide additional funding to SHICK Sponsoring Organizations for increased staffing during the enrollment phase.

- Additional training has been provided to approximately 80 individuals to assist Medicare beneficiaries with on-line enrollment. The number toll-free SHICK phone lines are being expanded and additional temporary staff will be hired. Additional funding also will be provided to Sponsoring Organizations and the Ombudsman office.

Dual Eligibles Not Receiving Medications: When it became clear that pharmacists were having problems filling prescriptions for dual-eligible beneficiaries, Gov. Sebelius assured Kansans that the State of Kansas will cover the cost of the prescription drugs directly. Kansas, then will seek appropriate compensation from CMS or the health plans that failed to properly enroll the individual.

Delaying May 15th Deadline: Gov. Sebelius and Commissioner Sandy Praeger have called for an extension of the May 15th deadline for enrolling in the program.

Co-pays for Duals: Advocates for seniors and persons with disabilities are concerned that some dual eligibles are being charged co-payments. This is an on-going system design issue. These groups may be bringing this issue to your attention. CMS is evaluating the impact of the co-payments on persons who are dually eligible.

To help direct your constituents to help, I have attached to my testimony a list of the SHICK regional sponsoring organizations and contact information for each. Also attached is a copy of the standard prescription drug benefit chart from the Legislator's Resource Guide and a chart giving a state-by-state breakdown on the number of Medicare Part D enrollees.

Thank you for the opportunity to discuss this important issue and to bring you up-to-date with our efforts to help seniors receive the medications they need.

SHICK Call Center (Statewide) 1-800-860-5260

SHICK Regional Sponsoring Organizations

Kansas City area
Donna Bosilevac
Wyandotte/Leavenworth County AAA
913-573-8532
1-888-661-1444
Counties: Wyandotte, Leavenworth

Anita Riffel
Johnson County Area Agency on Aging
913-477-8131
1-888-214-4404
County: Johnson

Lawrence area
Katie Glendening
Douglas County Senior Services
785-842-0543
County: Douglas

Topeka area
Diane McDermed
Jayhawk Area Agency on Aging
785-235-1367
1-800-798-1366
Counties: Shawnee, Jefferson

Tanya Turner
LULAC Senior Center
785-234-5809
County: Shawnee

Judy Mattox
Healthwise 55
Stormont-Vail Resource Center
785-354-6784
County: Shawnee

Wichita area
Jenell Smith
Sedgwick County Extension Service
316-722-7721
County: Sedgwick

Peggy Maggard
Butler County Extension Service
316-321-9660
County: Butler

Susan Jackson
Harvey County Extension Service
316-284-6930
County: Harvey

Northwest Kansas
Glenna Clingingsmith
Northwest Kansas Area Agency on Aging
785-628-8204
1-800-432-7422
Counties: Cheyenne, Rawlins, Decatur, Norton, Phillips, Smith, Sherman, Thomas, Sheridan, Graham, Rooks, Osborne, Wallace, Logan, Gove, Trego, Ellis, Russell

Southwest Kansas
Kathy McGee
Southwest Kansas Area Agency on Aging
620-225-8230
1-800-742-9531
Counties: Greeley, Wichita, Scott, Lane, Ness, Rush, Barton, Hamilton, Kearny; Finney, Hodgeman, Pawnee, Edwards, Stafford, Stanton, Grant, Haskell, Gray, Ford, Kiowa, Pratt, Morton, Stevens, Seward, Meade, Clark, Commanche, Barber

North Central Kansas
Shirley Wickman
North Central/Flint Hills AAA
785-776-9294
1-800-432-2703
Counties: Jewell, Republic, Mitchell, Cloud, Clay, Riley, Pottawatomie, Lincoln, Ottawa, Dickinson, Geary, Wabaunsee, Ellsworth, Saline, Morris, Marion, Chase, Lyon

South Central Kansas
Kristin Sparks
South Central Kansas Area Agency on Aging
Arkansas City, KS 67005
620-442-0268
1-800-362-0264
Counties: Rice, McPherson, Reno, Kingman, Harper, Sumner, Cowley, Chautauqua, Elk, Greenwood

SHICK Call Center (Statewide) 1-800-860-5260

SHICK Regional Sponsoring Organizations

Northeast Kansas
Cathy Koenig
Northeast Kansas Area Agency on Aging
785-742-7152
1-800-883-2549
Counties: Washington, Marshall, Nemaha, Brown, Doniphan, Jackson, Atchison

East Central Kansas
Leslea Rickabaugh
East Central Kansas Area Agency on Aging
785-242-7200
1-800-633-5621
Counties: Osage, Franklin, Miami, Coffey, Anderson, Linn

Southeast Kansas
Kathy Pavlu
Southeast Kansas Area Agency on Aging
620-431-2980
1-800-794-2440
Counties: Woodson, Allen, Bourbon, Wilson, Neosho, Crawford, Montgomery, Labette, Cherokee

Update: Officials working to fix glitches in Medicare drug program

KANSAS HEALTH INSTITUTE

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

www.khi.org

Thursday, Jan. 26 — U.S. Health and Human Services Secretary Mike Leavitt was in Kansas Thursday to affirm that the federal government will reimburse the state for the cost of providing medicines to citizens who so far have been unable to obtain them through the new Medicare prescription drug program.

Gov. Kathleen Sebelius, who participated in a joint news conference with Leavitt, said the state had incurred more than $2 million in costs so far filling more than 28,000 prescriptions for more than 10,000 Kansans.

Most of the people who have experienced problems are so-called dual eligibles —approximately 40,000 low-income and disabled Kansans who previously received their prescription drugs through the Medicaid program. Those individuals were automatically enrolled on Jan. 1 in one of the 40 Medicare drug plans being offered in Kansas. But recordkeeping errors and other system glitches prevented many of them from obtaining their prescriptions.

The dual eligible population is a relatively small portion of the more than 400,000 Kansas Medicare beneficiaries who are eligible for the prescription drug program. People are classified as dual eligible when they are both low-income and elderly or disabled. Individuals who are not classified as dual eligibles have until May 15, 2006, to enroll in a plan. But several governors, including Gov. Sebelius, and many members of Congress have called for an extension of the enrollment deadline.

Commissioner seeking regulatory authority

State Insurance Commissioner Sandy Praeger is urging the Legislature to approve a bill requiring private companies offering Medicare prescription drug plans in Kansas to register with her office so that it can help with consumer complaints. She said most of the 16 companies offering plans are currently under her department's jurisdiction, but at least five are not. Praeger's bill, SB-405, is scheduled for an initial hearing Tuesday, Jan. 31, at 9:30 a.m. in the Senate Financial Institutions and Insurance Committee.

Additional funds sought for counseling

To bolster the capacity of the largely volunteer network of counselors helping Medicare beneficiaries choose a plan, Gov. Sebelius has proposed a $500,000 increase in funding for the program. If the Legislature approves, funding would increase from $345,812 to $845,812. The program is administered by the Senior Health Insurance Counseling of Kansas (SHICK) office in the Department on Aging.

What they said:

"We are going to solve this problem. We are not going to leave anyone stranded."

—U.S. Health and Human Services Secretary Mike Leavitt

"We're still seeing claims rise every day. We are hopeful that maybe we're seeing the peak, but each day the claims have been rising."

—Gov. Kathleen Sebelius

"We shouldn't be surprised. It's a huge program. We just have to keep the pressure on and make sure we get the problems solved."

—Insurance Commissioner Sandy Praeger

The Standard Medicare Prescription Drug Benefit

KANSAS HEALTH INSTITUTE

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www.khi.org

KANSAS DEPARTMENT ON AGING
Security, Dignity, and Independence for Kansas Seniors

The Kansas Department on Aging uses public and private resources to improve the security, dignity and independence of Kansas seniors, their families, seniors' caregivers and all Kansans living in adult care homes.

www.agingkansas.org

At-A-Glance

Prescription Drug Spending	Plan Pays	Beneficiary Pays
$0–$250	$0	Up to $250 deductible
$250–$2,250	75% of drug costs – up to $1,500	25% of drug costs – up to $500
$2,250–$5,100 (coverage gap/ "donut hole")	0% of drug costs – $0	100% of drug costs – up to $2,850
Subtotal:	**Up to $1,500**	**Up to $3,600 out-of-pocket**
More than $5,100 (Catastrophic Benefit)	95%	5% or $2 copay per generic drug or $5 copay per brand name drug

Note: Premium costs are not included in this chart. The beneficiary will pay monthly premiums, therefore, in addition to the amounts shown on the chart. These premiums range from $9.48 per month to $67.88 per month for plans available in Kansas.

Adapted from: AARP, *The New Medicare Prescription Drug Coverage: What You Need to Know,* 2005

State Enrollment in Medicare Prescription Drug Plans *Nov. 15, 2005 – Jan. 13, 2006*

State	Stand-Alone Prescription Drug Plan	Medicare Advantage with Prescription Drugs*	Medicare-Medicaid (Automatically Enrolled)	Medicare Retiree Drug Subsidy	Estimated Federal Retirees (Tricare, FEHB)	Total With Drug Coverage
Alabama	74,807	76,867	82,098	107,684	72,991	414,447
Alaska	2,737	95	11,255	9,914	17,671	41,672
Arizona	48,595	244,249	49,528	103,576	32,770	478,718
Arkansas	62,788	3,684	60,294	49,668	69,784	246,218
California	155,394	1,222,191	875,243	424,223	310,997	2,988,048
Colorado	30,584	129,563	37,546	72,114	68,510	338,317
Connecticut	46,841	30,722	66,388	105,986	19,587	269,524
Delaware	25,889	424	9,432	30,110	10,916	76,771
District Of Columbia	3,017	4,687	15,115	3,035	23,597	49,451
Florida	226,391	601,193	328,919	427,022	237,921	1,821,446
Georgia	140,541	34,629	135,814	108,828	123,468	543,280
Hawaii	3,082	47,087	22,740	32,824	47,748	153,481
Idaho	17,417	12,867	17,909	18,524	17,077	83,794
Illinois	251,339	66,726	248,315	318,813	66,695	951,888
Indiana	108,309	7,179	94,379	181,559	33,649	425,075
Iowa	42,139	13,406	54,545	39,799	17,913	167,802
Kansas	42,595	13,415	38,927	27,607	35,626	158,170
Kentucky	80,019	26,933	78,240	122,087	43,700	350,979
Louisiana	34,972	68,151	134,174	91,909	43,921	373,127
Maine	29,582	748	44,945	32,114	18,012	125,401
Maryland	80,092	27,923	56,536	119,900	130,157	414,608
Massachusetts	71,082	109,619	183,359	179,047	40,626	583,733
Michigan	160,824	24,844	190,062	446,984	38,489	861,203
Minnesota	46,428	84,814	58,047	73,040	24,571	286,900
Mississippi	45,209	3,933	129,089	28,440	39,923	246,594
Missouri	74,228	114,201	137,409	115,301	58,212	499,351
Montana	10,856	1,434	14,750	12,494	13,496	53,030
Nebraska	24,703	10,630	31,360	21,620	19,630	107,943
Nevada	15,285	84,921	17,126	38,602	31,110	187,044
New Hampshire	18,862	1,434	18,827	31,657	13,333	84,113
New Jersey	182,104	55,811	135,048	259,907	52,390	685,260
New Mexico	15,092	44,542	31,385	39,975	32,979	163,973
New York	110,566	300,585	494,346	498,597	90,736	1,494,830
North Carolina	137,210	90,342	215,945	204,717	130,624	778,838
North Dakota	8,720	751	10,413	4,595	9,748	34,227
Ohio	118,454	197,716	172,056	505,489	73,761	1,067,476
Oklahoma	68,110	40,146	73,297	46,110	61,165	288,828
Oregon	56,312	109,593	32,042	43,044	31,894	272,885
Pennsylvania	133,062	478,537	146,752	287,170	95,593	1,141,114
Rhode Island	7,869	51,367	25,939	12,154	10,940	108,269
South Carolina	64,759	18,074	113,045	106,393	70,649	372,920
South Dakota	12,696	1,066	11,551	5,972	10,303	41,588
Tennessee	84,144	94,309	212,299	108,277	60,085	559,114
Texas	234,159	223,653	295,043	410,590	248,025	1,411,470
Utah	25,339	11,814	19,987	26,883	32,140	116,163
Vermont	14,478	96	15,722	13,428	5,069	48,793
Virginia	120,518	20,824	102,290	107,022	221,530	572,184
Washington	61,233	72,341	94,042	96,132	108,435	432,183
West Virginia	41,208	4,776	40,801	82,919	14,852	184,556
Wisconsin	60,919	44,448	108,676	132,954	26,470	373,467
Wyoming	8,073	335	5,443	6,792	7,767	28,410
Puerto Rico	9,873	163,219	793	10,059	0	183,944
Virgin Islands	865	42	12	3,030	0	3,949
Other	1,461	1,920	711	0	0	4,092
Total	**3,551,831**	**5,094,876**	**5,600,009**	**6,386,690**	**3,117,255**	**23,750,661**

* Medicare Advantage includes 600,000 Medicare-Medicaid beneficiaries.

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KANSAS
DIVISION OF HEALTH POLICY AND FINANCE
ROBERT M. DAY, DIRECTOR
KATHLEEN SEBELIUS, GOVERNOR

Testimony on:
Medicare Part D and Dual Eligibles

presented to:
House Committee on Appropriations

by:
Scott Brunner
Division of Health Policy and Finance

February 1, 2006

For additional information contact:
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Kansas Division of Health Policy and Finance

Robert M. Day, Director

House Committee on Appropriations
February 1, 2006

Medicare Part D and Dual Eligibles

Mr. Chairman and members of the committee, my name is Scott Brunner and I am the State Medicaid Director with the Division of Health Policy and Finance (DHPF). I am providing testimony on the transition of Medicaid beneficiaries into the Medicare prescription drug benefit.

The Medicare Modernization Act

The Medicare Modernization Act of 2003 (MMA) made a prescription drug benefit available to every Medicare beneficiary beginning on January 1, 2006. This benefit, known as Medicare Part D, also pays for prescription drugs for low-income seniors and persons with disabilities who are eligible for both Medicare and Medicaid. These individuals are referred to as dual eligibles and there are approximately 40,000 dual eligibles enrolled in Kansas Medicaid. Before Medicare Part D, the Kansas Medicaid program paid for prescription drugs for these beneficiaries.

The federal government created regions across the country and contracted with private insurers to provide prescription-drug coverage to Medicare beneficiaries, either through a drug-only plan or a comprehensive health plan (i.e., prescription drugs and regular medical care).

On January 1, 2006, Kansas blocked dual eligibles from receiving Medicaid coverage for any prescription drugs covered by Medicare Part D. They had to choose a Part D plan or lose prescription drug coverage. There have been concerns about which drugs Part D plans will cover and whether dual eligibles will be able to receive the specific drugs they need. This population is often sicker and in need of more medications than the rest of either the Medicare or Medicaid populations. Part D plans are required to cover at least two drugs in every therapeutic class and must provide all or substantially all drugs in specific classes, but the plans have flexibility in the determination of drug classes and they can establish closed formularies.

The Center for Medicare and Medicaid Services (CMS) reviewed the formularies developed by the Part D plans and contracted with the U.S. Pharmacopoeia Convention to develop model guidelines for classifying drugs and drug categories. However, dual eligibles with HIV/AIDS, epilepsy, or mental illness may be vulnerable if Part D plans cover only a limited number of newer, more effective drugs. States have the option to cover specific drugs that are not covered by Part D plans, but no federal match will be available.

CMS automatically enrolled dual eligibles in Part D plans in November. Dual eligibles were randomly assigned to Part D plans that met benchmark benefit and cost levels. These auto-

assignments were shared with the states in November through an electronic file exchange. Kansas Medicaid was able to validate that dual eligibles were enrolled in a plan; however we were not able to check that the auto-assigned plan was the best fit for each beneficiary. Dual eligbles were allowed to change plans before December 31, 2005 and can change plans each month. Other Medicare beneficiaries have until May 15, 2006 to enroll in a Part D plan to avoid a financial penalty in their cost sharing. Companies began marketing their Part D plans on October 1 of last year.

Other low-income people (with incomes up to 150.0 percent of the Federal Poverty Level (FPL)) are potentially eligible for assistance with premiums and co-payments. Others, who have higher income and asset levels, and who have greater than $2,250, but less than $5,100, in total annual drug costs will have a gap in coverage. This gap is commonly referred to as the "doughnut hole." CMS has issued guidance to states on how to treat the costs Medicare beneficiaries will have in this doughnut hole. Some people may become eligible for Medicaid through the medically needy population category, which allows people to spend down their resources on medical services to achieve income eligibility. We do not anticipate significant increases in the medically needy population, if CMS does allow this out-of-pocket spending for drug costs in the doughnut hole. More likely, we will see a reduction in the number of medically needy who use their monthly drug costs to achieve their spenddown and be eligible for Medicaid.

Preparing for the Transition to Part D

State agencies have been working for almost two years to prepare for the implementation of Medicare Part D. I led an interagency workgroup, made up of senior program directors within the Department of Social and Rehabilitation Services (SRS), the Department on Aging, the Kansas Department of Health and Environment, the Kansas Insurance Department, and the Division of Health Policy and Finance. The groups charge was to coordinate the activities of state agencies to identify all populations affected by Part D, to make consistent policy decisions across agencies, and to identify resources in each agency that could be used for outreach activities. The group also was used to share information coming from CMS and the Social Security Administration.

An early decision of this group was to divide responsibilities for the populations affected by Part D. The Department on Aging was primarily responsible for conducting general outreach to Medicare eligible beneficiaries and specific insurance counselling through the Senior Health Insurance Counselling Program of Kansas (SHICK). DHPF and SRS were responsible for notification and outreach for Medicare and Medicaid dual eligibles and preparing to receive applications for the Low Income Subsidy. The Department of Health and Environment and the Insurance Department had a role in providing information to individuals and community organizations through existing publications, call centers, and networks. Other specific workteams were established for issues such as training and publications, which involved staff from each agency.

Within DHPF and SRS, transitioning the duals involved mailing notices to beneficiaries to raise awareness of Part D and the impact on Medicaid benefits. CMS provided a schedule of mailings for the dual eligibles and all Medicare beneficiaries soon after the final regulations were

complete last January. DHPF planned additional notices that would match and hopefully explain what was in the CMS letters to reduce confusion among Medicaid beneficiaries. The hope was to raise awareness of the change in benefit without creating panic. These notices were sent to beneficiaries and their responsible parties if a family member or guardian helped make decisions.

At the same time, SRS developed training for regional office staff on Medicare Part D. The first round of training provided an overview of Medicare and how the new benefit was structured to interact with Medicaid. Since most of the policy details had not been developed when this training was developed, it was used to raise awareness of the coming changes. A second round of training occurred during November and December after the detailed transition policy was developed and changes in the eligibility system were completed. Current training efforts are focusing on working with eligibility staff to help beneficiaries use the Part D plan finder tool to evaluate the costs and formulary offerings of different plans.

Transition Issues for Dual Eligibles

Auto enrollment created the first issue for Medicaid. The initial auto enrollment process occurred in October 2005 for all full benefit dual eligibles beneficiaries enrolled from April 1, 2005 through October 15, 2005. A monthly auto enrollment process will occur thereafter to ensure prescription drug coverage is available for new Medicaid beneficiaries. All individuals identified as a full dual eligible since May 2005 were automatically enrolled into a Medicare prescription drug plan. In Kansas, about 38,000 people were auto enrolled. This includes individuals who received Medicaid during this time period, but are no longer eligible. CMS specifically designed the process to include a broad group of individuals, and some ineligible individuals were included in the auto enrollment process. All dual eligibles were deemed eligible for the Low Income Subsidy and that eligibility lasts until December 2006.

CMS auto enrolled individuals by their current Medicare address. This could be different than the address reflected in the Medicaid file. If both files indicated a Kansas address, there was little impact on the process of auto enrollment. However, persons who lived in another state, or who recently moved to Kansas from another state, may be auto enrolled into an out of state plan. This occurred in approximately 250 cases, and another 1,000 beneficiaries were enrolled in a plan that operates in Kansas but with that plan in another state. CMS provided lists of the auto enrollment results that were shared with SRS caseworkers, Home and Community Based Service waiver case managers, and state institution reimbursement officers. This information was provided to help case workers and case managers assist beneficiaries that had questions about auto enrollment or assist in clarifying the impact of Part D on their Medicaid benefit.

DHPF and SRS issued specific guidance to eligibility staff to ensure that questions about the impact of Part D on Medicaid beneficiaries would be answered without referring the question to SHICK or another agency. Eligibility determination staff were not supposed to provide direct assistance on choosing among Part D plans. Instead, questions about plan choice and coverage decisions were referred to Medicare, Community Mental Health Center and Community Developmental Disability Organization case managers, the individual's pharmacist or medical provider, Working Health Benefit Specialists, or specific staff designated by each Regional Office.

DHPF and SRS are continuing to work with beneficiaries to trouble shoot issues with enrollment. We are receiving calls from community partners and CMS to work on specific eligibility cases and resolve them through CMS and the Part D plans.

Emergency Actions after January 1, 2006

As the Part D benefit started, we received many calls from pharmacists about difficulties in identifying dual eligibles in Medicare system. CMS created a central electronic point of sale system that contained all Part D enrollees, their plan assignment, and benefit coverage for each plan. This system was not responsive or correct for much of the first week of Part D. There were a variety of issues including not being able to find beneficiaries in the system, confusion over which Part D plan dual eligibles were enrolled in, and incorrect cost sharing amounts. To make matters worse, pharmacists were unable to contact the Part D plans through customer service lines and the emergency mechanisms CMS had put in place to ensure that beneficiaries would not leave the pharmacy without needed medications was unable to handle the volume of requests.

Governor Sebelius directed DHPF to take emergency action to ensure that dual eligible beneficiaries would not leave a pharmacy without medically necessary prescription drugs. On January 13, we turned off the block in the Medicaid Management Information System that prevented pharmacy payments for Medicare eligible beneficiaries. We provided direction to pharmacies that Medicaid could be billed for prescription drugs for Medicaid eligible beneficiaries if the Part D eligibility information in the point of sale system was incorrect or unavailable, if the cost sharing amounts that were indicated were incorrect, or if the temporary mechanism for payment created by CMS failed. The Medicaid payment was not intended to supplement a Medicare payment. As of January 30, 37,470 prescriptions have been paid for by Kansas Medicaid for 11,732 individual beneficiaries. We have expended $2.66 million. Below is a detailed table of expenditures and prescriptions filled by date.

This temporary measure was only offered until February 1, 2006. We will be evaluating this decision next week to determine if it should be extended. We were also notified last week that CMS is working on a mechanism to provide full federal reimbursement for costs incurred by states providing transitional coverage for dual eligibles. There are 26 states that have taken similar actions to protect dual eligible beneficiaries.

Date	Unique Beneficiaries	Claims	Paid Amount
01/13/2006	662	1237	$82,901.76
01/14/2006	713	1600	$99,268.90
01/15/2006	199	437	$28,356.62
01/16/2006	1687	3551	$250,953.37
01/17/2006	1505	3243	$241,569.91
01/18/2006	1395	2847	$215,630.33
01/19/2006	1364	2622	$188,021.58
01/20/2006	1226	2457	$170,081.29
01/21/2006	534	1032	$74,582.17
01/22/2006	166	315	$25,634.32
01/23/2006	1571	3329	$239,692.64
01/24/2006	1281	2538	$191,491.64
01/25/2006	1231	2538	$167,132.82
01/26/2006	1184	2469	$183,507.88
01/27/2006	1262	2702	$188,763.26
01/28/2006	516	1024	$66,609.64
01/29/2006	239	546	$32,738.90
01/30/2006	1525	2983	$212,957.50
Total		**37470**	**$2,659,894.53**

Future Part D Activities

Governor Sebelius has asked DHPF to begin planning on a method to provide copayment assistance for dual eligibles. Under Part D, full benefit dual eligibles are charged a $1 or $3 co payment per prescription. For some dual eligibles, especially individuals on the Home and Community Based Service Waiver programs, Medicaid did not charge a copayment for prescriptions. We are developing a mechanism to pay these costs for dual eligibles that were not subject to copays before Part D and gathering information on the number of people that could be affected and the total costs.

Another impact that has not been assessed is the ability of beneficiaries to get the prescription drugs they need through the Part D plans. The plans are required to cover two drugs in each therapeutic class, but evaluating whether each plan covers the drugs that auto assigned beneficiaries' need has to be done on a case by case basis. The plans were required to provide a transitional supply of the medications each beneficiary was taking for the first 30 days of the Part D benefit. After that supply runs out, beneficiaries will have to determine if their plan covers that drug, if a therapeutic substitution to a formulary drug is appropriate, or if they need to work with their physician to change prescriptions. Each plan also has an exception process to appeal coverage decisions, but these have not been evaluated. Medicaid covered most, if not all, prescription drugs for dual eligibles prior to January 1. The next round of Part D impacts will surface for beneficiaries that were on established drug regimens that will not be sustained by the Part D plan formularies.

That concludes my testimony. I am happy to stand for questions.

Date	Unique Beneficiaries	Claims	Pd Amount	Unique Benes Across All Dates
01/13/2006	660	1234	82,825.01	
01/14/2006	705	1584	98,225.71	
01/15/2006	198	435	28,356.62	
01/16/2006	1677	3529	247,555.79	
01/17/2006	1499	3227	240,638.24	
01/18/2006	1387	2828	214,371.43	
01/19/2006	1356	2594	186,959.15	
01/20/2006	1221	2449	169,660.91	
01/21/2006	529	1026	73,378.50	
01/22/2006	159	302	24,517.16	
01/23/2006	1553	3288	237,564.72	
01/24/2006	1258	2500	188,461.65	
01/25/2006	1214	2507	165,536.12	
01/26/2006	1166	2418	178,749.84	
01/27/2006	1252	2673	187,638.05	
01/28/2006	508	1014	66,126.06	
01/29/2006	233	536	32,229.22	
01/30/2006	1469	2842	202,652.97	
01/31/2006	1250	2736	180,031.29	
02/01/2006	1178	2532	160,647.08	12580
Total		**42254**	**$2,966,125.52**	

HOUSE APPROPRIATIONS

DATE 2-02-2006

ATTACHMENT 3