

Contract No.: HHSM-500-2006-00006I  
MPR Reference No.: 6394-320

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**MATHEMATICA**  
Policy Research, Inc.

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**Easing the Part D  
Transition: An Evaluation  
of Federal and State Efforts  
to Ensure Dual Eligibles  
and Other Low-income  
Beneficiaries Maintain  
Prescription Drug  
Coverage**

*Final Report*

*September 15, 2008*

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## EXECUTIVE SUMMARY

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Leading up to the implementation of Medicare Part D in January 2006, the Centers for Medicare & Medicaid Services (CMS) anticipated problems transitioning drug coverage for dual eligible beneficiaries from Medicaid to Medicare. To forestall these problems, CMS expanded its Part D contract with WellPoint (Anthem), a national prescription drug plan (PDP) with a Part D plan premium at or below the low-income premium subsidy amount in all 34 PDP regions across the United States, to provide temporary drug coverage at the pharmacy counter for those full-benefit dual eligible beneficiaries who were eligible for but not yet enrolled in a Part D prescription drug plan. This contract, called the “Point-of-Sale Facilitated Enrollment” (POS FE) process, was later modified to cover not only full-benefit dual eligible beneficiaries, but also partial-benefit dual eligible beneficiaries (or Medicare Savings Program beneficiaries), supplemental security income (SSI) cash assistance recipients with no Medicaid (SSI-only), and beneficiaries who applied for, and were awarded the Part D low-income subsidy (LIS applicants).

CMS also exercised its waiver demonstration authority in early January 2006 in response to temporary action taken by states to provide emergency drug coverage for dual eligibles and other low-income beneficiaries no longer receiving coverage through state Medicaid programs. In light of the problems experienced with the implementation of Part D, CMS officials judged such state responses appropriate for reimbursement for legitimate drug and administrative costs between January 1, 2006, and March 31, 2006. In order to be fully compensated for such costs, states had to follow the guidelines and requirements provided in the state-to-plan (S2P) demonstration. In addition to costs incurred by state Medicaid agencies, the S2P demonstration also reimbursed applicable costs incurred by participating State Pharmaceutical Assistance Programs (SPAPs).

Since the POS FE process and the S2P demonstration have assisted millions of Medicare beneficiaries in obtaining drug coverage through Part D, CMS wanted to examine the specific effects of each program on targeted beneficiaries. CMS contracted with Mathematica Policy Research, Inc. (MPR) to (1) evaluate the relative administrative efficiency of the POS FE process and S2P demonstration through the use of qualitative interviews—including interviews with key CMS personnel, pharmacists and pharmacy representatives, state officials affiliated with Medicaid and SPAP programs, and contractors either currently or previously involved in the POS FE or S2P processes—as well as

quantitative analyses of prescription drug claims data provided by CMS and its contractors; (2) learn more about the characteristics of those individuals who, by virtue of their use of either POS FE or S2P were in the process of transitioning from Medicaid to Medicare drug coverage, were never reported by states as Medicaid eligible, or were missed by routine administrative processes intended to enroll dual eligibles and other low-income beneficiaries into a PDP; and (3) research prospects for alternative strategies for ensuring prescription drug coverage for dual eligibles as they transition from state Medicaid programs to Part D.

### **THE POINT-OF-SALE FACILITATED ENROLLMENT PROCESS**

Interviews with key informants and secondary data analyses revealed two striking trends about the POS FE process: (1) over time, administration of the program became more efficient and, correspondingly, (2) utilization of POS FE decreased among eligible beneficiaries. In early 2006, WellPoint paid millions of claims for prescriptions that were later found ineligible for the POS FE process (due, for example, to an invalid Health Insurance Claim Number [HICN] being submitted on the claim or the beneficiary's ineligibility for Medicaid). As a result, WellPoint had to reverse its payments back to the pharmacies; the pharmacies were forced to repay WellPoint for the ineligible claims and seek reimbursement for the claim from the responsible party (usually either an individual beneficiary or PDP). Gains in administrative efficiency came about as a result of "front-end edits," or filters (such as verifying beneficiary eligibility on a real-time basis), put into place to decrease the likelihood of inappropriate claims submissions under the POS FE process. As processes for refining these edits were added under CMS supervision, a decreasing trend of claims reversals emerged. At the same time, beneficiaries relied less heavily on the POS FE process for drug coverage and corresponding enrollment in a PDP as most were auto-enrolled into a Part D plan by CMS on a monthly basis.

Not every problem associated with the POS FE process was due to the lack of sufficient edits. One particular group of pharmacies—those serving long-term care populations—experienced an inordinate number of reversals due to an edit put in place to reject POS FE claims with greater than 30 days between the date a pharmacy filled a prescription and the date it submitted a claim for that prescription to WellPoint for payment. Furthermore, pharmacists (including those serving long-term care populations as well as those operating in the retail chain and independent pharmacy market) cited poor communications regarding the POS FE process between CMS, WellPoint, and pharmacy staff responsible for submitting claims. Ongoing problems with the POS FE process also included submission of duplicate claims. CMS officials acknowledged all of these issues and indicated that they have, and will continue to, address and resolve them. Although pharmacists and pharmacy representatives provided a number of recommendations for improving the POS FE process, they reported that the process as it currently operates is effective.

Analyses of claims data provided by WellPoint do not suggest that beneficiaries using the POS FE process were significantly different from the general population of dual eligible beneficiaries. However, many of the claims lacked a valid HICN and could not be matched to the Medicare Enrollment Database (EDB) for analysis of beneficiary characteristics.

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## **THE STATE-TO-PLAN DEMONSTRATION**

Unlike the POS FE process, which was intended as a long-term backup to provide temporary drug coverage for those not already enrolled and to facilitate enrollment in a PDP, the S2P demonstration was intended only as a temporary arrangement to reimburse states for costs they incurred to ensure drug coverage for dual eligible and other LIS-eligible beneficiaries. One of the preconditions for participating in the demonstration was an assurance from states that they would encourage pharmacists to use the POS FE process prior to billing the state for problematic claims. Although several interview respondents associated with state Medicaid programs thought that pharmacists welcomed the S2P demonstration as an alternative to POS FE, other respondents affiliated with the pharmacy industry indicated that the S2P process was confusing. For example, they said that CMS and states provided mixed messages regarding when to use POS FE versus the S2P process.

A major problem with the S2P process was that states were required to submit claims files using unfamiliar formats. States incurred considerable costs to adapt their electronic systems to the requirements of the S2P demonstration. In some cases, states chose not to participate in the demonstration despite having provided temporary drug coverage to eligible beneficiaries because they believed the costs required to conform to the S2P requirements were more excessive than the costs they incurred to provide coverage.

Another problem was that the demonstration required that reimbursements to the states exclude Medicare cost-sharing amounts. This led to a two-stage process of claims submission whereby the states received 95 percent of their payments upon validation of paid claims and the remaining 5 percent of payments after reconciliation with PDPs to exclude Medicare co-payments. The need to reconcile payments with PDPs created delays in claims submission and processing, in turn leading to delays in final payments to the states. CMS officials agreed that any future reimbursement procedure similar to the S2P demonstration would benefit from a standardized payment method relying on estimated cost-sharing amounts rather than processing claims through PDPs to calculate exact costs owed to states.

## **ALTERNATIVES FOR ENSURING DRUG COVERAGE**

As part of the evaluation, MPR spoke with state Medicaid officials regarding two possible alternative approaches to eliminating gaps in coverage for dual eligible beneficiaries. However, MPR did not review existing laws or regulations to determine if these two models would be feasible, absent a legislative or regulatory change. The first, referred to as the “state coverage model,” would require state Medicaid agencies to provide drug coverage to beneficiaries as soon as they become full-benefit dual eligibles up to the point in time when CMS can confirm their enrollment in a PDP. States would receive direct reimbursement from CMS in the form of federal financial participation (FFP) for the costs they incur during the transition period between eligibility and enrollment confirmation. Under the alternative “handshake” approach, CMS would set a limit for the period of time (for example, a two- to three-month period) during which states could receive FFP for claims. Payments would cover drug costs and reimbursement for administrative costs incurred by the Medicaid program to enroll the beneficiary in the PDP that best meets his or her needs before the

transition period ends. At the end of the transition period, the state would no longer be eligible to receive the FFP, even if the beneficiary had not yet been enrolled in a PDP.

The state coverage model received an overwhelmingly more favorable response from the states. In some cases, states have already implemented similar procedures to ensure continuous drug coverage for eligible beneficiaries, although without the financial support of the FFP. However, several respondents expressed potential concerns about issues related to embarking on such a federal-state partnership, including the need for greater administrative capacity within the states to implement this type of system; assurance of federal funding; and the need for feasible, universal guidelines. Nevertheless, most officials acknowledged the utility of having such an option for a more seamless transition of dual eligibles and expressed an openness to pursuing mutually beneficial federal-state arrangements for doing so.

## CONCLUSIONS

In summary, this report presents MPR's findings regarding (1) the administrative efficiency of the POS FE process and S2P demonstration, (2) the characteristics of beneficiaries involved in these two programs, and (3) alternative approaches for ensuring continuity of drug coverage for dual eligible and other LIS-eligible beneficiaries. First, the study documented gains in administrative efficiency within the POS FE process due, in part, to edits put in place by CMS and WellPoint over the two-year period since January 2006 that led to significant reductions in the number of inappropriate claims submissions that otherwise resulted in payment reversals. In addition, although the S2P demonstration laid the groundwork for future efforts that States and CMS may undertake to facilitate access to Part D benefits for dual eligible beneficiaries, analyses of the S2P demonstration highlighted pitfalls to avoid and options to pursue now that the number of beneficiaries needing help is substantially smaller, and there is more time to test and implement new options. The report identifies a number of approaches CMS could take to facilitate collaboration with the states on similar future endeavors. Second, based on analyses of claims from the POS FE process and S2P demonstration, beneficiaries using these programs did not appear to differ significantly from the general population of dual eligible beneficiaries. Finally, all parties interviewed recognized the need to improve coverage for low-income Medicare beneficiaries by eliminating gaps in coverage that occur as a result of data sharing among the states, CMS, and PDPs. Although state officials supported a hypothetical approach whereby states and CMS share financial responsibility for beneficiaries transitioning between Medicaid and Medicare until such time that CMS can confirm their enrollment in a PDP, such a proposal would have to address the legal feasibility of implementing such an approach since CMS could not implement it under current statutory authority.

# CHAPTER I

## INTRODUCTION

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In the months leading up to the implementation of the Medicare Part D program (January 1, 2006), officials at the Centers for Medicare & Medicaid Services (CMS) and state Medicaid directors were concerned about the possibility that administrative problems associated with transitioning beneficiaries dually eligible for Medicare and Medicaid (“dual eligibles”) into the Part D program would lead to gaps in their prescription drug coverage. A major challenge for CMS was the need to coordinate with 51 separate Medicaid programs to identify dual eligibles who would need to be transitioned into Medicare.<sup>1</sup> To manage this task, CMS reassigned staff with significant Medicaid experience to assist with program implementation and worked with states in advance to enroll as many eligible beneficiaries as possible into Part D prior to the implementation date. CMS also worked with the states to develop a number of additional measures to ensure continuity of drug coverage for dual eligibles and other beneficiaries eligible for low-income subsidies (LIS),<sup>2</sup> including the point-of-sale facilitated enrollment (POS FE) process and the state-to-plan (S2P) payment demonstration, described in greater detail later in this report.

The administrative process for enrolling low-income beneficiaries in stand-alone Part D plans (PDPs) differs considerably depending on the degree of personal responsibility the beneficiary bears for applying for the LIS and enrolling in a Part D plan. For example, full-benefit dual eligible beneficiaries are automatically deemed LIS eligible and enrolled in a Part D plan.<sup>3</sup> Medicare beneficiaries who attain full-benefit Medicaid eligibility after January 1, 2006, can qualify for retroactive coverage under Part D to their date of eligibility for Medicaid benefits, no earlier than January 1, 2006. In August 2006, CMS introduced a

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<sup>1</sup> Although CMS has historically had to coordinate coverage for dual eligible beneficiaries with the states and the District of Columbia under Medicare Parts A and B, Part D poses a new challenge in that eligibility determinations must take place in a real-time setting.

<sup>2</sup> Partial-benefit dual eligible beneficiaries are individuals who are enrolled in Medicare Savings Programs, including Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs), most of whom qualify for assistance only with Medicare cost sharing.

<sup>3</sup> Prior to the implementation of Part D, full-benefit dual eligibles were automatically enrolled in a PDP in the final quarter of 2005.

prospective Part D enrollment process for “imminent Medicare attainers,” defined as those Medicaid beneficiaries who would become newly eligible for Medicare within three months (either by aging into Medicare or by reaching the end of their 24-month disability waiting period).<sup>4</sup> For individuals who are full-benefit Medicaid first and then become Medicare eligible, the effective date of enrollment in Part D is the first day of their Part D eligibility.

Two other groups of beneficiaries (partial-benefit dual eligibles enrolled in a Medicare Savings Program and supplemental security income [SSI] only cash assistance recipients) are also “deemed eligible” for the LIS and are, therefore, eligible to use the POS FE process. Other low-income Medicare beneficiaries must apply for LIS benefits through either the Social Security Administration (SSA) or their state Medicaid agency, but they are also eligible to use the POS FE process. It is not possible to facilitate the enrollment of these beneficiaries until CMS is made aware of their existence by the state or SSA. Once CMS is informed of their low-income status, they are deemed eligible for the LIS by CMS and their enrollment into a Part D plan is facilitated by CMS with a prospective effective date. These beneficiaries may use POS FE prior to their prospective enrollment date.

## **THE POS FE PROCESS**

On December 1, 2005, CMS announced its partnership with WellPoint (Anthem) to provide drug coverage at the pharmacy counter (point-of-sale coverage) for dual eligible beneficiaries who require a prescription filled but lack evidence of Part D enrollment (that is, the POS FE process).<sup>5</sup> Although the program was originally intended to provide facilitated enrollment only to full-benefit dual eligibles, CMS expanded the process to accommodate other LIS-eligible Medicare beneficiaries. In 2006, WellPoint incurred costs for beneficiaries ultimately found to be ineligible for Part D or the LIS.<sup>6</sup> WellPoint was unwilling to assume the risk of paying claims and later having to reverse the claims to pharmacies for these ineligible beneficiaries after the first year of the contract. In 2007, CMS negotiated a new sole-source contract with WellPoint in which CMS underwrote the risk for individuals whose LIS eligibility was unknown at the point of sale and who were later found to be ineligible to substantially reduce the number of reversals to pharmacies.<sup>7,8</sup>

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<sup>4</sup> The Social Security Administration (SSA) sends out approximately 120,000 to 130,000 applications for the LIS every month to current Social Security Disability Insurance (SSDI) beneficiaries who turn 65 or reach the 25th month of their disability (Disman 2007).

<sup>5</sup> WellPoint was selected as the sole source contractor because it was the only Part D plan sponsor at the time that could accommodate auto-enrollment in every prescription drug plan (PDP) region. From WellPoint’s perspective, this auto-enrollment would increase its number of PDP enrollees and Medicare revenue.

<sup>6</sup> The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provided CMS with the authority to pay for drug claims only for *enrolled* beneficiaries, so CMS lacked the statutory authority to reimburse WellPoint for beneficiaries later determined to be ineligible for Part D but CMS allowed WellPoint to market to and enroll those who were later found to be ineligible for the LIS.

<sup>7</sup> In mid-2006, CMS modified the process to provide greater control over the claims-eligibility determination process and issued a competitive solicitation to three potential contractors under a competitive bidding process. However, none of the potential bidders submitted a proposal.

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## THE S2P DEMONSTRATION

Immediately following implementation of Part D, CMS and states began receiving reports that many dual eligibles appearing at pharmacies without Part D coverage were unable to utilize the POS FE process because the data systems in place could not identify them as eligible for Part D or the LIS. To supplement the POS FE process and to ensure that dual eligibles continued to obtain needed prescriptions, many states instructed their Medicaid and State Pharmaceutical Assistance Programs (SPAPs) to provide drug coverage through state funding.<sup>9</sup> On January 24, 2006 (under Section 402 demonstration authority), CMS introduced a plan to reimburse state Medicaid programs and SPAPs for the costs they incurred during the transition period for full-benefit dual eligible individuals and LIS-entitled beneficiaries.<sup>10</sup> Under the S2P approach, Medicaid and SPAP administrators were advised to encourage pharmacists to bill the appropriate Part D plan or use the POS FE process to cover drug costs for eligible beneficiaries before submitting claims to a state Medicaid agency or SPAP. The demonstration provided federal reimbursements to states for the provision of Part D-covered drugs as well as associated administrative costs. Although the S2P demonstration was initially scheduled to end on February 15, 2006, CMS eventually extended it through March 31, 2006.

## EVALUATING THE POS FE PROCESS AND S2P DEMONSTRATION

Since the POS FE process and S2P demonstration have assisted millions of Medicare beneficiaries in obtaining drug coverage through Part D, CMS wanted to examine the specific effects of each on targeted beneficiaries. CMS contracted with Mathematica Policy Research, Inc. to conduct an evaluation of the two programs and examine possible alternative means of ensuring drug coverage to low-income Medicare beneficiaries. The primary goals of the evaluation were to (1) examine the administrative efficiency of the POS FE process and S2P demonstration by identifying procedural changes that increased the accuracy of claims payments and reduced the number of steps necessary to identify eligible beneficiaries and ensure their enrollment in a PDP, (2) explore the characteristics of beneficiaries utilizing the two programs in order to identify subgroups of beneficiaries who may have been missed in the initial outreach efforts or who otherwise experienced problems

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*(continued)*

<sup>8</sup> Under the 2007 contract, CMS paid WellPoint a risk payment for the assumption of risk of unrecoverable claims but avoided making direct payments for non-recovered Part D claims for beneficiaries ultimately found to be ineligible. Although CMS continues to contract with WellPoint for the POS FE process in 2008, this report focuses on the process as it existed in 2006 and 2007.

<sup>9</sup> As of March 15, 2006, a total of 44 states had provided some type of transitional or emergency payments (National Conference on State Legislatures 2006). All of these states provided coverage to full-benefit dual eligible beneficiaries, but a handful covered LIS-eligible State Pharmaceutical Assistance Program (SPAP) beneficiaries as well. The legal authority for providing coverage and the structure of the programs differed from state to state.

<sup>10</sup> An LIS-entitled beneficiary is an individual who is eligible to receive the LIS and was enrolled into a Part D prescription drug plan during the transition period.

in transitioning into Part D or enrolling in a PDP, and (3) examine the feasibility of alternative models for transitioning newly dual eligible beneficiaries into Part D. The evaluation relied on key informant interviews and secondary data analysis to address these research issues.

This report provides a summary of study findings and offers recommendations for implementing future demonstrations targeting Part D enrollment of dual eligible and other low-income Medicare beneficiaries. Chapter II provides a detailed overview of the research questions and methods used to address the primary study goals. Chapter III describes the POS FE process and discusses findings on the first two study goals in the context of the POS FE process; Chapter IV does the same with respect to the S2P demonstration. Chapter V examines the characteristics of beneficiaries who continue to be missed by the systems designed to identify and enroll eligible beneficiaries into a PDP and presents findings regarding two possible alternative methods for ensuring continuity of drug coverage. Finally, Chapter VI discusses the study findings in the broader policy context and discusses ways to enhance future collaborations among CMS, states, and the pharmacists serving the dual eligible population and other LIS-eligible beneficiaries.

## CHAPTER II

### STUDY METHODS

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Each of the three main study objectives was subdivided into a number of specific research questions to be addressed using a combination of qualitative and quantitative methods. Qualitative data were collected through key informant interviews, and quantitative methods involved an analysis of claims data from the Point-of-Sale Facilitated Enrollment (POS FE) process and the State-to-Plan (S2P) demonstration. Table II.1 provides a list of the study objectives and describes the research questions explored under each, along with the study methods and data sources used to address each research question.

#### KEY INFORMANT INTERVIEWS

Key informant interviews were conducted via telephone and ranged from 30 minutes to one and a half hours. A senior researcher usually led the interviews with a research analyst taking notes and asking follow-up questions. The interview protocols (included in the Appendix) were developed with input from the project officer and other staff at CMS.

Informants included CMS staff involved in the POS FE process and S2P demonstration as well as staff from six state Medicaid programs (California, Florida, Michigan, Missouri, South Carolina, and Texas).<sup>1</sup> To ensure a diversity of state experiences, we classified states into the three groups: states that (1) participated in the S2P demonstration and received drug and/or administrative payments from CMS, (2) applied for the S2P demonstration but did not submit a claim for payment, and (3) did not provide temporary coverage and did not apply for the S2P demonstration. From among these three groups, we attempted to interview contacts from the state with the largest total number of dual eligibles (that is, both partial- and full-benefit dual eligibles) in 2006, according to estimates from the Urban Institute.<sup>2,3</sup>

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<sup>1</sup> In Texas, both the Medicaid and SPAP programs participated in the S2P demonstration.

<sup>2</sup> We chose to select the states with the largest dual eligible populations on the assumption that these states would have experienced the greatest demand for assistance under Part D.

**Table II.1. Study Objectives, Research Questions, Methods, and Data Sources**

Objective	Research Questions	Methods	Data
Examination of administrative efficiency of the POS FE process and S2P demonstration	<ul style="list-style-type: none"> <li>• What are the administrative processes for providing transitional coverage to LIS-eligible beneficiaries?</li> <li>• How do these processes differ for full-benefit dual eligibles versus other groups of LIS-eligible beneficiaries?</li> <li>• How could the efficiency of the programs be improved?</li> </ul>	Development of a flowchart to describe the administrative processes for the POS FE process and S2P demonstration	WellPoint and state claims data; key informant interviews with staff at CMS, state Medicaid and SPAP programs, WellPoint, and other contractors
Description of characteristics of missed beneficiaries	<ul style="list-style-type: none"> <li>• What are the characteristics of beneficiaries who continue to present at the pharmacy without evidence of Part D enrollment?</li> <li>• To what extent do technical problems, administrative processes, and beneficiary errors or misunderstandings account for the continued failure to enroll these beneficiaries prior to the point of sale?</li> <li>• Is there a way to minimize or prevent the need for the POS FE process?</li> </ul>	<p>Descriptive statistics regarding the characteristics of beneficiaries who used the POS FE and S2P processes</p> <p>Qualitative analyses drawing on the administrative flowchart to identify factors responsible for the failure of beneficiaries to enroll in a Part D plan</p>	WellPoint claims, CMS enrollment data, key informant interviews with pharmacists
Determination of the feasibility of alternative methods for enrollment and reimbursement	<ul style="list-style-type: none"> <li>• What would be the costs involved in establishing an alternative enrollment system?</li> <li>• Would an alternative system be more cost efficient than the POS FE or S2P reimbursement models?</li> <li>• How soon would CMS realize cost savings if the agency chose to establish a direct payment mechanism?</li> <li>• Would states be willing to participate?</li> </ul>	Qualitative analyses to examine the costs involved in an alternative model	Key informant interviews with state Medicaid agency personnel and CMS staff

(continued)

<sup>3</sup> Urban Institute estimates are based on data from the Medicaid Statistical Information System (MSIS) prepared for the Kaiser Commission on Medicaid and the Uninsured. For more information, see “Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003”; available at <http://www.kff.org/medicaid/7346.cfm>.

In two cases, we did not receive a response from the state with the largest number of dual eligibles and contacted the state with the next largest number.

In addition to CMS, state Medicaid, and SPAP staff, we conducted interviews with representatives from the four contractors involved in the POS FE process and S2P demonstration (their specific roles in the POS FE process and the S2P demonstration are described in Chapters III and IV): (1) WellPoint, the enrollment contractor for the POS FE process; (2) RelayHealth, the Medicare eligibility verification contractor for the POS FE process;<sup>4</sup> (3) Z-Tech Corporation,<sup>5</sup> the Medicaid eligibility verification contractor for POS FE process; and (4) the Public Consulting Group (PCG), the reconciliation contractor for the S2P demonstration. Finally, we interviewed individual pharmacists and representatives from three pharmacy trade associations (representing chain drug stores, independent pharmacies, and long-term-care pharmacies) to understand better how the POS FE process and S2P demonstration operated at the point of sale. Table II.2 provides details regarding those persons participating in the key informant interviews.<sup>6</sup>

**Table II.2. Organizations Participating in Key Informant Interviews**

Organization	Role in the POS FE and S2P
CMS	Designed and administered both programs
States	
California	Participated in the S2P demonstration
Florida	Participated in the S2P demonstration
Michigan	Did not participate in the S2P demonstration
Missouri	Applied for the S2P demonstration but did not submit claims
South Carolina (Medicaid/SPAP)	Did not participate in the S2P demonstration
Texas (Medicaid/SPAP)	Participated in the S2P demonstration
CMS Contractors	
WellPoint	Primary contractor for the POS FE process
RelayHealth	Medicare eligibility verification contractor for the POS FE process
Z-Tech	Medicaid eligibility verification contractor for the POS FE process
PCG	Primary contractor for the S2P demonstration
Pharmacists/Trade Associations	
Long-term-care pharmacies	Served beneficiaries under the POS FE process and S2P demonstration
Chain drug stores	Served beneficiaries under the POS FE process and S2P demonstration
Independent pharmacies	Served beneficiaries under the POS FE process and S2P demonstration

<sup>4</sup> As discussed at greater length in Chapter III, RelayHealth was also eventually given the responsibility for implementing claim edits to prevent ineligible claims from reaching WellPoint for payment. Edits are electronic filters within the pharmacy claims-processing system that flag problems with the claims submission.

<sup>5</sup> Many of the staff at Z-Tech who were involved in POS FE had left the company and could not be located by the time interviews were undertaken.

<sup>6</sup> To protect the privacy of our informants, specific names and titles are not provided.

A detailed written summary was completed by the analyst within 24 hours of the telephone interview. The researcher and analyst compared notes and edited the summary to reflect shared understandings of the content of the call. When we could not come to agreement on the meaning of a particular passage or piece of information, we sought clarification from the original informant. Analyses focused on the three primary objectives of the study and utilized an iterative process of identifying themes, organizing information into topics and subtopics, and shaping the data into a comprehensive and consistent narrative (Seidel 1998).

## **ANALYSES OF SECONDARY DATA**

Secondary data were derived from three principal sources. First, WellPoint provided claims data from the POS FE process for 2006 and 2007. We created two separate analytic files from these claims. The first, a claims-level file, was used to analyze patterns of claims payments over the first two years of the POS FE process. The second, a beneficiary-level file, was used to identify the characteristics of beneficiaries using the POS FE process. Second, CMS staff working on the S2P demonstration provided claims data submitted by states and processed by PCG for the S2P demonstration. These data were also converted into claims- and beneficiary-level analytic files. Finally, based on the claims data we received, we generated a list of unique Health Insurance Claim Numbers (HICNs) and matched them with those reported on the Medicare Enrollment Database (EDB) to understand the demographic characteristics of beneficiaries participating in the POS FE process and S2P demonstration.

### **Limitations of Secondary Data Analyses**

The data provided by WellPoint for the POS FE process include all paid and reversed claims from 2006 and 2007.<sup>7</sup> The data do not include the individual claims that WellPoint rejected as ineligible for payment (that is, rejected claims) or the reasons for those rejections. The analyses, therefore, cannot capture the characteristics of all beneficiaries who attempted to use the POS FE process; some of the beneficiaries represented by the rejected claims may have had a legitimate basis for using the POS FE but were unable to do so because, for example, CMS eligibility databases incorrectly identified them as ineligible for Part D. Without details on the number of rejected claims and the reasons for rejection, it is impossible to quantify the extent of these problems. However, WellPoint provided aggregate counts of the number of rejected claims (for 2006 and 2007) and reasons for rejection (for 2007 only), which have been included in our analyses.<sup>8</sup>

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<sup>7</sup> A *reversed claim* is a claim that was originally paid but later determined to be ineligible for payment. These claims were typically “reversed” (that is, sent back) to the pharmacy for payment. The pharmacies were responsible for repaying WellPoint for the costs of the claims and then rebilling the appropriate payee (usually either a PDP or an individual beneficiary).

<sup>8</sup> Complete data on rejected claims were unavailable for 2006 because WellPoint’s subcontracted claims switch operator was not actively keeping a record of all rejected claims.

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Data from the S2P demonstration include only information for the 30 states that (1) participated in the demonstration and (2) submitted drug claims for beneficiaries. The data do not, therefore, include information for states, such as Florida, that participated in the demonstration but received payments only for administrative costs. Among the states interviewed for the evaluation, only California and Texas were included in the S2P data file.



## CHAPTER III

### THE POINT-OF-SALE FACILITATED ENROLLMENT PROCESS

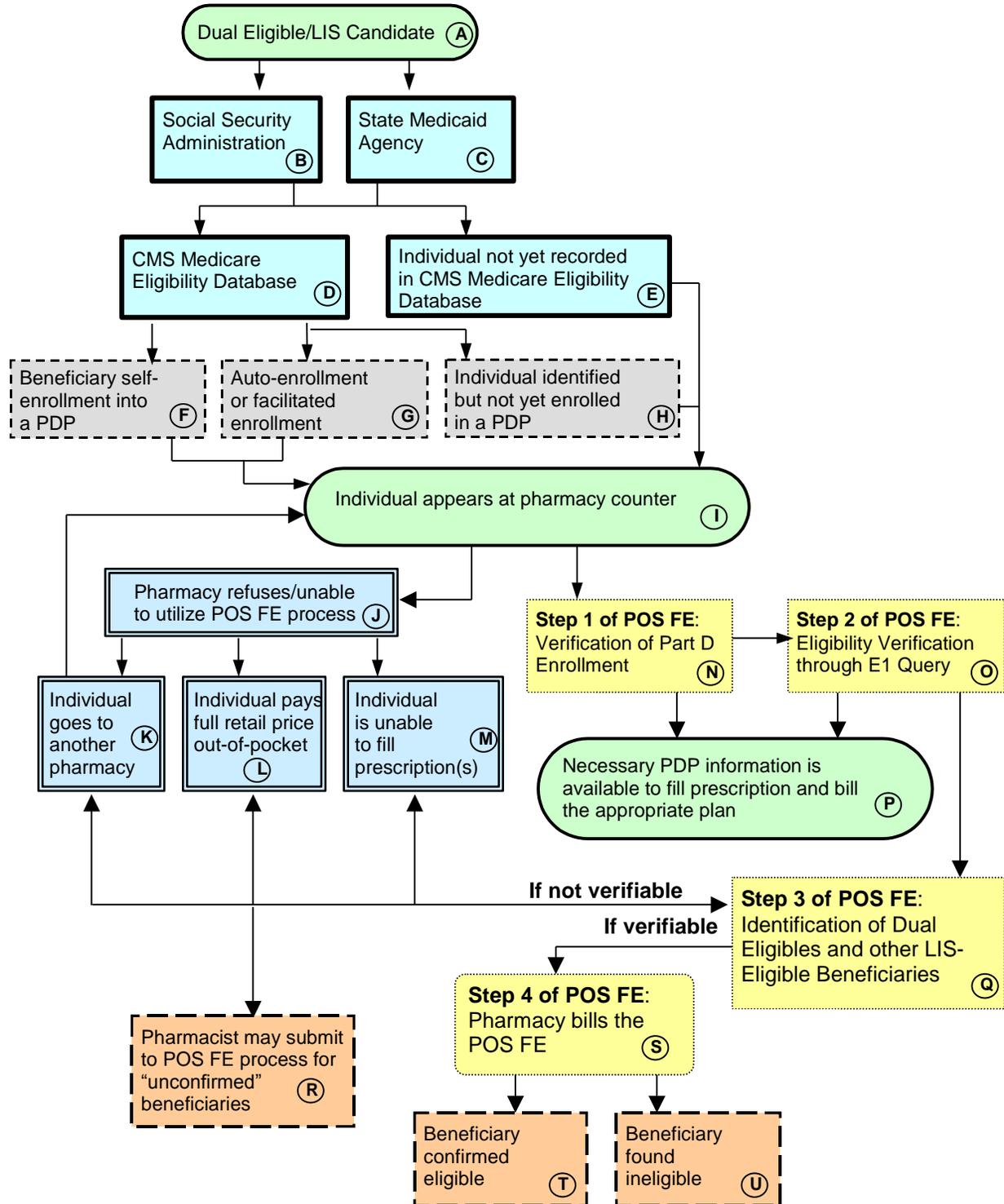
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On December 1, 2005, the Centers for Medicare & Medicaid Services (CMS) announced its partnership with WellPoint (Anthem) to provide point-of-sale drug coverage for dual eligible and other LIS beneficiaries who were not enrolled in a prescription drug plan (PDP). Existing statutory authority limits CMS's ability to provide this type of coverage through an entity other than a Part D plan provider because the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) offers no mechanism for paying other types of organizations (such as a claims processor or a pharmacy benefits manager). As a consequence, in establishing the POS FE process, CMS had to contract with a national Part D Plan that had a premium at or below the LIS threshold in all 34 PDP regions across the United States; WellPoint was the only organization meeting such requirements in 2006.

#### OVERVIEW OF HOW THE POS FE WORKS

Figure III.1 provides an overview of the role the POS FE plays in ensuring continuity of drug coverage for dual eligibles and other LIS-eligible beneficiaries. State Medicaid programs generally deal with eligibility determinations for dual eligible beneficiaries while the Social Security Administration (SSA) determines eligibility for other LIS-eligible beneficiaries (boxes B and C). Once a determination of LIS eligibility is made, the beneficiary's information is sent to CMS for processing. By the time the beneficiary arrives at the pharmacy counter (box I), one of four situations may occur. (1) The beneficiary may arrive at the pharmacy counter before CMS has had time to record his or her eligibility in the Medicare eligibility database (box E). (2) Alternatively, the beneficiary's eligibility for Medicare may appear in the eligibility database, but his or her enrollment into a PDP may not have been confirmed before the beneficiary's pharmacy visit. In Figure III.1, boxes F and G indicate confirmation of Medicare eligibility and enrollment in a PDP, while box H describes a situation in which Medicare eligibility has been confirmed but PDP enrollment has not. (3) The third situation occurs when the beneficiary arrives at the pharmacy and the pharmacist either refuses or is unable to use the POS FE process (described in the path from box J to boxes K, L, and M). (4) Alternatively, the pharmacist may begin the POS FE

**Figure III.1. Point-of-Sale Facilitated Enrollment Process for Dual Eligibles and Other LIS-eligible**



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process. As defined by CMS, the POS FE process entails up to four steps that the pharmacist must take to confirm Medicare and LIS eligibility and PDP enrollment.<sup>1</sup> The necessity of continuing the process through all four steps depends largely on the information that the beneficiary provides at the point of sale. The four steps are described next.

### **Step 1: Verification of Part D Enrollment**

As the first step in the process, the pharmacist asks the beneficiary to provide evidence of his or her enrollment in a PDP (box N). The two forms of evidence available are either a PDP identification card issued by the beneficiary's plan or a plan enrollment acknowledgment letter that has the four data elements (4Rx data) necessary to bill a claim to a PDP.<sup>2</sup> If the beneficiary can provide evidence of plan enrollment via one of these sources, the pharmacy can bill the correct PDP (box P) and the four-step process is terminated. If the beneficiary cannot provide this information, the pharmacist proceeds to the next step in the process (box O).

### **Step 2: Eligibility Verification Through the E1 Query**

If the beneficiary cannot provide evidence of PDP enrollment, the pharmacist initiates an eligibility verification transaction through a process known as the E1 query. The E1 query is an electronic system that provides the 4Rx data for Part D enrollment. Nearly all pharmacies have access to the E1 query system. If the pharmacist can verify plan enrollment, the pharmacist bills the correct PDP (box P), and the process is terminated; otherwise, the pharmacist moves on to the third step (box Q).

### **Step 3: Identification of Dual Eligibles and Other LIS-Eligible Beneficiaries**

In the absence of the 4Rx data, the pharmacist can request other documents from the beneficiary (as specified by CMS) to verify the patient's eligibility for Medicare and Medicaid or the LIS. Proof of Medicaid eligibility includes a Medicaid ID card, recent history of Medicaid billing in the pharmacy's patient profile, or a copy of a current Medicaid award letter.<sup>3</sup> Evidence of Medicare eligibility can be determined from a Medicare card or

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<sup>1</sup> The most recent version of the CMS documentation describing this process for pharmacists can be accessed at: <http://hiicap.state.ny.us/counselors/documents/Update08162008POSFourStepsFINAL.pdf>.

<sup>2</sup> The 4Rx data elements include the bank identification number (BIN), the processor control number (PCN), the group identification number for the patient's specific plan (GROUP), and the member identification number. The BIN is an identifier assigned by the American National Standards Institute to each pharmacy claims processor. The PCN is used to route an electronic claim within the pharmacy processor to the appropriate area for adjudication. The 4Rx data are the minimal data necessary to identify a unique plan enrollee and are generally included in the payer sheets that payers send to the pharmacies to provide instructions on billing the payer.

<sup>3</sup> As noted in Chapter 1, although the POS FE process was originally intended to assist only dual eligibles, CMS and WellPoint expanded the process to accommodate other LIS-eligible Medicare beneficiaries. As a result, there are cases in which proof of Medicaid eligibility is not a prerequisite.

Medicare Summary Notice (the Medicare monthly benefits statement), through an enhanced E1 query (to determine eligibility for Medicare Parts A and B), or by a call to a dedicated Medicare pharmacy eligibility line. If the pharmacist cannot verify dual eligibility or eligibility for the LIS, the four-step process stops, and the patient is determined ineligible for the POS FE process. At this point, the beneficiary may either pay out of pocket for the drug (box L), leave without having the prescription filled (boxes K and M), or the pharmacy may still submit a claim to POS FE if they believe the beneficiary is indeed eligible (box R). The individual is considered an “unconfirmed beneficiary” and his or her record is sent to the Medicaid Eligibility Verification contractor (Z-Tech) for research. Evidence of eligibility for Medicare and Medicaid prompts the fourth step in the process (box S).

#### **Step 4: Billing of the POS FE Process by Pharmacist**

Once the pharmacist has verified eligibility for Medicare and Medicaid or the LIS, the pharmacy can bill WellPoint in accordance with instructions on a special payer sheet (a technical document on how to bill claims) for the POS FE. The pharmacist must submit both the Medicare identification number (the Health Insurance Claim Number, or HICN) and the Medicaid ID number (except for beneficiaries eligible for the LIS who are not Medicaid beneficiaries) to WellPoint. Enrollment in a PDP is retroactive to the first day of the month in which the beneficiary first used the POS FE process. The POS FE provides the beneficiary with a temporary prescription fill until he or she can be enrolled into a PDP (box T). As of March 2006, the fill could be for up to 30 days and as of January 2007, the fill could be for up to 31 days. If the beneficiary is later found to be ineligible for the POS FE process, WellPoint is responsible for recovering the claims cost (box U).

When eligibility for Part D was confirmed by CMS but eligibility for Medicaid or the LIS could not be confirmed, the eligibility contractor (Z-Tech in 2006 and 2007) may be able to verify dual eligibility status using state eligibility verification systems (EVSs) and return data on its findings to WellPoint.<sup>4</sup> In interviews with staff from Z-Tech and CMS, respondents indicated that Z-Tech did not have connectivity with all EVSs as of January 1, 2006, and the verification process occasionally had to be performed through manual inspection of state records. For these reasons, the process of Medicaid confirmation in early 2006 took several weeks in some cases. However, once connectivity with all EVS was complete in early 2006, 95 percent of all records were returned to WellPoint within three days or less. Z-Tech began using the Medicare Beneficiary Database (MBD) as a backup system in early 2007 to research discrepancies in data and to research LIS eligibility for those beneficiaries who were reported to CMS by SSA as states did not house data on SSI-only beneficiaries and LIS applicants.

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<sup>4</sup> The Medicaid EVS is an electronic system that provides real-time access to information on Medicaid eligibility for a state.

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## EVOLUTION OF THE POS FE PROCESS

### Experiences with the POS FE Process in Early 2006

The POS FE process was implemented in 2006 but underwent changes in response to a variety of problems that arose early on in the process of Part D implementation. In the first few months after Part D implementation, problems with the Part D program in general included E1 data indicating enrollment in a plan that was different from the one the beneficiary originally chose to enroll in (often due to a lag in data administration) and beneficiaries being charged inappropriate co-payments; in many of these cases, the attendant (a pharmacist, pharmacy technician, or pharmacy student) inappropriately resolved the problem by submitting the claim to POS FE. In interviews, pharmacists affiliated with chain drug stores acknowledged that many of the claims that were submitted to the POS FE process fell outside the scope of its intended use.

Another problem was that many claims were submitted with invalid HICNs or other data inaccuracies. Interview respondents affiliated with long-term care pharmacies indicated that the E1 query did not work for them until mid-December 2005, which meant that they could not fully implement the E1 query by the end of the month (in time for the switch to Part D). In some cases, pharmacists reportedly believed that a particular patient was dual eligible, based on prior claims history, but the E1 query would not return any information on dual eligible status (until January, 2007 when the enhanced E1 query was introduced).<sup>5</sup> In such cases, the patient may have lost dual eligibility status or inaccurate data may have been returned via the E1 query. Until September 2006, many claims could not be matched against the MBD in real time.

Because many of these problems were not discovered until days after the original claim submission, WellPoint initially paid most submitted POS FE claims. Ultimately, however, WellPoint reversed a large percentage of paid claims back to the pharmacy for the pharmacy to re-bill the patient or appropriate Part D plan. According to WellPoint staff, approximately 10 percent of the claims it paid in the early months of Part D were for eligible beneficiaries; of the remaining 90 percent of ineligible claims, 50 percent were due to an individual's already being enrolled in a PDP, while the other 50 percent resulted from data problems such as invalid HICNs. However, according to CMS officials, by mid-2006, approximately 20 to 30 percent of paid claims were for eligible beneficiaries, and by the end of 2006, this number increased to 40 to 50 percent of all paid claims. By April 2006, approximately 60 percent of ineligible claims were for enrollment in another Part D plan, and approximately 40 percent were for invalid HICN.

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<sup>5</sup> It is relatively easy for long-term care pharmacies to identify a patient as Medicaid eligible since the pharmacy has evidence that the Medicaid program has paid for the person's nursing home stay. However, it is more difficult for long-term care pharmacists to verify Medicare eligibility because they have historically not had to request proof of Medicare eligibility to fill prescription claims.

## Introduction of Front-End Edits

Because of the problems encountered in early 2006, WellPoint and CMS officials determined that front-end edits were necessary to ensure more accurate information and more timely confirmation of claims. During the first eight months of 2006, WellPoint and CMS conducted their own eligibility checks when a claim came through the POS FE process. Starting in September 2006, WellPoint contracted with RelayHealth to run real-time eligibility checks before a prescription could be filled.<sup>6</sup> The E1 query was only one portion of the POS FE eligibility check; it primarily provided a check for Medicare entitlement and Part D coverage.<sup>7</sup> The new edits went beyond this functionality and led to four major changes. Table III.1 provides a summary of the major edits implemented over the course of the first two years of the POS FE to reduce the number of improper claims. The following discussion focuses only on those edits seen by WellPoint as most instrumental in improving the efficiency of the POS FE process.

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**Table III.1. Edits Introduced into the POS FE Process in 2006 and 2007**

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- Exclude claims not processed through RelayHealth
  - Exclude claims with missing or invalid Medicare IDs
  - Identify beneficiaries with enrollment in another PDP in order to bill the appropriate plan
  - Identify and reject claims whose date of service has passed the 30-day submission limit
  - Reject those who are not Medicare eligible
  - Reject claims with incomplete required fields
  - Reject for HICN found in the eligibility database but no longer effective
  - Reject for HICN found in the eligibility database but beneficiary is now deceased
  - Reject because beneficiary voluntarily opted out of Part D
  - Reject due to beneficiary's membership in an employer subsidy program
  - Reject because beneficiary resides outside the 50 states and the District of Columbia
  - Reject because beneficiary is enrolled in a Medicare Advantage-only plan
- 

Source: Interviews with staff at CMS, WellPoint, and RelayHealth.

**Check for Valid HICNs and Other Evidence of Part D Enrollment.** The first major edits were introduced in September 2006. In that month, RelayHealth implemented front-end edits to check for valid HICNs and other evidence of Part D enrollment. This

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<sup>6</sup> RelayHealth is the largest switching company in the United States. Switching companies connect pharmacies to insurance providers for electronic pharmacy transactions. RelayHealth was chosen by CMS as the TrOOP Facilitation contractor to provide eligibility query responses for pharmacies and facilitate transfer of information on secondary claims payments on behalf of Medicare beneficiaries. As the TrOOP Facilitator, RelayHealth routes transactions not only from pharmacies, but also from competitor switching companies. Although the company's contract as the TrOOP Facilitator is with CMS, the contract for claims eligibility edits under the POS FE process was with WellPoint.

<sup>7</sup> According to CMS, many pharmacy providers did not use the E1 query in 2006 or the enhanced E1 query which was introduced in January 2007. However, the pharmacy industry has been informed that CMS will no longer support the old version of the E1 query after April 2009, due to the limitations associated with it.

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mimicked the E1 query but took place up front to prevent the claim from passing to the next stage of processing. However, these edits were not a comprehensive fix because RelayHealth was only one of four major switching companies sending claims through the POS FE process but accounted for 70 percent of all claims switching. The edits, therefore, were applied only to those claims switched through RelayHealth.

**Rejection of Claims More Than 30 Days Old.** The second set of edits, implemented in January 2007, rejected claims with more than 30 days between the date of service (when a prescription was filled) and the date a claim was submitted to WellPoint. These edits also discontinued pharmacists' ability to electronically override claims rejections. According to the pharmacists we interviewed, before that time, they were encouraged by representatives in certain states' Medicaid programs to use the POS FE process for any problematic claims. In some cases, the pharmacist would override a claim rejection message and submit the claim to WellPoint for payment. In most circumstances, paid claims were eventually reversed, which created difficulties for WellPoint and pharmacies because of the expense and difficulty of collecting payment on such claims from the appropriate entity (usually either another PDP or the consumer). In discussions with informants regarding these edits, pharmacists and CMS staff reported they would prefer to see the claims window kept open for at least three to six months. However, WellPoint indicated, and RelayHealth confirmed, that a limited claims window is necessary because the TrOOP database contains only 90 days of eligibility and enrollment history.

**Prospective Eligibility Determination.** In May 2007, the POS FE process moved to a fully prospective eligibility determination system. Prior to this time, WellPoint's ability to screen otherwise ineligible candidates for the POS FE was primarily limited to a retrospective process (because it relied on presentation of reasonable evidence with more thorough checks later). Edits put in place in May 2007 allowed RelayHealth to process all beneficiary records against CMS's internal data systems. At the same time, the other three major switching companies began to route their claims through RelayHealth. With the new process in place, WellPoint was able to reject any claim that was otherwise not routed through RelayHealth's own switch. According to WellPoint staff, this change was responsible for dramatically reducing the need for claims reversals.

**Recovery of Claims Payments for Ineligible Beneficiaries.** Toward the end of July 2007, CMS instituted a recovery process whereby WellPoint could attempt to recover ineligible beneficiary claims by sending a notice to beneficiaries. As previously mentioned, all claims were now being switched through RelayHealth to verify Part D eligibility status. If RelayHealth verifies that the patient is qualified to participate in the POS FE process, WellPoint pays the claim; if the beneficiary is found ineligible, the claim is denied. When WellPoint can confirm eligibility for the POS FE process but not the beneficiary's LIS status, WellPoint will still pay the claim and send the claim to the eligibility verification contractor (Z-Tech in 2006 and 2007) for verification of LIS eligibility. For those individuals ultimately found ineligible for the LIS, WellPoint will attempt to recover claim costs by notifying the individual by letter that he or she must either provide proof of Medicaid or LIS status or reimburse WellPoint for the claim costs.

## The Role of Pharmacists in the POS FE Process

Pharmacists are key to implementing the POS FE process. WellPoint and CMS have worked together to use input from pharmacists to improve administrative procedures. For example, CMS and WellPoint have performed extensive outreach to pharmacists regarding the POS FE process. Because of the difficulty of communicating with beneficiaries who may be eligible to participate in POS FE, CMS staff noted that most communications regarding the POS FE process have been through pharmacies and beneficiary advocacy groups. CMS staff gave two primary reasons for this. First, such outreach is difficult for CMS to do directly because it cannot identify beforehand which beneficiaries will be eligible for the POS FE; most are new to Medicaid (such as long-term care residents) and many are Medicare beneficiaries who have to spend down to Medicaid eligibility on a month-to-month basis.<sup>8</sup> Second, CMS staff reported that communications regarding the POS FE process do not lend themselves to inclusion in the Medicare handbook because the process is relatively complex, and it is difficult for beneficiaries to determine their eligibility for the process. WellPoint and CMS have extensive information about the POS FE process on their respective websites.<sup>9</sup> Pharmacy trade association representatives acknowledged the utility of these forms of outreach and reported that most of their members were aware of the POS FE process. However, pharmacists representing independent pharmacies reported that they were less likely than pharmacists working in other settings (especially large chain drug stores) to utilize the POS FE process because of perceived costs of using the system.

In addition to outreach regarding the POS FE process, WellPoint reordered the hierarchy of edits in order to make them more helpful to pharmacists and responsive to the two biggest problems that pharmacists reportedly encountered in submitting claims. Currently, the first edit is a check for Medicare eligibility (that is, a check for a valid HICN). Pharmacists must submit a valid HICN in order to proceed to the next stage of claims processing. The second edit is for PDP enrollment. When a pharmacist submits a claim for a patient who WellPoint (through RelayHealth) is able to confirm is already enrolled in an alternate PDP, the pharmacist will receive a reject message indicating the reason for rejection. In addition, the message includes information regarding the appropriate plan to bill.

Pharmacist interview respondents indicated that the reordered edits and reject messages have been very helpful in streamlining claims processing using the POS FE process. They noted that having correct information about PDP enrollment was the most important item

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<sup>8</sup> Dual eligibles who are new to Medicare are auto-assigned by CMS into a Part D plan before their Medicare Part D eligibility becomes effective and the enrollment into the assigned plan becomes effective when their Medicare Part D eligibility becomes effective to prevent any gap in coverage.

<sup>9</sup> Pharmacists noted that the WellPoint website is particularly useful because it includes the payer sheets they need to submit claims for the POS FE process. CMS staff acknowledged that its agency is not able to post these forms on its website because they lack compliance with Section 508 of the Disabilities Act, which requires the federal government to make accommodations for those with visual, hearing, motor, or speech disabilities to ensure that they have the same access as the general population to electronic information that is developed, procured, maintained, or used by federal agencies.

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for them to know since the plans provide information on co-payment requirements. CMS notes that pharmacies were able to obtain this information from the E1 query, but many chose not to use it. Pharmacists we interviewed suggested that, for future purposes, the information provided during the POS FE process also should include data on current plan effective and termination dates. However, RelayHealth officials responded that the reject message includes coverage dates and suggested that pharmacists may not be aware of this feature if they are not regularly using the POS FE process.

### **CHARACTERISTICS OF BENEFICIARIES USING THE POS FE PROCESS**

Table III.2 presents the demographic characteristics of beneficiaries whose claims were paid through the POS FE process, by quarter. For comparative purposes, we include similar information for all dual eligible beneficiaries in Medicare.<sup>10</sup> Approximately 15 percent of the HICNs from both paid and reversed claims processed through POS FE in the first quarter of 2006 could not be matched to the EDB; therefore, we could not identify the demographic characteristics of beneficiaries with unmatched claims. The percentage of unmatched claims declined to less than 10 percent by the second quarter of 2007, likely reflecting the greater accuracy in claims submission that occurred as a result of improvements in the efficiency of the POS FE process (as discussed later).

Based on estimates from the most recent Medicare Payment Advisory Commission (MedPAC) report, the characteristics of beneficiaries whose claims were submitted through the POS FE process were somewhat different from those of the larger population of dual eligible beneficiaries; however, the inability to match a large percentage of claims to the EDB creates a margin of error that cannot be evaluated with the available data (MedPAC 2007). For example, focusing only on the final quarter of 2007 (for which the data are more complete), women represented 46 percent of all beneficiaries whose claims were paid through the POS FE process, but they were 62 percent of dual eligibles overall. Similarly, African Americans represented a smaller percentage of beneficiaries with paid claims than all dual eligibles (15 percent versus 21 percent). Given the potential for bias with respect to the characteristics of beneficiaries whose claims could not be matched to the EDB, it is unclear whether the differences in beneficiary characteristics represent true variations. However, the available data do not suggest that beneficiaries using the POS FE process were significantly different from the general population of dual eligible beneficiaries.

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<sup>10</sup> There are no published data on the characteristics of all LIS-eligible Medicare beneficiaries due to the inability to identify this population on a month-to-month basis. Therefore, we used the population of dual eligibles as a proxy for beneficiaries eligible to use the POS FE process.

**Table III.2. Unique Beneficiaries Utilizing POS FE and Distribution by Selected Characteristics, Paid Claims (2006-2007)<sup>a</sup>**

	1st Quarter 2006 (N=121,679)	2nd Quarter 2006 (N=70,022)	3rd Quarter 2006 (N=45,888)	4th Quarter 2006 (N=28,734)	1st Quarter 2007 (N=16,593)	2nd Quarter 2007 (N=8,487)	3rd Quarter 2007 (N=9,175)	4th Quarter 2007 (N=9,043)	All Dual Eligibles <sup>b</sup>
	%	%	%	%	%	%	%	%	%
<b>Gender</b>									
Male	34.8	36.0	36.9	38.3	37.7	40.0	43.5	44.2	38.0
Female	49.7	50.0	49.7	48.5	47.7	50.1	46.9	46.2	62.0
No Match to EDB <sup>c</sup>	15.5	14.0	13.4	13.1	14.6	9.9	9.5	9.6	
<b>Race</b>									
White (Non-Hispanic)	60.9	62.2	62.8	63.9	60.7	62.5	60.8	61.0	55.0
Black (Non-Hispanic)	14.4	14.8	15.2	14.7	14.9	14.9	16.3	15.4	21.0
Hispanic	3.5	4.4	4.4	4.4	3.6	1.7	2.0	1.7	15.0
Other <sup>d</sup>	5.6	4.3	4.0	3.6	5.5	9.5	10.1	10.9	9.0
No Match to EDB	15.5	14.0	13.4	13.1	14.6	9.9	9.5	9.6	
<b>Age</b>									
Under 65	26.7	27.3	30.9	34.1	34.4	42.3	48.5	47.9	40.0
Aged 65 - 74	19.1	18.8	18.3	17.0	17.6	17.0	17.5	17.7	25.0
Aged 75 - 84	21.0	21.3	19.8	18.8	18.1	15.8	13.4	14.3	22.0
Aged 85 and Older	17.6	18.6	17.6	16.9	15.3	14.9	11.1	10.5	13.0
No Match to EDB	15.5	14.0	13.4	13.1	14.6	9.9	9.5	9.6	
<b>Medicare Status</b>									
Aged	48.6	49.9	47.6	45.8	42.8	39.6	34.6	34.5	NA
Disabled	23.3	23.9	27.1	30.1	31.2	38.1	44.2	43.1	NA
ESRD	1.6	1.6	1.7	1.8	1.9	2.6	2.8	3.1	NA
Other	8.7	8.3	7.6	6.8	7.3	7.5	6.1	5.6	NA
Missing	2.3	2.4	2.6	2.3	2.2	2.2	2.8	4.1	NA
No Match to EDB	15.5	14.0	13.4	13.1	14.6	9.9	9.5	9.6	NA
<b>Beneficiary Death After Use of POS FE</b>									
Within 30 days	2.0	2.5	2.2	2.6	2.6	2.3	1.9	1.8	NA
31 to 60 days	3.1	3.7	3.5	3.9	3.9	3.3	3.0	2.8	NA

Table III.2. (continued)

	1st Quarter 2006 (N=121,679)	2nd Quarter 2006 (N=70,022)	3rd Quarter 2006 (N=45,888)	4th Quarter 2006 (N=28,734)	1st Quarter 2007 (N=16,593)	2nd Quarter 2007 (N=8,487)	3rd Quarter 2007 (N=9,175)	4th Quarter 2007 (N=9,043)	All Dual Eligibles <sup>b</sup>
	%	%	%	%	%	%	%	%	%
61-90 days	4.1	4.8	4.8	5.2	4.9	4.4	3.8	3.2	NA

Source: POS FE claims files provided by WellPoint for 2006 and 2007 and MedPAC report (2007).

NA Comparable data unavailable from MedPAC report.

<sup>a</sup>Time periods are based on calendar year.

<sup>b</sup>Estimates provided from the 2004 Medicare Current Beneficiary Survey (MedPAC 2007).

<sup>c</sup>Indicates that the HICN for the claim could not be matched to any records in the Medicare Enrollment Database. Many of these cases may be a result of pharmacy error in submitting an invalid HICN.

<sup>d</sup>"Other" includes Asian-Americans, Native Americans, and "other" (a non-descript category used in the EDB).

### ADMINISTRATIVE EFFICIENCY OF THE POS FE PROCESS

One of the goals of the evaluation was to examine the administrative efficiency of the POS FE system, defined as the minimization of steps and effort necessary to process and pay a claim and to ensure that only legitimate claims are paid. This definition includes two components. First, for the process to be efficient, data systems must be working as intended. For example, CMS data systems and the E1 query must be available and contain accurate and timely information. Second, claims must be appropriately submitted. This includes pharmacists submitting claims only for individuals eligible for the POS FE process and data edits to eliminate inappropriate submissions.

Analyses of the efficiency of the POS FE process were based on information reported by key informants as well as claims data provided by WellPoint. With the available data, it is difficult to associate changes in utilization patterns with changes in the POS FE process; however, a number of trends suggest both less reliance on the POS FE process and increasing improvements in program efficiency, measured in terms of reducing the ratio of reversed-to-paid claims. For example, the total number of claims submitted through the POS FE process that were initially paid by WellPoint, regardless of whether they ultimately remained paid or were instead reversed, declined dramatically and consistently between January 2006 and December 2007 (see Figure III.2). This suggests that utilization of the POS FE process was substantial during the early months of 2006 relative to later periods in 2006 and all of 2007. For example, compared to the period immediately after the introduction of the Part D benefit when more than 200,000 paid claims were processed each month, the number of paid claims fell to less than 50,000 per month after the first full year of the program.

**Figure III.2. Number of Paid and Reversed Claims by Month**

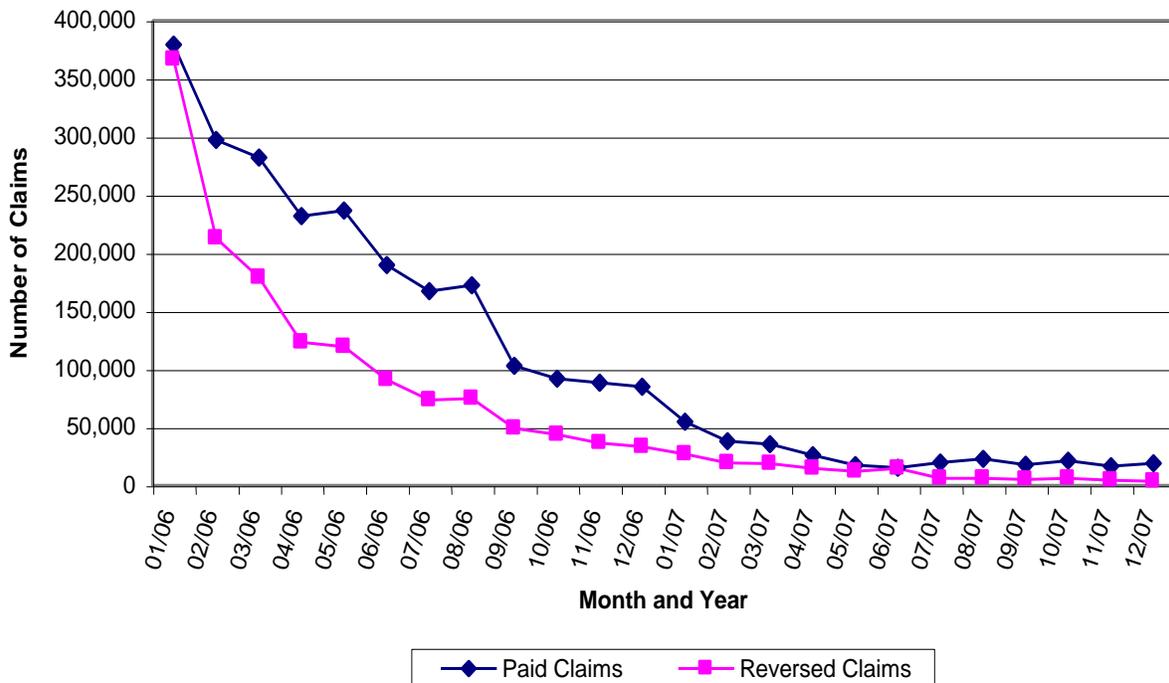
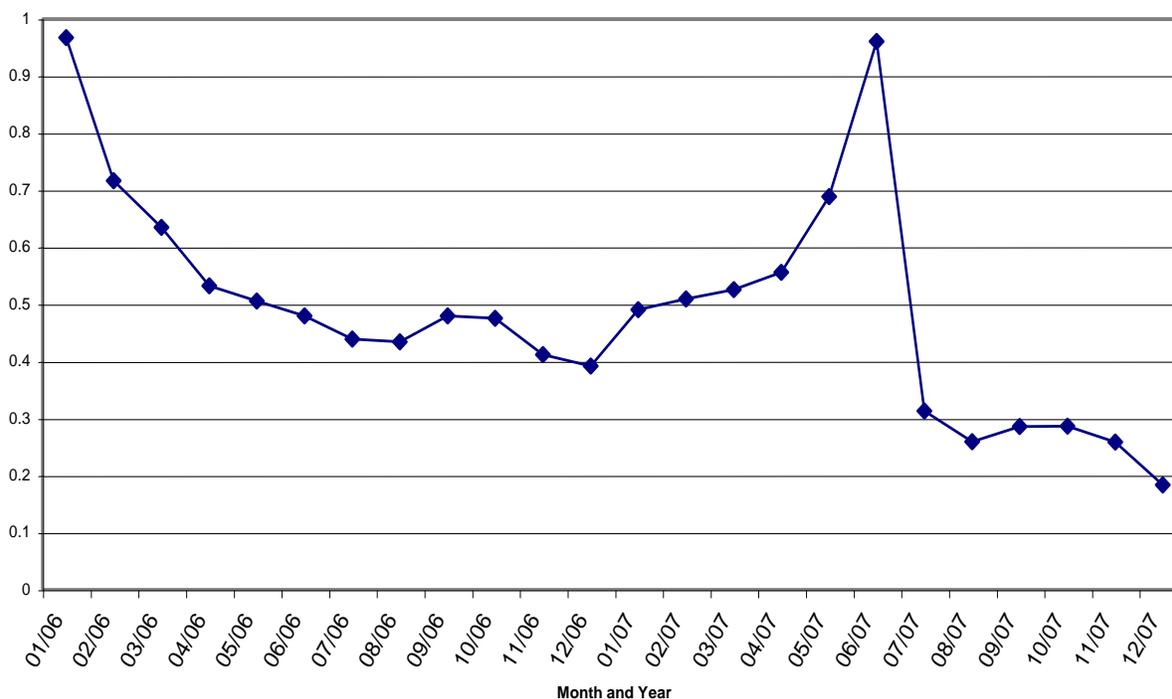


Figure III.3 demonstrates one measure of the increasing efficiency of the POS FE process over the 2006–7 period as the number of reversed claims gradually declined relative to the number of paid claims.<sup>11</sup> When the POS FE process began in January 2006, reversed claims represented 49 percent of total claims (as compared to paid claims, which represented 51 percent of total claims, hence a nearly one-to-one ratio of reversed to paid claims); by December 2007, the number of reversed claims had declined to 15 percent (representing a reversed-to-paid claim ratio of 0.18). There are a number of potential explanations for this trend. First, a larger number of eligible beneficiaries had been successfully enrolled in a PDP by mid-2006.<sup>12</sup> However, during this time, there were problems verifying plan enrollment for many beneficiaries, and, as previously noted, pharmacists often submitted claims through the POS FE process for these beneficiaries. As these problems were resolved, the number of claims that needed to be submitted through the POS FE process diminished. Second, the subsequent rounds of edits put into place by WellPoint prevented many ineligible claims

**Figure III.3. Ratio of Reversed-to-Paid Claims**



<sup>11</sup> The temporary spike of reversals relative to paid claims in May and June 2007 is likely due to the fact that WellPoint submitted a large batch of PDE claims at this time in order to meet the PDE submission deadline.

<sup>12</sup> By June 2006, CMS reported that 10.4 million beneficiaries had been enrolled in a stand-alone PDP, another 6.0 million were in Medicare Advantage plans, and 6.1 million dual eligibles were automatically enrolled in Part D (DHHS 2006).

from being processed. Finally, key informants from the pharmacy industry suggested that many pharmacists stopped using the POS FE process because of the large number of claim reversals that took place in the first few months of program implementation. One pharmacy association interview respondent indicated that his organization recommended that its members not use the POS FE process because of a perceived risk of having claims reversed by WellPoint.

Table III.3 presents information on the number of unique pharmacy encounters that involved use of the POS FE process in 2006 and 2007.<sup>13</sup> These data provide further evidence of the declining use of the POS FE process from 2006 to 2007 as the number of encounters fell from 1.26 million to a little more than 151,000. The average number of encounters per beneficiary also declined from 6.4 to 3.9. There were some variations by demographic characteristics in the mean number of encounters per beneficiary, with racial and ethnic minority groups and younger beneficiaries experiencing fewer encounters than white and older beneficiaries.

Table III.4 provides further evidence of the efficiency of the POS FE process based on the reasons for claims rejection in 2007, as documented by RelayHealth.<sup>14</sup> The patterns of claims rejections are a function of both the dates that edits were put into place by WellPoint and the reordering of the hierarchy of edits. For example, date-of-service edits were put in place in January 2007; the first rejections for claims with a service date greater than 30 days are evident in February 2007. The number of these rejections increases dramatically from February 2007 to October 2007 (from 9,191 to 30,626) and then begins to decline again, possibly indicating greater awareness of and response to the claims edits and messaging among pharmacists. Similarly, after the implementation of the May 2007 round of edits, there were far more instances of rejections resulting from missing required fields, while categories of rejections not previously recorded, such as rejection resulting from evidence of retiree drug coverage, began to appear.

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<sup>13</sup> A “unique encounter” represents an unduplicated visit by the same beneficiary to the same pharmacy on a given date. If the beneficiary had claims processed through the POS FE system by two or more pharmacies on a given date, each of these would be treated as a separate encounter. Each unique encounter could, however, involve the filling of more than one prescription at the same pharmacy on the same date.

<sup>14</sup> As noted in Chapter II, rejected claims were unavailable for analyses, although WellPoint had these data at the aggregate level; reasons for claim rejection were not available at the individual claim level for either 2006 or 2007, and aggregated reasons for rejection were unavailable for 2006.

**Table III.3. Unique Encounters with POS FE and Statistical Measures by Selected Characteristics, Paid Claims (2006-2007)<sup>a</sup>**

	2006			2007		
	Claims (2,322,579)	Encounters <sup>b</sup> (1,262,804)	Number of Encounters Per Beneficiary	Claims (303,508)	Encounters <sup>b</sup> (151,021)	Number of Encounters Per Beneficiary
	%	%	Mean	%	%	Mean
<b>Gender</b>						
Male	35.2	34.6	6.2	39.7	39.6	3.8
Female	50.0	50.2	6.4	47.8	47.5	3.9
No Match to EDB <sup>c</sup>	14.7	15.2	---	12.6	12.9	---
<b>Race</b>						
White (Non-Hispanic)	65.5	66.6	6.9	63.5	65.2	4.2
Black (Non-Hispanic)	13.4	12.8	5.6	14.8	14.0	3.6
Hispanic	3.1	2.5	4.0	1.8	1.5	2.3
Other <sup>d</sup>	3.1	2.9	3.4	7.3	6.3	2.5
Missing <sup>e</sup>	0.2	0.2		0.9	0.7	
No Match to EDB <sup>c</sup>	14.7	15.2	---	12.6	12.9	---
<b>Age</b>						
Under 65	23.1	20.8	4.4	35.9	33.2	3.0
Aged 65 - 74	17.9	16.5	5.5	17.0	16.1	3.6
Aged 75 - 84	24.1	25.0	7.9	19.0	20.1	5.2
Aged 85 and Older	20.2	22.6	8.5	15.5	17.6	5.4
No Match to EDB <sup>c</sup>	14.7	15.2	-	12.6	12.9	-
<b>Original Reason for Medicare Eligibility</b>						
Aged	55.0	58.1	7.9	44.8	48.0	5.0
Disabled	19.9	17.8	4.3	32.3	29.9	3.0
ESRD	1.5	1.3	5.1	2.3	2.1	3.1
Other	6.8	5.8	4.4	5.7	5.1	3.0
Missing <sup>f</sup>	2.1	1.8	---	2.4	2.1	---
No Match to EDB <sup>c</sup>	14.7	15.2	---	12.6	12.9	---

Source: POS FE claims files provided by WellPoint for 2006 and 2007.

<sup>a</sup>Time periods are based on calendar year.

<sup>b</sup>Unique encounter is defined as use of the POS FE process by the same person at the same pharmacy on the same day.

<sup>c</sup>Indicates that the HICN for the claim could not be matched to any records in the Medicare Enrollment Database.

<sup>d</sup>"Other" includes Asian-Americans, Native Americans, and "other" (a non-descript category used in the EDB).

<sup>e</sup>"Missing" refers to individuals who matched to the EDB, but for whom race status was unknown.

<sup>f</sup>"Missing" indicates a missing value for Medicare status on the EDB; whereas "no match to EDB" indicates that the claim's HICN could not be matched to a HICN in the EDB.

A number of other general changes in reasons for claims rejections over the one-year period in Table III.4 reflect the implementation of the upfront edits. The first was better access to eligibility data from CMS, which can be seen in several measures—for example, a decline in the number of rejections resulting from an inability to verify either Part A or Part B eligibility. In the first quarter of 2007, there were more than 47,000 such rejections; this number declined to a little more than 29,000 by the fourth quarter of the year. Similarly, the data show a fairly steady decrease in these rejections from one month to the next.<sup>15</sup> Also, fewer rejections were for claims that should have been submitted to another Part D plan. In January 2007, the vast majority of rejected claims (69 percent) were for enrollment in another PDP. Although this remained the primary reason for rejection at the end of 2007 (accounting for nearly 30 percent of rejections), the number of rejected claims in this category dropped by close to 80 percent during the year (from 73,220 in January to 15,336 in December). Although a longer time frame would be needed to see the full effects of these changes on the administrative efficiency of the POS FE process, the evidence suggests that these edits had an immediate and sustained impact on the efficiency of POS FE claims processing.

The data in Table III.5 provide further evidence of the effect of the date-of-service edits, as the percentage of claims with 30 days or less between the date of service and the date the claim was submitted increases between 2006 and 2007, in contrast to the percentage of claims with more than 30 days between dates of service and claims submission, which declines steadily over the study period.

### **Additional Evidence Regarding the Efficiency of the POS FE Process**

Timely data sharing is an important element in the successful implementation of the POS FE process. According to RelayHealth, some of the problems experienced with the POS FE process were due to lags in receipt of the data. The CMS systems that RelayHealth uses to verify eligibility and process TrOOP payments rely on the Medicare Advantage Prescription Drug System (MARx) and the MBD. The fact that contractors associated with these systems had to process these data before they were available for RelayHealth created some delays in data processing.

Pharmacists reported that their access to data systems had also improved between 2006 and the present. In most instances, pharmacies are able to identify the 4Rx fields in order to process a claim. Part D Plans must now include these four required data items on their enrollment transactions to CMS or else they will be rejected (the only exception is for auto-enrollment transactions). However, there are still some instances when no eligibility

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<sup>15</sup> There are no obvious explanations for the increases that occurred between February and March and again between November and December.

**Table III.4. POS FE Rejected Claims by Reason for Rejection and Date of Claim Submittal (2007)<sup>a</sup>**

	January	February	March	April	May	June	July	August	September	October	November	December
Part A and Part B eligibility cannot be identified	19,143	12,315	15,582	12,479	12,336	11,293	11,423	11,152	8,902	9,802	8,740	10,708
Required fields missing	6	6	23	15	8,369	2,679	3,098	2,299	4,776	4,975	3,390	2,450
HICN is in Part A or B database, but not effective	861	580	472	576	273	280	196	127	220	186	143	54
Deceased on date of service	1,064	770	828	667	264	210	205	150	77	191	177	181
Date of service greater than 30 days	-	9,191	18,754	18,472	16,617	16,562	23,913	26,514	30,528	30,626	25,577	20,120
Already effective with another Part D plan	73,220	49,183	47,061	38,778	17,846	16,766	19,563	15,811	16,704	14,832	15,095	15,336
Missing or invalid HIC number	11,710	5,245	6,638	4,908	1,104	-	-	-	-	-	-	-
Patient voluntarily opted out of Part D	-	-	-	-	2,903	2,438	890	-	-	-	-	-
Member of an employer subsidy program	-	-	-	-	4,008	2,737	2,441	2,066	1,653	1,895	2,214	2,345
Does not reside in the 50 states or DC	-	-	-	-	4	3	3	-	5	2	-	2
Part of a plan that is ineligible <sup>b</sup>	-	-	-	-	16,117	2,361	988	363	242	232	238	197
<b>Total Rejected Claims</b>	<b>106,004</b>	<b>77,290</b>	<b>89,358</b>	<b>75,895</b>	<b>79,841</b>	<b>55,329</b>	<b>62,720</b>	<b>58,482</b>	<b>63,107</b>	<b>62,741</b>	<b>55,574</b>	<b>51,393</b>

Source: RelayHelath summary data; provided by WellPoint to MPR on 3/14/08 (not part of 2006 and 2007 claims data WellPoint submitted for this analysis)

<sup>a</sup>Time period is based on calendar year.

<sup>b</sup>Based on CMS definitions

**Table III.5. Number of POS FE Claims and Distribution by Selected Ranges of Days Between Date of Service and Date of Claim Submittal, Paid Claims (2006-2007)<sup>a</sup>**

Number of Days Between Unique Encounters	First Quarter 2006 (N=957,758)	Second Quarter 2006 (N=657,539)	Third Quarter 2006 (N=441,951)	Fourth Quarter 2006 (N=264,878)	First Quarter 2007 (N=128,033)	Second Quarter 2007 (N=58,676)	Third Quarter 2007 (N=59,985)	Fourth Quarter 2007 (N=56,814)
30 Days or less	74.4	81.1	82.7	78.8	96.3	96.1	93.7	99.8
31 to 90 days	12.2	10.5	9.1	11.8	2.3	1.5	2.8	0.1
More than 90 days	13.4	8.4	8.2	9.4	1.3	2.3	3.5	0.1

Source: POS FE claims files provided by WellPoint for 2006 and 2007

<sup>a</sup>Time period is based on calendar year.

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information can be found. Interview respondents affiliated with chain drug stores indicated the biggest problem early on was that the E1 process returned too many “no matches” when trying to identify the correct plan to bill. In some cases, the system returned a phone number for the attendant to call, but the phone call to resolve the issue would reportedly take 20 minutes of an associate’s time. These respondents added that the message indicating “no match” between submitted data and data on file is still the biggest problem they face; informants believe that the problem stems from the fact that PDPs send incomplete files to CMS.<sup>16</sup> They acknowledged that CMS has made a major effort to deal with the problem by issuing report cards for plans that do not submit their information on a timely and complete basis. Because this affects the plan’s rating, respondents expressed the opinion that this policy has been effective in forcing the plans to be more responsive.

### **ONGOING PROBLEMS WITH THE POS FE PROCESS**

Despite improvements in the POS FE process, informants reported a number of ongoing problems with the system. First, some claims are still being submitted for ineligible beneficiaries. In many cases, the beneficiary was enrolled in a Part D plan in the service month, but the enrollment was not yet present in CMS systems at the time of the claim payment. In these cases, the individual may have enrolled, or have been auto-enrolled, in a plan between the time he or she used the POS FE process and the time WellPoint attempted to enroll this individual in one of its plans. In many cases, the beneficiary was neither eligible as an LIS beneficiary nor did he or she have any Part D plan enrollment. A small number of ineligible beneficiaries are later found to be eligible.

In addition, despite improvements in efficiency within the POS FE process, pharmacists indicated that reversals still occur. CMS staff we interviewed suggested that pharmacies may not understand that some claims are still reversed when they are “duplicate” claims (that is, claims that the pharmacy has submitted but that have already been processed for the correct PDP or the pharmacy has been paid twice for the same claim). This problem has been especially common for claims submitted in 2006.

Finally, problems with the POS FE process have been particularly acute among long-term care pharmacies. According to pharmacists from this industry whom we interviewed, CMS has sought to reduce the rate of errors associated with claims submitted through the POS FE system for dual eligible beneficiaries to less than 5 percent of all claims. According to these interview respondents, although the overall error rate ranges from 5 percent to 10 percent, it is larger for long-term care pharmacies, ranging from 3 percent to 30 percent across states. The variability in the rate was said to be due to the speed and accuracy with which eligibility data are sent to CMS from the states, which directly affects the error rate.

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<sup>16</sup> CMS notes that some “no matches” are valid responses indicating that the customer has no Medicare or Part D eligibility or that the pharmacist has not entered enough data on the query to support the match.

## CONCLUSIONS REGARDING THE POS FE PROCESS

Based on key informant interviews and analyses of claims data, the efficiency of the POS FE process improved between January 2006 and the end of 2007. Although the reversals of previously paid claims created hardships that pharmacists did not anticipate, pharmacists are better informed about the POS FE process today, and the edits put in place by CMS and WellPoint over the two-year period since January 2006 have led to a significant reduction in the number of inappropriate claims submissions that otherwise resulted in payment reversals.

According to CMS staff, beneficiaries currently using the POS FE process are most likely individuals experiencing transitions into (and out of) Medicaid eligibility or changes in plan enrollment. Interview respondents from CMS indicated that these are the individuals for whom the POS FE process was intended; their use of the POS FE system is appropriate and indicates that program goals are being met.

Overall, pharmacists reported that the POS FE process operates effectively; however, they identified several areas for improvement. First, CMS and WellPoint should consider ways to improve the utility of the POS FE process for long-term care pharmacists. Because these pharmacists do not typically deal directly with a patient, as do their counterparts in retail pharmacies, they often do not have the evidence of Medicaid eligibility readily available in the format that CMS regulations require (for example, paper copies of Medicaid statements). The 30-day limit on claims submission is also problematic in these settings because, according to the long-term care pharmacists with whom we spoke, long-term care pharmacies often submit claims in batch format on a monthly basis rather than on a rolling basis. CMS staff note that batch submissions are not consistent with CMS requirements and that many LTC pharmacies have since learned to submit POS FE claims on a more frequent basis. Finally, pharmacist interview respondents indicated that WellPoint and CMS may also need to provide additional outreach to pharmacists who continue to deal with claims reconciliations from 2006 and 2007, adding that it may help these pharmacists to understand that many of these claims were reversed because of their duplicate nature.

CMS has acknowledged that the POS FE process is not the optimal solution for serving the needs of the dual eligible and other LIS-eligible populations because of the complexity of coordinating the multiple systems required to determine eligibility and enrollment in Medicare and Medicaid and to adjudicate claims in real time at the point of sale. The process is also reliant on the timeliness and accuracy of the data submitted from states regarding the dual eligibility and long-term care status of beneficiaries. Nevertheless, the process serves a valuable safety net function for the enrollment of low-income Medicare beneficiaries in Part D and has made important gains in administrative efficiency during the first two years of the new benefit.

## CHAPTER IV

### THE STATE-TO-PLAN DEMONSTRATION

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The most significant problems in transitioning dual eligible beneficiaries into the Part D program occurred during the first three months of 2006. Although the POS FE process was in place during that time, there were early reports of beneficiaries experiencing problems using the system and many pharmacists were not yet familiar with the process. A number of states implemented emergency measures in January of that year to ensure continuity of drug coverage for their dual eligible beneficiaries. Other states soon followed; by the end of March, 43 states and the District of Columbia had made some type of payment to ensure the continuity of drug coverage for low-income Medicare beneficiaries (National Conference on State Legislatures 2006). The S2P demonstration (officially known as the Reimbursement of State Costs for Provision of Part D Drugs demonstration) was developed in response to states' actions during the first quarter of 2006.

Many groups within the CMS were involved in developing the S2P demonstration. Because there was no precedent for this type of demonstration and it had to be implemented quickly, CMS set up a workgroup with the states to determine the program's structure. CMS staff reported that leadership from members of the National Association of State Medicaid Directors (NASMD) facilitated the process and encouraged state participation in the demonstration.

The S2P demonstration was announced on January 24, 2006, in response to the actions of a number of states that had already implemented temporary coverage by that time. Beneficiaries covered under the demonstration included all dual eligibles and LIS-eligible enrollees in SPAPs.<sup>1</sup> The demonstration provided reimbursements for certain drugs and

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<sup>1</sup> SPAPs have traditionally provided drug coverage or assistance for elderly persons or persons with disabilities who are not eligible for Medicaid. However, in anticipation of the Part D benefit, a number of states introduced new programs or expanded existing programs to provide "wraparound" benefits to Part D coverage. Among the 28 states with SPAP programs in 2006, a total of 11 received reimbursements for SPAP expenditures under the S2P demonstration. The decision to include SPAPs in the S2P demonstration was not mandated by statute but rather was made by high-level officials in the Department of Health and Human Services, Office of Management and Budget, and the White House. Staff at CMS could not elaborate on why the SPAPs were included in the demonstration. The decision came about later in the development of the demonstration, which some key informants believed complicated the payment process.

some administrative costs, within certain limitations. Drugs eligible for reimbursement were limited to Part D–covered drugs or those drugs treated as covered due to the transition policy CMS had in place in the beginning of 2006, but payments to states excluded Medicare cost-sharing amounts. Eligible administrative costs were those directly related to facilitating plan enrollment (including technical support to providers) and costs for developing and processing claims associated with the provision of Part D drugs.

The S2P demonstration was originally limited to services provided between January 1, 2006, and February 15, 2006, but it was eventually extended to March 31, 2006. Although some states implemented temporary coverage before January 1, those earlier payments were not eligible for reimbursement under the demonstration (for example, some states allowed duals early refills of their prescriptions under Medicaid prior to January 1, 2006, so that they had enough medication as they transitioned onto Part D). In addition, some states ended payments to beneficiaries prior to March 31, while others extended their coverage (with no federal assistance) beyond that date.

There were two primary requirements for participation in the S2P demonstration. First, states had to confirm the beneficiary’s status as a dual eligible or other LIS eligible beneficiary. For SPAP enrollees, CMS also had to confirm enrollment in a PDP (unlike dual eligible beneficiaries for whom verification of eligibility was sufficient for reimbursement). The requirement for PDP enrollment for SPAP beneficiaries was dictated by statute because under the MMA CMS is permitted to make payments only on behalf of beneficiaries enrolled in a Part D plan and is mandated to autoenroll only dual eligible beneficiaries. All other enrollments are voluntary. In addition to these requirements, states agreed to require pharmacists to attempt to bill the Medicare PDP or POS FE system before relying on state coverage.

#### **STATE PAYMENTS UNDER THE S2P DEMONSTRATION**

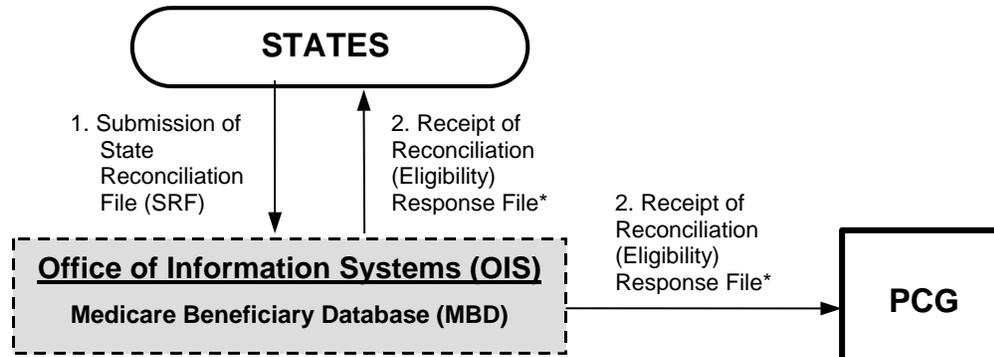
Under the S2P demonstration, states received payments through a two-step process (Figure IV.1). The first step involved verification of Part D eligibility (the upper portion of Figure IV.1). States were required to submit to CMS’s Office of Information Systems a State Reconciliation File including beneficiary identifying information for all individuals covered by the state’s temporary program.<sup>2</sup> The identifying information were then matched against the CMS MBD to verify Medicare eligibility. An eligibility file called the Reconciliation Response File (RRF) was sent back to the state for all positive matches and

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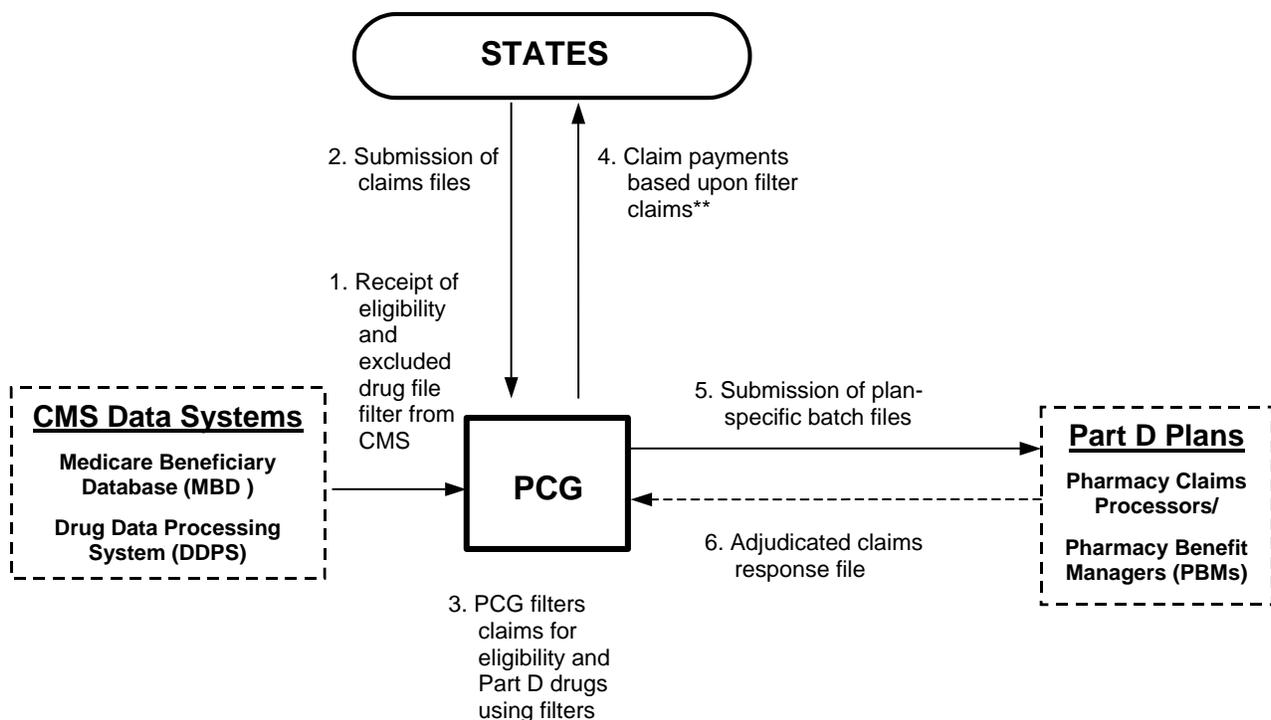
<sup>2</sup> States were supposed to send records only for individuals who actually used the temporary benefit; however, key informants noted that some states did not filter the files beforehand but sent the IDs for all beneficiaries in their files, which created significant processing delays.

**Figure IV.1. State to Plan Flowchart: Processing Claims and Reimbursements**

**Step 1: Eligibility Verification**



**Step 2: Claims Payment**



\*Process was used to ensure that beneficiaries were entitled to Medicare and claims were for eligible Part D drugs. States could file claims for all individuals verified as dual eligible; for dual eligibles not already enrolled in a Part D plan, states could assist with enrollment. States could file claims for other beneficiaries only if they are verified as LIS-eligible *and enrolled in a Part D plan*.

\*\*The remaining 5% of payments were adjusted for Medicare cost-sharing, amounts for claims previously denied for ineligible beneficiaries, amounts previously denied for covered drugs, and amounts for claims previously paid for over the counter products not included in the DPPS drug filter.

simultaneously to the Public Consulting Group (PCG), the private consulting group that was chosen as the reconciliation contractor for the demonstration. According to an interview respondent at PCG with whom we spoke, the RRF was treated as the “gold standard” against which claims were processed. Once the file was prepared, claims would be accepted only for beneficiaries included in the RRF.

The second step of the process involved the actual payment of claims (illustrated in the bottom portion of Figure IV.1). CMS sent two files to PCG to assist claims processing, an eligibility file (RRF) and an excluded drug file filter (from CMS’s Drug Data Processing System [DDPS] for PDE data). The latter was included to ensure that claims were paid only for qualified Part D drugs. States submitted to PCG claims from beneficiaries who had been verified as Part D eligible in Step 1 of the process. PCG filtered these claims using the RRF and the DDPS filter, and states received 95 percent of the eligible claim payments based on this process. The remaining 5 percent of the claims were to be paid after reconciliation with the PDPs to determine the applicable Medicare cost-sharing amount. For this final stage of reconciliation, PCG submitted plan-specific batch files to PDPs (via their pharmacy benefit managers [PBMs]). An adjudicated claims response file was returned from the PDPs (again, via their PBMs) to PCG and the final payments were made to the states.

#### **STATES’ APPROACHES TO TEMPORARY COVERAGE**

States developed a variety of mechanisms to provide drug coverage to beneficiaries who temporarily lost coverage as a result of the transition from Medicaid to Medicare. Key informants from several states included in our study provided descriptions of the methods they used:

- Florida simply removed the edit in its data system that would normally deny a claim if the beneficiary had Medicare eligibility and the state paid the claim.
- Texas’s coverage provided full formulary benefits to dual eligibles. The state excluded people already enrolled in a PDP but continued to pay for these beneficiaries if the claims went to the Medicaid program. Texas used the plan enrollment date (rather than the Medicare eligibility date) to cut off Medicaid benefits.
- Key informants from California indicated that they foresaw serious problems with Part D implementation and developed a system in December 2005 through which pharmacists could bill the state for drug claims for dual eligibles. The system was implemented on January 7, 2006. The demonstration paid program expenses through March, but California continued it on a state-only basis until January 2007.

Although 44 states provided some form of temporary drug coverage to dual eligibles, some of these states received reimbursements only for drug payments, others received only administrative payments, and 14 (including 2 of those states with which we spoke) did not

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seek reimbursement from CMS under the demonstration.<sup>3</sup> Missouri's key informants indicated that they tried to submit documentation under the demonstration but could not allocate sufficient staff hours to the task. They decided that the relative costs needed to submit the data in the manner CMS required would have been higher than the actual costs incurred to pay the original claims. South Carolina considered participating in the demonstration but rejected the idea, believing that the state would not receive full reimbursement for its costs. This state also cited the file formatting and reporting standards as barriers to participation, reiterating the lack of resources to devote to the task. Finally, this state thought that as a relatively small state, it did not have the kind of high demand that larger states experienced, which would have justified its participation.

### **SPAP Coverage Provided Under the S2P Demonstration**

Two of the states included in the study had SPAPs that provided coverage during the three-month transition period covered by the S2P demonstration, but only Texas's program participated in the demonstration.<sup>4</sup> In Texas, a Medicaid vendor coordinated claims payments for the SPAP through its system and the SPAP was treated as a secondary payer. The program covered beneficiaries receiving dialysis treatments (including coverage for immunosuppressants). Beneficiaries saw a social worker three times a week, so there was greater assurance that the beneficiary was enrolled in a PDP. Texas's SPAP implemented coordination of benefits in January and, in the words of one interview respondent, "rode Medicaid's coattails" in getting the demonstration files submitted in order to receive its reimbursements (that is, the state adopted the processes used by the Medicaid program once the "kinks" were worked out).

### **NUMBER AND CHARACTERISTICS OF BENEFICIARIES USING THE S2P DEMONSTRATION**

Table IV.1 presents the total number of unique beneficiaries for whom claims were processed through the S2P demonstration by type of program. As noted earlier, the data include information only for states that submitted drug claims through the S2P demonstration. There were a total of 940,942 beneficiaries for whom claims were submitted

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<sup>3</sup> States chose which type of reimbursements to pursue based on the efforts they undertook to provide continuity of coverage. For example, some states did not want to undertake the process of claims submission as required for the demonstration and chose to request reimbursement only for administrative costs. Other states did not pay for drugs but provided educational materials and assistance to help beneficiaries enroll in a plan. In these cases, the state was not eligible for claims reimbursement.

<sup>4</sup> Missouri's SPAP is run by the Medicaid program and provides wraparound coverage for drug benefits. A key informant representing Missouri indicated that his state set up a process to take calls for individuals without coverage in order to help them obtain coverage; in addition, the state worked with three preferred PDPs that provided coordination of benefits. Although these efforts were eligible for reimbursement under the demonstration, the state decided not to pursue payment.

**Table IV.1. Unique Beneficiaries Utilizing S2P by Program Type and State (January-March 2006)**

<b>State</b>	<b>Program</b>	<b>Total Beneficiaries</b>
Alaska	Medicaid	601
Arizona	Medicaid	13,416
Arkansas	Medicaid	16,762
California	Medicaid	169,462
Connecticut	Medicaid	36,026
	SPAP	1,958
Delaware	SPAP	2,883
District of Columbia	Medicaid	2,266
Hawaii	Medicaid	3,884
Idaho	Medicaid	15
Illinois	Medicaid	25,962
Kansas	Medicaid	12,955
Maine	Medicaid	22,332
	SPAP	4,988
Maryland	Medicaid	11,553
Massachusetts	Medicaid	74,203
	SPAP	12,492
Minnesota	Medicaid	14,724
Montana	Medicaid	129
Nevada	Medicaid	1
	SPAP	1,540
New Hampshire	Medicaid	759
New Jersey	Medicaid	117,850
	SPAP	54,167
New Mexico	Medicaid	4,121
New York	Medicaid	263,661
	SPAP	63,865
North Dakota	Medicaid	1,719
Oregon	Medicaid	487
Pennsylvania	Medicaid	2,334
	SPAP	17,488
Rhode Island	Medicaid	6,448
	SPAP	1,623
South Dakota	Medicaid	1,907
Texas	Medicaid	93,360
	SPAP	994
Utah	Medicaid	6,437
Vermont	Medicaid	11,045
	SPAP	4,125
Virginia	Medicaid	26,060
Wisconsin	Medicaid	502
<b>Total</b>	<b>Medicaid</b>	<b>940,942</b>
	<b>SPAP</b>	<b>166,114</b>

Source: Claims data provided from CMS for the S2P demonstration.

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under the S2P demonstration through Medicaid and 166,114 beneficiaries through SPAPs. Of the 31 jurisdictions submitting claims, Idaho submitted claims for the smallest number of beneficiaries (15) and New York for the highest (327,526). Of the states included in our analysis, California submitted claims for 169,462 beneficiaries and Texas for 94,354 (994 of whom were SPAP beneficiaries). Table IV.2 presents the demographic characteristics of beneficiaries whose claims were processed through the S2P demonstration, in total and by claim status. For comparative purposes, we include the demographic characteristics of all dual eligibles as well. Paid and reversed claims are defined in the same way as in the POS FE process. However, Table IV.2 includes a third type of claim outcome, “unprocessed claims,” which represents claims that PCG was not able to process by the June 2007 deadline (discussed at greater length later). Approximately 15 percent of the claims received for the S2P demonstration could not be matched to the EDB. The rate of match varied considerably among the three claims types, with paid claims having the lowest unmatched rate (4.9 percent) and unprocessed claims the highest (22.2 percent); reversed claims were in between (at 9.7 percent).

As in the case of the POS FE process, the characteristics of beneficiaries in the S2P demonstration (particularly those whose claims were paid and not reversed) are similar to those of the larger population of dual eligible beneficiaries (MedPAC 2007). Women were 61 percent of all beneficiaries whose claims were paid through the S2P demonstration, close to the 62 percent noted in the MedPAC report. Similarly, African Americans represented a smaller percentage of total claims than all duals (15 percent versus 21 percent), but the percentage was closer among paid claims (almost 19 percent). The available data do not suggest that beneficiaries using the S2P demonstration were significantly different from the general population of dual eligible beneficiaries; however, to the extent that the differences reported are real, there may have been some disparities in the experiences of beneficiaries involved in the S2P demonstration.<sup>5</sup>

#### **ADMINISTRATIVE EFFICIENCY OF THE S2P DEMONSTRATION**

It is hard to apply the same criteria for efficiency with the S2P demonstration that were used for the POS FE process because, unlike the latter, the S2P demonstration was developed on short notice and was implemented—and intended—for only a brief period of time. The following discussion of program efficiency highlights states’ experiences with the S2P demonstration and the problems they faced.

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<sup>5</sup> Beneficiaries with reversed or unprocessed claims may have had more difficulties filling their prescriptions. Differences in the characteristics of beneficiaries across claims types could indicate a bias in the process for a particular group of beneficiaries. For example, African Americans represent approximately 21 percent of dual eligibles, according to the MedPAC estimates. If African Americans were 30 percent of beneficiaries with unprocessed claims, this could indicate that African Americans experienced greater problems filling their prescriptions than did people of other racial and ethnic backgrounds.

**Table IV.2. Unique Beneficiaries Utilizing S2P by Claim Status and Selected Characteristics (January-March 2006) Compared with Data for All Dual Eligibles**

	Total Claims <sup>a</sup>	Paid Claims	Reversed Claims <sup>b</sup>	Unprocessed Claims <sup>c</sup>	All Dual Eligibles <sup>d</sup>
	Beneficiaries (1,104,912)	Beneficiaries (303,981)	Beneficiaries (392,026)	Beneficiaries (571,943)	
<b>Gender</b>					
Male	30.2	33.7	31.7	27.8	38.0
Female	55.0	61.4	58.7	50.3	62.0
Missing from EDB <sup>e</sup>	15.0	4.9	9.7	22.2	
<b>Race</b>					
White (Non-Hispanic)	51.1	54.6	54.3	47.4	55.0
Black (Non-Hispanic)	14.8	18.6	15.7	12.9	21.0
Hispanic	9.1	10.7	9.9	8.3	15.0
Other <sup>f</sup>	10.1	11.2	10.4	9.6	9.0
Missing <sup>g</sup>	0.3	0.3	0.3	0.2	
Missing from EDB	15.0	4.9	9.7	22.2	
<b>Age</b>					
Under 65	31.8	35.8	34.5	28.1	40.0
Aged 65 - 74	22.2	26	23.3	20.4	25.0
Aged 75 - 84	19.7	22	20.9	18.3	22.0
Aged 85 and Older	11.4	11.4	11.8	11.2	13.0
Missing from EDB	15.0	4.9	9.7	22.2	
<b>Medicare Status</b>					
Aged	35.6	38.7	37.3	33.0	NA
Relief	6.9	9.2	6.8	6.1	NA
Disabled	29.5	33.2	32.1	26.0	NA
ESRD	1.4	1.6	1.5	1.4	NA
Other	6.0	6.6	6.3	5.7	NA
Missing	5.7	5.8	6.4	5.8	NA
Missing from EDB	15.0	4.9	9.7	22.2	NA
<b>Mortality</b>					
Death within 30 days	0.8	0.7	0.9	0.7	NA
Death within 60 days	1.4	1.2	1.5	1.3	NA
Death within 90 days	1.8	1.7	2.0	1.8	NA

Source: Claims data provided from CMS for the S2P demonstration and MedPAC report (2007).

NA Comparable data unavailable from MedPAC report.

<sup>a</sup> Since a beneficiary could have a paid claim and a reversed or unprocessed claim in the same month, the total number of unique beneficiaries may differ from the total paid, reversed, and unprocessed claims.

<sup>b</sup> S2P data labeled claims as "rejected" rather than "reversed," but for purposes of this evaluation, an ineligible claim whose originally paid status was later reversed will be described as "reversed" throughout.

<sup>c</sup> Unprocessed claims represent those that the Public Consulting Group (PCG) could not process for either paid or reversed status by June 2007

<sup>d</sup> Estimates provided from the 2004 Medicare Current Beneficiary Survey (MedPAC 2007).

<sup>e</sup> "Missing from EDB" indicates that the individual beneficiary's data could not be matched to data contained in the Medicare Enrollment Database whereas "Missing" refers to cases where the EDB value was defined as missing.

<sup>f</sup> The race "other" category consists of Asian-Americans, Native Americans, and "other" (a non-descript category used in the EDB).

<sup>g</sup> "Missing" refers to individuals who matched to the EDB, but for whom race status was unknown.

According to key informants from the states we interviewed, there was a perception that pharmacists welcomed the S2P demonstration. An interview respondent from one state said that the early problems with the POS FE system (described in Chapter III) led many pharmacists to rely more heavily on the S2P process instead. In some cases, this was much easier than billing either POS FE or the Part D plan for the pharmacists since it was effectively the status quo, that is, they simply continued to bill Medicaid when permitted. However, some states imposed new and different rules on pharmacies for obtaining payments. An informant from another state indicated that pharmacists found the POS FE system confusing because the details of the program were announced too late. This informant believed that pharmacists were happy when the states stepped in and found the S2P demonstration much easier to use than the POS FE procedures in place at that time. A third informant representing yet another state said that he thought pharmacists were probably overly reliant on the S2P early on, but that his state subsequently made its system less user-friendly in order to discourage inappropriate use.

### **Pharmacists' Perceptions of the S2P Demonstration**

Although experiences may have differed from one state to the next, pharmacists we interviewed reported that the S2P demonstration created more confusion than the POS FE process. Long-term care pharmacists described the S2P as “chaotic.” They acknowledged that they did try to “work the system” as it was put in place (for example, submitting claims to whichever system they thought would provide faster payment) but indicated they did not understand the systems well and did not always know what they were doing. Independent pharmacists reported receiving conflicting instructions from the states. Whereas pharmacists were instructed to use the S2P as a last resort, some states told them to go ahead and process the claims, even in cases where other potential payees had not yet been billed. Some states assumed that they would be reimbursed by CMS for all Part D claims, but this was not the case. Key informants representing independent pharmacies indicated that, in general, there was a lot of confusion about the correct entity to bill. Representatives from chain drug stores also indicated that the S2P process was more difficult than the POS FE system. Echoing the independent pharmacists, pharmacists representing chain drug stores said that states were trying to recoup costs for claims that CMS refused to pay. They said that proper edits were not in place to bill drugs excluded from Part D. These drugs were supposed to be rejected through Part D, but states did not have the edits in place to limit billing to particular drugs. In such cases, the pharmacist could bill everything to the S2P process, but CMS would eventually refuse to reimburse the states for ineligible drugs, which meant the states would later try to recoup the costs from the pharmacists. According to our informants, the biggest problems with the S2P process were in the northeastern states that have large SPAP programs because these programs incurred millions of dollars in costs and did not receive timely reimbursements.

### **Communication Between States and CMS**

Informants from the states said that they predicted that there would be problems with the implementation of Part D and voiced their concerns through the final months of 2005. In particular, states anticipated that many beneficiaries who were enrolled in PDPs would

not be able to confirm their enrollment and, therefore, would not be able to use Part D.<sup>6</sup> Although states had been participating in regular calls with CMS about the implementation of Part D, they believed that they were not being treated as equal partners. One state expressed its concern about the data-sharing gap to CMS but did not get a response (even when its commissioner went to Washington, D.C., to meet with representatives at the Department of Health and Human Services). Another state reported a similar experience and said that CMS became responsive only after Secretary Michael Leavitt toured the nation in January 2006, meeting with between 20 and 30 governors.

### **Demonstration Developed in the Midst of a Crisis**

Several respondents (from the states and CMS) noted that the key problem was that the S2P process was developed in the midst of a crisis, with no prior experience to draw from, whereas developing the demonstration in an organized fashion would have required issuance of requests for proposals, legislative mandates, allocation of funds, and other bureaucratic procedures. The need to stick to deadlines exacerbated problems that the states were facing in preparing files for claims submission using a new file format. According to the states, there was also not always time to evaluate the circumstances of individual beneficiaries, so pharmacists ended up having to bill the state for claims that CMS could not reimburse.

### **Rules for Payments**

According to one state key informant, the S2P demonstration worked well overall but faced three significant problems related to state payments. First, this informant believed that states lost money inappropriately on the co-payments guaranteed by the federal government, indicating that he disagreed with CMS's decision to collect co-payment amounts owed under Medicare (rather than Medicaid). He thought that states could not apply Medicare's rules when they paid a claim to the pharmacy and that Medicaid cost-sharing rules should have been applied instead. Second, although the 95 percent payment went well, the informant indicated that delays in receipt of the 5 percent payment created problems for smaller, cash-strapped states.<sup>7</sup> Key informants from other states concurred, noting that (1) although most states received payments in 2006, some did not receive their payments until April 2007; (2) some claims were never processed; and (3) some larger states are still awaiting payment from CMS. Finally, this informant indicated that he thought the program should have continued for at least three to four more months, or at least until CMS closed the initial enrollment period on May 15, 2006. However, some states did not see the necessity of this and terminated their programs before the demonstration's end date of March 31, 2006.

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<sup>6</sup> These were the concerns that prompted California to implement emergency measures to ensure drug coverage in December 2005.

<sup>7</sup> Much of the delay was attributed to the decision to collect Medicare co-payments and the difficulty of reconciling claims for this purpose. CMS staff members acknowledged large problems in trying to calculate exact cost-sharing amounts and said that this route should have been avoided; they are likely to use estimated cost sharing for future endeavors.

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### **Difficulties Using the Excluded Drug List**

PCG reported problems using the excluded drug list to filter claims, preferring instead to use an approved drug list.<sup>8</sup> It reported that the final list of excluded drugs was not available until the spring of 2007, which created difficulties in providing Medicaid programs and SPAPs with clean files of eligible drugs. In some cases, the process had to be repeated. CMS acknowledged this delay since the only available drug lists at the national drug code (NDC) level were still under development for DDPS processing during this period.<sup>9</sup> Use of the NDCs is required to uniquely identify drugs.

### **Problems in Developing Proper File Formats**

Another major problem in developing the S2P demonstration was that states were used to paying, rather than billing, claims; as a result, it was difficult for states to establish systems to submit claim files to PCG. They wanted to use the system already in place for file submission related to state phase-down contributions (also referred to as “clawback”), which would have used an existing administrative format. A key informant from one state indicated that it would have been more efficient to utilize standards established by the National Council for Prescription Drug Programs (NCPDP) for submitting claims files.<sup>10</sup> According to this informant, states were required to provide fields under the demonstration that pharmacies do not typically submit on claims. In at least one state, the file formatting problems were exacerbated by the restriction, imposed by CMS and PCG, that states could submit the same data files only twice. In the case of this informant’s state, the first file was sent late, and 30,000 to 40,000 beneficiaries were incorrectly deemed ineligible for the demonstration because the file had been populated incorrectly. As a result, the state had to request special permission to resubmit its eligibility files.

### **Problems in Processing Claims**

Key informants reported a number of problems specific to the procedures for claims processing. SPAPs were not well positioned to participate in the S2P demonstration because they lacked the necessary operational experience. Meanwhile, PCG often had to work with a contracted PBM, rather than the SPAP itself, to process SPAP claims, which created communication gaps.

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<sup>8</sup> However, CMS notes that no such drug list exists.

<sup>9</sup> The NDCs are unique, universal product identifiers for drugs used in humans. They are three-segment numbers identifying the (1) labeler or manufacturer’s code (assigned by the Food and Drug Administration), (2) product code (specific strength, dosage form, and formulation for a particular firm), and (3) package code (package size and type).

<sup>10</sup> However, no NCPDP standard exists for payer-to-payer rather than payer-to-pharmacy billing.

PCG tried to set up a system to submit claims to Part D plans through RelayHealth (known at the time as Per-Se) and Daytech, but the system ultimately failed.<sup>11</sup> Automating the claims transmission process between payers proved far more difficult than even industry experts anticipated. According to PCG, each processor system had idiosyncratic edits that even process administrators did not understand; to mimic them in batch form was not a viable approach. As a result, PCG had to work out with each processor iteratively a customized system that was designed to bypass edits intended for real-time processing. The nature of the batch process was to develop the system in an iterative fashion with piece-by-piece adjustments. For example, some claims would be flagged by a system for payment and some would be flagged for denial, so PCG would have to make adjustments to the electronic claims processing system. The plan would resubmit the files, and, again, some claims would be marked for payment and some for rejection. Ultimately, CMS suspended the plan processing activities and instituted alternative processes to finalize and issue the state reimbursements prior to June 30, 2007.

A significant setback in the S2P demonstration claims processing system was that PCG failed to develop the system logic for excluding SPAP beneficiaries who were not enrolled in a PDP. As noted earlier, CMS was prohibited, by statute, from paying drug costs for beneficiaries not enrolled in a PDP. PCG acknowledged that this problem was largely a result of its failure to follow CMS instructions and as a result, some earlier state overpayments had to be recovered.

Finally, there were problems with the data exchange in the claims processing phase of the demonstration. According to PCG, the data received from states were not in a wholly NCPDP-compliant format. Indeed, PCG staff indicated that most PBMs are not equipped for batch processing and experienced problems getting the response claims from the PDPs to send to PCG. In general, the lack of preexisting automated standards for payer-to payer coordination of benefits created very significant costs and challenges in managing the data transfers and processing among all the project participants.

### **Evidence from S2P Demonstration Claims Data**

Table IV.3 presents data on the number of claims processed under the S2P demonstration. The table presents information on the total number of claims submitted as well as the final status of the claims, as of June 2007, when claims processing was terminated.

The data in Table IV.3 support some of the statements from key informants regarding the efficiency of the S2P demonstration. First, the table shows wide variation in the number of claims filed by Medicaid and SPAP programs, reflecting the size of these programs. With respect to Medicaid claims, Idaho had the smallest number (51) and New Jersey the largest

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<sup>11</sup> Per-Se was the primary switch vendor and Daytech was the software vendor for the claims adjudication process. Adjudicated claims were to be sent through Daytech's CE2000 software and on to Per-Se for routing. Per-Se established a separate portal for claims submission to prevent inappropriate transaction charges to pharmacies for claims that had already been paid to pharmacies.

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(1,532,628).<sup>12</sup> Within SPAPs, the number of claims ranged from 5,175 (Rhode Island) to 538,241 (New York). The large percentages of reversed and unprocessed claims are consistent with statements from key informants that pharmacists often submitted claims to the S2P demonstration without proper evidence of eligibility under the demonstration and that the claims submission process took considerably longer than originally envisioned. Overall, nearly 37 percent of Medicaid claims were reversed, and another 40 percent could not be processed by PCG by June 2007. Paid claims were a small fraction of total claims submitted by SPAPs, with the vast majority (78 percent) unprocessed.

The perception that problems with the S2P demonstration were greatest in the northeastern states is also substantiated from the information in Table IV.3.<sup>13</sup> Although these states did not uniformly have the highest rates of reversed and unprocessed claims for either Medicaid or SPAP programs, SPAP claims represented a large proportion of claims in most of these states (for example, SPAP claims were more than 96 percent of claims submitted in Pennsylvania and nearly 30 percent of New York's claims), and in all of these states, the percentage of unprocessed claims was high (from a low of 41 percent in Massachusetts to a high of 86 percent in Rhode Island).

## **CONCLUSIONS REGARDING THE S2P DEMONSTRATION**

Key informants had mixed reactions regarding the success of the S2P demonstration. Some states regarded it as generally successful, but pharmacists found the process confusing. In general, key informants agreed that the short time frame for developing and implementing the demonstration was the key impediment to its lack of greater success.

A number of factors were cited as sources of problems that CMS might consider when designing similar state-based safety net Part D enrollment programs in the future. First, to the extent possible, it is best to work in file formats that states are already using. Having to adapt to new formatting requirements was cited as the most difficult and time-consuming task of the demonstration. If it is necessary to revise file formats, CMS should allow states sufficient time to incorporate changes into their systems.

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<sup>12</sup> Although Nevada had one claim paid through its Medicaid program, its remaining claims were filed through the state's SPAP program.

<sup>13</sup> We are including Connecticut, Maine, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont as northeastern states for purposes of this analysis.

**Table IV.3. S2P Claims by Claim Status and State (January-March 2006)**

State	Program	Total Claims	Percent Paid Claims	Percent Reversed Claims <sup>a</sup>	Percent Unprocessed Claims <sup>b</sup>
Alaska	Medicaid	4,286	0.2	22.9	76.9
Arizona	Medicaid	71,796	6.8	74.8	18.4
Arkansas	Medicaid	66,976	20.7	19.9	59.5
California	Medicaid	668,418	20.4	32.5	47.1
Connecticut	Medicaid	216,429	14.7	46	39.3
	SPAP	5,185	3.8	30.	66.2
Delaware	SPAP	12,087	5.2	26.4	68.4
District of Columbia	Medicaid	6,959	31.8	29.7	38.5
Hawaii	Medicaid	14,876	20.2	31.2	48.6
Idaho	Medicaid	51	47.1	52.9	0
Illinois	Medicaid	188,175	20.8	28.9	50.3
Kansas	Medicaid	45,863	30.5	16	53.5
Maine	Medicaid	123,897	30.4	28	41.5
	SPAP	24,569	2.2	18.2	79.6
Maryland	Medicaid	50,184	29.2	15.0	55.8
Massachusetts	Medicaid	226,887	25.8	31.2	43.1
	SPAP	46,893	7.7	49.4	42.9
Minnesota	Medicaid	42,576	24.8	23.9	51.3
Montana	Medicaid	534	4.5	17.4	78.1
Nevada	Medicaid	1	100	0	0
	SPAP	13,280	0.7	3.8	95.5
New Hampshire	Medicaid	2,027	31.2	20.1	48.7
New Jersey	Medicaid	1,495,697	15.2	47.8	37.0
	SPAP	506,625	3.7	10.4	86.0
New Mexico	Medicaid	10,249	27.6	4.9	67.6
New York	Medicaid	1,211,381	38.4	26.4	35.2
	SPAP	536,929	8.2	17.5	74.4
North Dakota	Medicaid	4,764	14.8	23.9	61.3
Oregon	Medicaid	1,738	19.3	37.6	43.1
Pennsylvania	Medicaid	6,274	35.8	38.7	25.5
	SPAP	166,292	1.9	16.4	81.7
Rhode Island	Medicaid	19,981	15.3	43.1	41.7
	SPAP	5,175	6.5	7.2	86.3
South Dakota	Medicaid	5,621	12.3	22.8	64.9
Texas	Medicaid	269,400	20.8	22.2	57.1
	SPAP	8,961	6.2	16.6	77.1
Utah	Medicaid	19,801	26.9	24.1	49
Vermont	Medicaid	88,972	22.9	37.8	39.3
	SPAP	44,546	11	31.5	57.4
Virginia	Medicaid	81,948	30.0	30.1	39.9
Wisconsin	Medicaid	1,955	0.4	45.9	53.7
<b>Total</b>	<b>Medicaid</b>	<b>4,947,708</b>	<b>23.8</b>	<b>35.4</b>	<b>40.9</b>
	<b>SPAP</b>	<b>1,370,542</b>	<b>5.6</b>	<b>16.2</b>	<b>78.2</b>

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**Table IV.3 (continued)**

Source: Claims data provided from CMS for the S2P demonstration.

- <sup>a</sup> S2P data labeled claims as "rejected" rather than "reversed," but for purposes of this evaluation, an ineligible claim whose originally paid status was later reversed will be described as "reversed" throughout.
- <sup>b</sup> Unprocessed claims represent those that the Public Consulting Group (PCG) could not process for either paid or reversed status by the end of June 2007.

Ideally, rules for payment should be worked out beforehand, in a process of determining the overall terms and conditions of the demonstration. The fact that the S2P demonstration originated in response to states' actions complicated coordination between the states and CMS. Discussions between both parties must address the cost-sharing requirements. State respondents indicated that they believed that Medicare rules should not apply when states are paying the claim. According to states, it is more efficient to use estimated costs (rather than actual costs) if Medicare cost-sharing amounts are going to be excluded. Key informants from states also cautioned that CMS should ensure that contractors apply the appropriate rules for reimbursements to avoid the claims processing problems experienced with the SPAPs.

In general, the development of the S2P demonstration laid the groundwork for future efforts that states and CMS may undertake to facilitate access to Part D benefits for dual eligible beneficiaries. The S2P demonstration highlighted pitfalls to avoid and options to pursue now that the number of beneficiaries needing help is substantially smaller, and there is more time to test and implement new options. Although beneficiaries will continue to experience transitions in program enrollment, necessitating a point-of-sale process such as the current POS FE system, enhanced cooperation between the states and CMS could substantially reduce dependency on POS FE to ensure continuity of coverage under Part D.



## CHAPTER V

### ALTERNATIVES FOR ENSURING DRUG COVERAGE

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The point-of-sale facilitated enrollment (POS FE) process and the state-to-plan (S2P) demonstration have assisted the Centers for Medicare & Medicaid Services (CMS) in resolving transition issues between Medicaid and Medicare drug coverage for dual eligibles and low-income subsidy (LIS) eligible beneficiaries, but gaps in coverage still remain because of problems with data sharing among CMS, the states, and prescription drug plans (PDPs). All of our informants noted that eliminating information gaps is a priority, but also that any solution must be one that all 50 states and the District of Columbia are capable of implementing.

As part of our evaluation, Mathematica Policy Research, Inc. (MPR) explored two possible alternative approaches to eliminating gaps in coverage for dual eligible beneficiaries.<sup>1</sup> In the first approach, which we referred to in interviews as the “state coverage model,” state Medicaid agencies would provide drug coverage to beneficiaries as soon they become full-benefit dual eligibles up to the point in time when CMS can confirm their enrollment in a PDP. States would receive direct reimbursement from CMS in the form of federal financial participation (FFP) for the costs they incur during the transition period between eligibility and enrollment confirmation.

Under the alternative “handshake” approach, CMS would set a limit for the period of time (for example, a two- to three-month period) during which states could receive FFP for claims. Payments would cover drug costs and an administrative match for costs incurred by the Medicaid program to enroll the beneficiary in the PDP that best meets his or her needs before the transition period has ended. At the end of the transition period, the state would no longer be eligible to receive the FFP, even if the beneficiary had not yet been enrolled in a PDP. If the state failed to enroll a beneficiary in a PDP, CMS would auto-enroll him or her. The earliest effective date of enrollment would not be the date of Part D eligibility, but

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<sup>1</sup> MPR did not review existing laws or regulations to determine whether the recommendations described in this Chapter would be feasible absent a legislative or regulatory change.

the first day of the following month (as occurs with other beneficiaries). The state would be responsible for any payments before that time.

We presented each of the temporary coverage options to the states and asked for an evaluation with respect to efficiency, political will, FFP, time lines, and the need for CMS to seek a statutory change. We also asked states to suggest other alternatives.<sup>2</sup>

### **SUPPORT FOR THE STATE COVERAGE MODEL**

States were unanimous in their assessment that the state coverage model would be more feasible than the handshake approach. However, there was some variation with respect to the willingness among states to implement the changes required to set up this type of system. For example, one state key informant noted that many states had been reluctant to give up the provision of drug coverage for dual eligibles to CMS and expressed unwillingness to expend state resources on managing problems within the new system.<sup>3</sup> A second state key informant expressed similar concerns regarding state budgets and the need to make administrative staffing changes under either model. This informant noted that many states cannot afford to hire new staff to deal with problems that arise and suggested that the federal government would be in a better position to make investments to overcome coverage problems. Another state key informant expressed support for the state coverage model but indicated that CMS's first priority should be to improve its data systems to meet the needs of a real-time data-sharing environment.

Most of our state informants suggested that the state coverage model would not be difficult to implement, and, in some cases, the states already had similar types of systems in place. One state informant we interviewed said that the state currently tracks Part D information and overrides denials based on Part D coverage at the individual level (based on dates spanning a particular period of time) to allow Medicaid to continue to pay for a person's medications (if state payment is necessary) even after the state has evidence of that beneficiary's Medicare eligibility. According to this informant, implementing the state coverage model would probably not require a substantial amount of time or financial investment, but it would require clear guidelines from CMS and an understanding of the availability of matching funds. Two other state informants that expressed strong support for the state coverage model indicated that the political will likely existed to implement this type of model, and a change in state laws would likely be unnecessary. The biggest obstacle,

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<sup>2</sup> As discussed at greater length later, states did not express favorable opinions toward the handshake approach; most of the discussion focused on the state coverage model. States also did not suggest any alternatives to these two approaches.

<sup>3</sup> Although informants from other states admitted a similar "gut reaction" (that is, if the federal government has control of the drug benefits, it should be its responsibility to ensure that the system meets the needs of all beneficiaries), they said that it was not practical to expect CMS to overcome coverage problems without state assistance. At least one informant suggested that this sentiment might be more common in states in which the pharmacy benefit has traditionally been more isolated from other Medicaid benefits within the state. This suggests one difficulty CMS might face in designing a system that all states can, and will, use to eliminate gaps in coverage.

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according to informants we spoke to, would be the need to make changes to existing computer systems. Depending on the type of system changes required, an informant from one of the larger states thought that it could have a system up and running in 9 to 12 months.

The following points highlight suggestions from the states for ways to facilitate a state coverage model:

- **Enhance Communication Between Medicaid and Medicare.** State informants suggested that there should be regular communication between leaders of state Medicaid programs and CMS and that both parties need to be seen as equal partners in order to ensure better cooperation.
- **Provide Incentives to States to Participate.** Several informants suggested that CMS focus on revising the clawback as a means of encouraging state participation. One state key informant suggested that states get credit for any time that the state provides coverage for the beneficiary. Another state key informant said that financial support (that is, the FFP and the clawback) would be the most important component of such a state and federal partnership; this informant also indicated his belief that states should not have to pay clawback on the coverage they provide.
- **Ensure Good Communication with PDPs.** State informants wanted some assurance that they could communicate easily with PDPs to address issues regarding third-party reimbursements (for example, to identify beneficiaries already enrolled in a PDP in order to recover those costs).
- **Provide Clear Rules for Use in an Automated System.** To facilitate the development of data systems, one state informant noted the need for CMS to provide clear rules for implementation that could be readily incorporated into an automated system in order to ensure the efficiency of the system.
- **Use Existing File Formats.** In light of the problems states faced in setting up their systems under the S2P demonstration, several state informants noted that the most efficient approach would be to use existing formats or find ways to easily modify them for a new system.

## CONCLUSIONS REGARDING POSSIBLE ALTERNATIVE MODELS

All parties we spoke to recognized the need to improve coverage for low-income Medicare beneficiaries by eliminating gaps in coverage that occur as a result of data sharing among the states, CMS, and PDPs. State officials we spoke to were supportive of the state coverage model. Most believed that it would not involve much additional expense to implement; however, some state officials we spoke to were concerned about how such an agreement would affect clawback payments. In general, representatives from these states thought that the most efficient means of implementing a future safety net for full-benefit dual eligibles along the lines of the state coverage model would be to use or adapt existing file formats. However, the alternatives discussed would not address the problems of

beneficiaries who change plans or otherwise create their own gaps in drug coverage. It may be necessary to maintain the POS FE process in order to ensure continuity of coverage for these beneficiaries.

## CHAPTER VI

### CONCLUSIONS

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Moving forward, the Centers for Medicare & Medicaid Services (CMS) should consider a number of issues when working to improve existing systems or developing new methods for ensuring drug coverage for all eligible low-income Medicare beneficiaries. The three main problems that interview respondents mentioned were (1) gaps in coverage that beneficiaries experience because of plan changes, (2) lack of awareness of the role of the point-of-sale facilitated enrollment (POS FE) process, and (3) unmet needs of long-term care pharmacies. Each of these challenges is discussed separately here. State representatives and pharmacists mentioned a number of additional issues not directly related to the POS FE or state-to-plan (S2P) systems, but ones that CMS might consider when seeking ways to improve drug coverage among low-income beneficiaries under Part D; these suggestions are also included in this chapter.

#### **GAPS IN COVERAGE DUE TO PLAN CHANGES**

Several informants noted that beneficiaries create their own gaps in coverage as a result of the special enrollment period (SEP). SEPs are “open season” periods when beneficiaries can enroll in, disenroll from, or change their Medicare drug plan outside of the standard enrollment periods. The length of the SEP and the date when new coverage starts vary depending on the reason for the SEP. Dual eligible and other low-income subsidy (LIS) eligible beneficiaries automatically qualify for an SEP, whereby they can join, disenroll, or switch plans once a month. Other beneficiaries can qualify for SEPs under a variety of special circumstances (CMS 2007).

Beneficiaries may also create gaps in insurance coverage through voluntary plan changes. For example, an LIS-eligible beneficiary may voluntarily disenroll from a PDP and fail to re-enroll in another plan before coverage is needed. That is, the patient may arrive at the pharmacy without having re-enrolled in a plan, thereby creating a gap in coverage.

Pharmacists we spoke with concurred that those people who are now showing up at the pharmacy counter without evidence of coverage are generally those who have made a transition (for example, they have either disenrolled from a plan or are on Medicaid and

newly eligible for Medicare).<sup>1</sup> These gaps in coverage create problems for beneficiaries and the pharmacies that serve them. Pharmacists said that they generally find some way to ensure that the patient leaves the pharmacy with the needed medications, but in some cases, they are not aware that a change has been made. In the latter instance, the pharmacy may bill the patient's old plan and find out six months later that it billed the wrong plan; in some cases, the new plan will not cover the drug. To avoid such problems, pharmacies suggested that CMS require patients who change plans to do so by the 15th of the month (rather than the end of the month, as is currently permitted), with new coverage effective the following month. However, although this approach would help avoid ongoing coverage gaps resulting from plan switching, CMS staff noted that such a change would not be permitted under current laws and regulations, nor could CMS systems effectuate such a change.

The POS FE process may be able to capture many of these beneficiaries; however, pharmacists noted that even though the POS FE process generally works well, there are problems during the first week of January (when many beneficiaries become newly eligible for Medicare or are changing plans under the Open Enrollment Period). One suggestion was for CMS to change PDP start dates to March 1 in order to decrease the volume of changes that occur during the same period of time. However, CMS noted that the MMA stipulates that coverage begin January 1 of the following calendar year; therefore, this is also not a change that CMS could make.

### **ONGOING ROLE OF THE POS FE PROCESS**

A number of key informants indicated that many pharmacists are unaware of the POS FE process. In chain drug stores, a pharmacy student or pharmacy technician, rather than the pharmacist, is the attendant at the counter handling payments. Given high turnover among these employees, pharmacy staff members are not always aware of the claim submission options available to them. Staff at RelayHealth noted that this problem is not unique to the POS FE process but is common to the pharmacy industry at large. CMS staff members acknowledged that they had heard anecdotal reports about this problem and had already been looking into ways to better communicate with pharmacy staff.

There appears to be a difference in perception regarding the role of the POS FE process for providing continuity of coverage. Staff at WellPoint believed that the POS FE process was being used inappropriately as a safety net for the entire Part D industry. For example, as mentioned in an earlier chapter, the edit to reject claims greater than 30 days old (implemented in January 2007) was seen as particularly burdensome for long-term care pharmacies because they usually submit claims in batches. WellPoint staff indicated that the POS FE process was never intended for long-term care pharmacies because it is a point-of-sale system. CMS staff disagreed with this assessment, countering that the term point of sale may be a misnomer. According to CMS, the POS FE process was intended for anyone who

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<sup>1</sup> However, pharmacists we spoke to also said that they often see patients who simply do not understand that they need to bring their insurance card with them. According to these interview respondents, such patients are used to the more automated system of coverage under Medicaid.

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is missed by the system and not auto-enrolled in a plan (that is, any eligible beneficiary, including those in long-term care settings, who has an immediate need for a drug). This would include many long-term care residents who spend down to Medicaid eligibility; these beneficiaries, who are often infirm and incapable of making technical decisions on their own behalf, represent a substantial patient base for long-term care pharmacies.

WellPoint staff also suggested that the POS FE program itself introduces inefficiencies. For example, given that the POS FE contract has been awarded on an annual basis, there is a disincentive for the company to invest in new technology. WellPoint recommended extending the contract to a three-year period instead. In addition, both WellPoint and RelayHealth noted that if a new contractor were brought in to manage the POS FE process, that contractor would have to establish an independent system of edits with RelayHealth, because many of the edits in the POS FE process were developed by and are proprietary to WellPoint. CMS staff acknowledged that these are legitimate concerns but also noted two primary reasons why the contract has been managed this way. First, there was a need to get the program up and running with the intention of working out problems within the system on an ongoing basis. Second, given that CMS must work with a PDP, and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires autoenrollment only in plans below the benchmark; if WellPoint were to change its plan offerings, it could put this statutory requirement at risk.<sup>2</sup>

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<sup>2</sup> As noted in an earlier chapter, several other national PDPs that fulfill the requirements for participation were given the opportunity to bid on the POS FE contract but did not accept CMS's offer to do so. As such, WellPoint remains the only organization capable and willing to provide POS FE coverage.



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**APPENDIX A**

**DRAFT INTERVIEW GUIDE: CMS STAFF**

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## I. Introduction and Project Background

Hello, this is \_\_\_\_\_ from Mathematica Policy Research. We scheduled this time to talk with you about your knowledge and experience regarding [Point-of-Sale Facilitated Enrollment Process (POS FE)/State to Plan demonstration]. Is this still a good time for you? Are there any particular time constraints we should know about before we start?

As I said, my name is \_\_\_\_\_, and I'm a [title] here at MPR, and I'm joined by \_\_\_\_\_, [title]. During this interview, I'll be asking most of the questions. \_\_\_\_\_ will be mostly listening and taking notes, or following up on some points that I may have missed. Please let us know if any of the questions we ask are not within your realm of knowledge or experience and we can move on to the next question. Also, please note that this set of questions is meant to serve as an interview guide; if there are any topics not addressed in our discussion that you believe would contribute to our understanding, please feel free to raise them.

Do you have any questions at this time?

Before we start our questions, can each person participating in the call please tell us your name, your title, your role in the organization, and your responsibilities with respect to the [Point-of-Sale Facilitated Enrollment (POS FE) Process/State to Plan demonstration].

**QUESTIONS REGARDING THE POINT OF SALE FACILITATED ENROLLMENT PROCESS****II. Point of Sale Facilitated Enrollment Process**

- 1) Please describe the POS FE process.
  - a) How did this process differ between dual eligibles and other low-income Medicare beneficiaries?
- 2) Prior to this interview, we sent a set of flowcharts that describe the process for getting full benefit dual eligibles and other LIS-eligible beneficiaries who show up at a pharmacy without drug coverage enrolled in a Part D plan. Do the flowcharts accurately capture the administrative procedures for getting low-income Medicare beneficiary enrolled in a Part D plan at the point-of-sale? If not, what changes would be necessary to more accurately describe the process?
- 3) In general, how well has the POS FE process worked in getting unassigned LIS-eligible beneficiaries enrolled in a Part D plan?
  - a) What aspects of the process have worked well?
  - b) What aspects of the process have been problematic?
- 4) What changes has CMS made to these procedures since implementation of Part D to improve the efficiency of enrollment through the Point of Sale process?
  - a) What have been the effects of these changes?
  - b) Is CMS considering any other changes to further improve the Point of Sale enrollment process? *If so*, please describe these changes.
- 5) What has been your experience working with WellPoint?
  - a) How well was WellPoint able to adapt to changes in the Point of Sale Process during the first few months of 2006?
  - b) CMS opened bidding for the 2007 version of the Point of Sale process to other potential contractors. What reasons did the other potential bidders give for not submitting a bid for the contract? **Probe:** Has CMS continued to explore the possibility of teaming with a different contractor on the Point of Sale process? *If not*, why not?
- 6) What has CMS done to ensure that beneficiaries and providers are aware of the option of enrolling unassigned beneficiaries in a Part D plan at the point of sale?

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- a) Do you think CMS's communications with these groups have been adequate? **If not**, what could be done to communicate more effectively with these groups?
  - b) What kinds of feedback has CMS received from beneficiaries regarding the Point of Sale process?
  - 7) What kinds of feedback has CMS received from pharmacists regarding the Point of Sale process?
    - a) Have pharmacists expressed any difficulty obtaining the information necessary to verify Medicaid or Medicare eligibility?
    - b) Has CMS made any changes to the process as a result of feedback received from pharmacists?
    - c) Have you noticed any changes in the willingness of pharmacists to utilize the Point of Sale process? (i.e., as the Point of Sale system has been modified, have pharmacists become more or less willing to utilize it?)
  - 8) How well has the enhanced E1 query worked?
    - a) How accurately does the query identify eligible beneficiaries?
    - b) Have pharmacists reported any difficulties using the system?
    - c) How have the changes to the E1 query affected the efficiency of the Point of Sale process?
  - 9) What kinds of feedback have you received from states regarding the Point of Sale process?
    - a) Have states been encouraging beneficiaries to make use of the Point of Sale process? **If not**, why not?

### III. Direct to State Reimbursement

- 10) Can you describe the Direct to State reimbursement system that CMS has been considering?
  - a) What administrative efficiencies would you expect to be attained under the Direct to State approach? **Probe:** What new administrative systems would CMS have to implement in order to establish this type of payment system?
  - b) What types of cost savings would you expect under the Direct to State approach? **Probe:** What additional costs would CMS face in establishing this system?

- c) What are the challenges to implementing the Direct to State model?
  - d) In your opinion, how likely is it that CMS will pursue a demonstration to test the efficiency of the Direct to State approach? **Probe:** How difficult would it be to receive statutory authority to implement this model of reimbursement?
- 11) In your opinion, how willing will states be to participate in a Direct to State process?
- a) What would be the benefits to the states to participating in a Direct to State model? **Probe:** What would be the drawbacks?
  - b) Do you believe that states have the administrative structures in place to accommodate a Direct to State model?
  - c) **Probe:** What incentives do you think CMS would need to offer to encourage state participation under a Direct to State payment mechanism?
  - d) Are there any other approaches has CMS been considering to ensure continuity of drug coverage for low-income Medicare beneficiaries? If so, what other approaches have been considered?

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## QUESTIONS FOR STAFF INVOLVED WITH THE STATE TO PLAN DEMONSTRATION

### II. State to Plan Demonstration

- 1) Please describe the process for states to receive reimbursement under the State to Plan demonstration.
  - a) How did this process differ between Medicaid agencies and State Pharmaceutical Assistance Programs (SPAPs)?
- 2) What led CMS to establish the State to Plan demonstration?
  - a) Was it something CMS had been considering or was it primarily a response to states' actions in providing temporary coverage for Part D drugs during the transition?
  - b) What challenges did CMS face in establishing the State to Plan demonstration?
  - c) CMS' announcement of the demonstration indicates that a workgroup of states provided input in the development of the template for the demonstration. Which states (officials) participated in this workgroup? What type of input did the workgroup provide? How useful was it?
  - d) According to published resources, CMS created a team to conduct expedited review of State applications for the State to Plan demonstration. What were the goals of this expedited review process? **Probe:** How well did it work?
  - e) What other aspects of establishing the State to Plan demonstration have worked well?
  - f) What aspects of the process have been problematic?
- 3) The original cut-off date for the demonstration was February 15, 2006. At what point was the decision made to extend the demonstration to March 8th? **Probe:** Why use March 8th as the revised date? Why were some state given extensions past March 8th?
- 4) In what ways was the State to Plan demonstration successful in improving access to drug coverage for dual eligible and other LIS-eligible beneficiaries during the transition to Part D?
  - a) In what ways could the State to Plan demonstration have been improved to better meet the needs of eligible beneficiaries?

- b) Did the State to Plan process work better or worse for full dual eligibles versus other groups of beneficiaries? If so, how?
- 5) What was your experience working with PCG?
    - a) How well were they able to work with states to verify eligibility and manage reimbursements?
    - b) How well were they able to work with Part D plans to determine the amounts owed under the State to Plan demonstration?
    - c) How would you rate the efficiency of the work they performed? Probe: Were there aspects of their operations that you believe could have been run more efficiently?
  - 6) CMS processed claims for excluded Part D drugs using the Drug Data Processing System (DDPS). Available documentation indicates that the DDPS had to be updated for claims processing and that developing the drug filter took longer than expected. What was the source of delay in developing the drug filter?
  - 7) What types of feedback did you receive from the states regarding the State to Plan demonstration?
    - a) Did states provide input to CMS on ways to enhance plan and program performance in order to reduce state billing? If so, What type of input did CMS receive? Probe: Did CMS act on the information received? If so, What measures were undertaken?
    - b) Did States provide data on beneficiaries who were not included properly in the State's previous dual eligible files? If so, How many of these cases were encountered?
    - c) Were there costs to states in providing temporary coverage that could not be covered under the State to Plan demonstration? If so, what types of costs were not covered?
    - d) Did the states express any difficulties regarding the process of submitting claims for reimbursement? If so, what types of problems did the states encounter?

### **III. Direct to State Reimbursement**

- 8) Can you describe the Direct to State reimbursement system that CMS has been considering?

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- a) What administrative efficiencies would you expect to be attained under the Direct to State approach? **Probe:** What new administrative systems would CMS have to implement in order to establish this type of payment system?
  - b) What types of cost savings would you expect under the Direct to State approach? **Probe:** What additional costs would CMS face in establishing this system?
  - c) What are the challenges to implementing the Direct to State model?
  - d) In your opinion, how likely is it that CMS will pursue a demonstration to test the efficiency of the Direct to State approach? **Probe:** How difficult would it be to receive statutory authority to implement this model of reimbursement?
- 9) In your opinion, how willing will states be to participate in a Direct to State process?
- a) What would be the benefits to the states to participating in a Direct to State model? **Probe:** What would be the drawbacks?
  - b) Do you believe that states have the administrative structures in place to accommodate a Direct to State model?
  - c) **Probe:** What incentives do you think CMS would need to offer to encourage state participation under a Direct to State payment mechanism?
- 10) What other approaches has CMS been considering to ensure continuity of drug coverage for low-income Medicare beneficiaries?

**V. Conclusion**

- 1) In order to aid our understanding of the [Point of Sale/State to Plan] demonstration, as well as the Direct to State reimbursement model, are there any topics we have not yet covered (or questions that we have not asked) that we should now discuss?
- 2) If, in the near future, we have any future questions regarding answers provided during this interview or if any other future questions arise, may we contact you? **If yes**, what would be the most appropriate way to reach you?

*Thank you very much for your help today. Good bye.*

**APPENDIX B**

**DRAFT INTERVIEW GUIDE: STATES  
(CALIFORNIA, FLORIDA, MICHIGAN,  
MISSOURI, SOUTH CAROLINA, AND  
TEXAS)**



## I. Introduction and Project Background

Hello, this is \_\_\_\_\_ from Mathematica Policy Research. We scheduled this time to talk with you about your knowledge and experience regarding (1) approaches for ensuring prescription drug coverage for full benefit dual eligibles and other LIS-eligible beneficiaries during the transition to the Medicare Part D program during 2006 and (2) the feasibility of an alternative reimbursement approach. Is this still a good time for you? Are there any particular time constraints we should know about before we start?

As I said, my name is \_\_\_\_\_, and I'm a [title] here at MPR, and I'm joined by \_\_\_\_\_, [title].

During this interview, I'll be asking most of the questions. \_\_\_\_\_ will be mostly listening and taking notes, or following up on some points that I may have missed. Please let us know if any of the questions we ask are not within your realm of knowledge or experience and we can move on to the next question. Also, please note that this set of questions is meant to serve as an interview guide; if there are any topics not addressed in our discussion that you believe would contribute to our understanding, please feel free to raise them.

Do you have any questions at this time?

Before we start our questions, can each person participating in the call please tell us your name, your title, your role in the organization, and your responsibilities with respect to the State to Plan demonstration. ***(Note: not relevant to Michigan, Missouri, and South Carolina)***

**QUESTIONS FOR MICHIGAN AND SOUTH CAROLINA****(Did not provide temporary coverage/did not participate in S2P demonstration)****II. State to Plan Demonstration**

- 1) Prior to the implementation of the Part D program, was there any evidence to suggest that low-income Medicare beneficiaries in your state (including full benefit dual eligibles) might experience problems accessing medications during the transition to Part D?
- 2) During the first few weeks of January 2006, did you receive any anecdotal reports (or other evidence) of low-income Medicare beneficiaries experiencing gaps in drug coverage as a result of the transition to Part D?
  - a) **If so**, what types of problems did these beneficiaries encounter?
- 3) During the first few weeks of January 2006, did your state consider providing temporary drug coverage for low-income Medicare beneficiaries during the transition to Part D?
  - a) **If so**, in the end, what led the state to decide against providing temporary coverage?
  - b) **If not**, why not?
- 4) *On January 24, 2006, CMS announced the availability of a demonstration to reimburse states for some costs incurred to provide temporary drug coverage for low-income Medicare beneficiaries.* Did the announcement of this demonstration cause your state to reconsider its decision not to provide temporary drug coverage?
  - a) What were your thoughts about the demonstration?

*CMS cannot identify dual eligible and other low-income Medicare beneficiaries until states and the Social Security Administration have provided information on the individual's eligibility for Medicaid or the low-income subsidy via monthly reporting files. The delay in processing these files creates a gap in effective access to drug coverage for some beneficiaries. CMS and the states have taken steps to minimize this problem.*

- 5) What steps has your state undertaken to minimize gaps in drug coverage caused by these data processing delays?
  - a) **Probe:** What insight do you have regarding why these processing delays occur?
  - b) **Probe:** In your view, are these delays unavoidable, or could something be done to decrease their likelihood? *If so*, what?

### III. Direct to State Reimbursement

*CMS has explored a number of alternative demonstration approaches for ensuring drug coverage for dual eligible and other LIS-eligible beneficiaries.*

*One possibility is to test whether Medicaid agencies should provide drug coverage to beneficiaries when they become full benefit dual eligible to the point in time when CMS can confirm their enrollment in a prescription drug plan (PDP). States would then receive direct reimbursement from CMS in the form of Federal financial participation (FFP) for the costs they incur during the transition period between eligibility and enrollment confirmation. This type of direct-to-state (DTS) reimbursement model would have to be tested under a demonstration and proven more administratively and cost efficient for CMS in order to support a statutory change.*

- 1) What would be the benefits of this approach?
- 2) What might be some drawbacks?

*One alternative under the DTS approach would be to limit the period of time when states could receive FFP for claims (say a two – three month period). In addition to reimbursements for drug costs, the states would receive an administrative match under Medicaid to enroll the dual in the Part D plan that best meets his/her needs before the 2 to 3 transition period has ended. Once the transition period has ended, the state would no longer be eligible to receive the FFP, even if the beneficiary is not yet enrolled in Part D plan. In circumstances when the state could not enroll a beneficiary in a Part D plan, CMS would auto-enroll the beneficiary, however, the earliest effective date of enrollment will not be date of eligibility, but the first day of the month, like other beneficiaries. The state would be responsible for any payments before then.*

- 3) What would be the benefits of this approach?
- 4) What might be some drawbacks?
- 5) Do the administrative structures presently exist within your state to facilitate this type of payment arrangement? ***If not...***
  - a) What changes would be required to facilitate this type of payment mechanism?
  - b) What kind of investments would the state have to make to implement these changes?
- 6) What incentives would encourage state participation under this approach?

**QUESTIONS FOR MISSOURI**

**(Applied for the S2P demo but did not submit any administrative or drug claims for reimbursement under S2P)**

**II. State to Plan Demonstration**

- 1) Can you briefly describe the nature of the assistance the state provided during the transition to Medicare Part D?
  - a) What was the effective period of coverage?
  - b) What was covered?
  - c) Which beneficiaries were covered (both dual eligibles and SPAP members)?
  - d) What were the political or policy circumstances regarding this action (e.g., via executive order by governor, action by the legislature, etc.)
- 2) What prompted your state to provide temporary drug coverage for low-income Medicare beneficiaries during the transition to Part D? *(e.g., foresaw problems in Part D implementation, responded to CMS announcement of State to Plan demonstration, pharmacist unable to process claims)*
- 3) About how many beneficiaries did you expect to receive assistance during the period of transition?
  - a) Did you expect that most of these beneficiaries would receive their medications through CMS' POS facilitated enrollment process? *(This is the process through which pharmacists can fill prescriptions by temporarily enrolling a dual eligible or other low-income Medicare beneficiary in one of WellPoint's Unicare plans)*
  - b) Did the state receive reports of pharmacies refusing to use the Point of Sale system? *If so, how common were these reports?*
- 4) CMS' records indicate that although your state submitted an application to participate in its State to Plan demonstration, it did not file any claims associated with the demonstration. What were the reasons the state ended up not applying for reimbursement? *(This was a payment demonstration whereby states could recover some administrative and drug costs associated with providing temporary drug coverage to dual eligible and other LIS-eligible beneficiaries.)*

*CMS cannot identify dual eligible and other low-income Medicare beneficiaries until states and the Social Security Administration have provided information on the individual's eligibility for Medicaid or the low-income subsidy via monthly reporting files. The delay in processing these files creates a gap in effective access to drug coverage for some beneficiaries. CMS and the states have taken steps to minimize this problem.*

- 5) What steps has your state undertaken to minimize gaps in drug coverage caused by these data processing delays?
  - a) **Probe:** What insight do you have regarding why these processing delays occur?
  - b) **Probe:** In your view, are these delays unavoidable, or could something be done to decrease their likelihood? **If so**, what?

### III. Direct to State Reimbursement

*CMS has explored a number of alternative demonstration approaches for ensuring drug coverage for dual eligible and other LIS-eligible beneficiaries.*

*One possibility is to test whether Medicaid agencies should provide drug coverage to beneficiaries when they become full benefit dual eligible to the point in time when CMS can confirm their enrollment in a prescription drug plan (PDP). States would then receive direct reimbursement from CMS in the form of Federal financial participation (FFP) for the costs they incur during the transition period between eligibility and enrollment confirmation. This type of direct-to-state (DTS) reimbursement model would have to be tested under a demonstration and proven more administratively and cost efficient for CMS in order to support a statutory change.*

- 1) What would be the benefits of this approach?
- 2) What might be some drawbacks?

*One alternative under the DTS approach would be to limit the period of time when states could receive FFP for claims (say a two – three month period). In addition to reimbursements for drug costs, the states would receive an administrative match under Medicaid to enroll the dual in the Part D plan that best meets his/her needs before the 2 to 3 transition period has ended. Once the transition period has ended, the state would no longer be eligible to receive the FFP, even if the beneficiary is not yet enrolled in Part D plan. In circumstances when the state could not enroll a beneficiary in a Part D plan, CMS would auto-enroll the beneficiary, however, the earliest effective date of enrollment will not be date of eligibility, but the first day of the month, like other beneficiaries. The state would be responsible for any payments before then.*

- 3) What would be the benefits of this approach?
- 4) What might be some drawbacks?

- 5) Do the administrative structures presently exist within your state to facilitate this type of payment arrangement? ***If not...***
  - a) What changes would be required to facilitate this type of payment mechanism?
  - b) What kind of investments would the state have to make to implement these changes?
- 6) What incentives would encourage state participation under this approach?

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## QUESTIONS FOR CALIFORNIA, FLORIDA, AND TEXAS

(Received drug and/or administrative payments under S2P )

### II. State to Plan Demonstration

- 1) Can you briefly describe the nature of the assistance the state provided during the transition to Medicare Part D?
  - a) What was the effective period of coverage?
  - b) What was covered?
  - c) Which beneficiaries were covered (e.g., dual eligibles, SPAP, other low-income beneficiaries)?
  - d) What were the political or policy circumstances regarding this action (e.g., via executive order by governor, action by the legislature, etc.)
  - e) **Texas only:** Were there any differences in how the program operated for dual eligibles versus SPAP beneficiaries? **If so**, please describe these differences.
- 2) What prompted your state to provide temporary drug coverage for low-income Medicare beneficiaries during the transition to Part D? (*e.g., foresaw problems in Part D implementation, responded to CMS announcement of State to Plan demonstration*)
- 3) About how many beneficiaries did you expect to receive assistance during the period of transition?
  - a) How did you expect that beneficiaries would receive their medications upon transition from Medicaid to Medicare? **Probe:** Did you expect that most of these beneficiaries would receive their medications through CMS' POS facilitated enrollment process? (*This is the process through which pharmacists can fill prescriptions by temporarily enrolling a dual eligible or other low-income Medicare beneficiary in one of WellPoint's Unicare plan*)
  - b) Did the state receive reports of pharmacies refusing to use the Point of Sale system? **If so**, how common were these reports?
- 4) Can you describe the administrative process for participating in the State to Plan demonstration?
  - a) Were there any administrative changes you had to implement in order to participate?
  - b) How administratively efficient was the State to Plan demonstration? **Probe:** Were there stages in the process that you felt could have been implemented more efficiently? **If so**, how?

- 5) *One requirement for participation in the State to Plan demonstration was for States to provide input to CMS and Part D plans on ways to enhance plan and program performance in order to reduce state billing. Did your state provide input to CMS and Part D plans? **If so**, What type of input did you provide? Do you feel your input was acted upon?*
- 6) *Another requirement for participation was for States to provide data on beneficiaries who may not have been included properly in the State's previous dual eligible files. How many of these cases were encountered in your state?*
- 7) What was your experience with obtaining reimbursement under the State to Plan demonstration?
  - a) What was the process for creating claims files? How difficult was it to meet formatting requirements? **If state encountered difficulties with claim formatting**, What made it difficult to comply with the formatting requirements?
  - b) Did the demonstration cover all of the costs your state incurred in providing temporary drug coverage for low-income Medicare beneficiaries?
    - i) What were the components of your costs?
    - ii) What types of expenses were not covered by the demonstration?
    - iii) For how many beneficiaries did the state end up making payments that were unrecoverable through the State to Plan demonstration?
  - c) Has your state received all eligible payments for expenses incurred under the State to Plan demonstration?
    - i) **If yes**, how long did it take to receive reimbursement?
    - ii) **If not**, What is the total of all outstanding expenses that the state has not yet received?
- 8) Overall, how well did State to Plan demonstration work?
  - a) What were the benefits of the State to Plan approach? **Probe:** What worked well?
  - b) What were the drawbacks to the State to Plan approach? **Probe:** How could the process have been improved?
  - c) Now that the state has had experience submitting claims directly to the Part D Sponsor for reconciliation (*post State to Plan demonstration*), which process results in less administrative burden (i.e., cost) on the state?

*CMS cannot identify dual eligible and other low-income Medicare beneficiaries until states and the Social Security Administration have provided information on the*

*individual's eligibility for Medicaid or the low-income subsidy via monthly reporting files. The delay in processing these files creates a gap in effective access to drug coverage for some beneficiaries. CMS and the states have taken steps to minimize this problem.*

- 9) What steps has your state undertaken to minimize gaps in drug coverage caused by these data processing delays?
  - a) **Probe:** What insight do you have regarding why these processing delays occur?
  - b) **Probe:** In your view, are these delays unavoidable, or could something(s) be done to decrease their likelihood? *If so*, what?

### III. Direct to State Reimbursement

*CMS has explored a number of alternative demonstration approaches for ensuring drug coverage for dual eligible and other LIS-eligible beneficiaries.*

*One possibility is to test whether Medicaid agencies should provide drug coverage to beneficiaries when they become full benefit dual eligible to the point in time when CMS can confirm their enrollment in a prescription drug plan (PDP). States would then receive direct reimbursement from CMS in the form of Federal financial participation (FFP) for the costs they incur during the transition period between eligibility and enrollment confirmation. This type of direct-to-state (DTS) reimbursement model would have to be tested under a demonstration and proven more administratively and cost efficient for CMS in order to support a statutory change.*

- 1) What would be the benefits of this approach?
- 2) What might be some drawbacks?

*One alternative under the DTS approach would be to limit the period of time when states could receive FFP for claims (say a two – three month period). In addition to reimbursements for drug costs, the states would receive an administrative match under Medicaid to enroll the dual in the Part D plan that best meets his/her needs before the 2 to 3 transition period has ended. Once the transition period has ended, the state would no longer be eligible to receive the FFP, even if the beneficiary is not yet enrolled in Part D plan. In circumstances when the state could not enroll a beneficiary in a Part D plan, CMS would auto-enroll the beneficiary, however, the earliest effective date of enrollment will not be date of eligibility, but the first day of the month, like other beneficiaries. The state would be responsible for any payments before then.*

- 3) What would be the benefits of this approach?
- 4) What might be some drawbacks?

- 5) Do the administrative structures presently exist within your state to facilitate this type of payment arrangement? *If not...*
  - a) What changes would be required to facilitate this type of payment mechanism?
  - b) What kind of investments would the state have to make to implement these changes?
- 6) What incentives would encourage state participation under this approach?

#### IV. Conclusion

- 1) In order to aid our understanding of the State to Plan demonstration, as well as the potential for a Direct to State reimbursement model, are there any topics we have not yet covered (or questions that we have not asked) that we should now discuss?
- 2) If, in the near future, we have any future questions regarding answers provided during this interview or if any other future questions arise, may we contact you? **If yes**, what would be the most appropriate way to reach you?

*Thank you very much for your help today. Good bye.*



**APPENDIX C**

**DRAFT INTERVIEW GUIDE: CONTRACTORS  
(WELLPOINT, RELAY HEALTH, Z-TECH,  
PUBLIC CONSULTING GROUP)**



## I. Introduction and Project Background

Hello, this is \_\_\_\_\_ from Mathematica Policy Research. We scheduled this time to talk with you about your knowledge and experience regarding the [Point of Sale/State to Plan] demonstration. Is this still a good time for you? Are there any particular time constraints we should know about before we start?

As I said, my name is \_\_\_\_\_, and I'm a [title] here at MPR, and I'm joined by \_\_\_\_\_, [title]. During this interview, I'll be asking most of the questions. \_\_\_\_\_ will be mostly listening and taking notes, or following up on some points that I may have missed. Please let us know if any of the questions we ask are not within your realm of knowledge or experience and we can move on to the next question. Also, please note that this set of questions is meant to serve as an interview guide; if there are any topics not addressed in our discussion that you believe would contribute to our understanding, please feel free to raise them.

Do you have any questions at this time?

Before we start our questions, can each person participating in the call please tell us your name, your title, your role in the organization, and your responsibilities with respect to the [Point of Sale/State to Plan] demonstration.

**QUESTIONS FOR WELLPOINT****II. Point of Sale Facilitated Enrollment**

- 1) Can you briefly describe how the Point of Sale process operates, from WellPoint's perspective?
- 2) *Prior to this interview, we sent a set of flowcharts designed to describe various sequences possible (including the Point of Sale facilitated enrollment process) for full benefit dual eligibles and other LIS-eligible beneficiaries to enroll in a Part D plan.* Do the flowcharts accurately capture the administrative steps necessary for a low-income Medicare beneficiary to enroll in a Part D plan through the Point of Sale process? ***If not***, what revisions are necessary?
  - a) Can you walk us through how modifications were made to the adjudication process since Part D began in January 2006? (note: The three flowcharts are organized around our understanding of the modifications made to this process between January 2006 and the present)
  - b) We understand that, in some cases, WellPoint has paid claims for beneficiaries under the Point of Sale process that should have been paid for by another Part D plan. How does the plan-to-plan reconciliation process work in these cases?
    - i) How successful has WellPoint been in recovering payments for these claims?
    - ii) What percentage of claims have been unrecoverable?
    - iii) Have administrative changes in the Point of Sale process contributed to WellPoint's ability to recover its costs? ***If so***, how? (e.g., have there been fewer ineligible payments?)
- 3) What changes have been made since implementation of Part D to improve the efficiency of enrollment through the Point of Sale process?
  - a) What have been the effects of these changes?
  - b) Are there additional approaches being considered that could further improve the enrollment process?
- 4) What kinds of feedback have you received from pharmacists regarding the Point of Sale process?
  - a) Have you made any changes to the process as a result of feedback received from pharmacists?

- b) As the Point of Sale system has been modified, have there been any changes in the willingness of pharmacists to utilize the Point of Sale process? (i.e., have pharmacists become more or less willing to utilize it?)

**QUESTIONS FOR RELAY HEALTH****II. Point of Sale Facilitated Enrollment**

- 1) Can you briefly describe Relay Health's role on the Point of Sale facilitated enrollment process?
  - a) How does Relay Health make eligibility and enrollment determinations for the Point of Sale process?
  - b) Have you experienced any problems coordinating with payers (e.g., Part D plans, Medicare Advantage Prescription Drug Plans or carriers of supplemental coverage) to track cost-sharing payments?
  - c) How well has the determinations process worked? **Probe:** Are there ways the process could be improved? *If so*, how?
- 2) How have changes in the E1 query affected the efficiency of the Point of Sale process?
  - a) How accurately does the enhance E1 query identify eligible beneficiaries?
  - b) Have pharmacists reported any difficulties using the system?
- 3) What feedback have you received from pharmacists regarding the Point of Sale process?
  - a) Have you received any feedback from pharmacists regarding the E1 query? *If so*, what have you heard?
- 4) What has been your experience working with WellPoint?
  - a) Has there been any difficulty adapting the system in response changes in the Point of Sale process (e.g., implementing new edits)?
- 5) What has been your experience working with CMS?
  - a) Have there ever been delays in receiving updates to the eligibility file?

## QUESTIONS FOR Z-TECH

### II. Point of Sale Facilitated Enrollment

- 1) Can you briefly describe Z-Tech's role on the Point of Sale facilitated enrollment process?
  - a) Were there ever any delays in receiving beneficiary data on the paid claims from WellPoint?
  - b) Did you ever experience difficulties accessing CMS records in order to validate eligibility?
- 2) How did Z-Tech validate Medicaid eligibility using state Medicaid eligibility verification systems (EVS)?
  - a) Did you ever experience difficulties accessing or utilizing the EVS?
- 3) Did changes in the Point of Sale process affect Z-Tech's ability to fulfill its responsibilities to WellPoint and CMS? ***If so***, how?

**QUESTIONS FOR PCG****II. State to Plan Demonstration**

- 1) Can you briefly describe PCG's role on the State to Plan demonstration?
  - a) Can you describe how procedures differed for claims submitted for full dual eligibles versus State Pharmaceutical Assistance Program (SPAP) beneficiaries?
  - b) Did states submit costs that could not be covered under the S2P demonstration? **If so**, what types of claims were they?
- 2) Please describe the process of eligibility verification under the State to Plan demonstration.
  - a) How did the process differ between full dual eligibles and SPAP beneficiaries?
  - b) How well did the process work?
  - c) Did you experience any problems matching beneficiary identification numbers to eligibility files? **Probe:** About what percentage of beneficiary identification numbers could not be matched with the eligibility files?
  - d) Can you describe any ways the process could have operated more efficiently?
- 3) Now please describe the claims payment system. **Probe:** How did the process differ between full dual eligibles and SPAP beneficiaries?
  - a) *PCG held a call with pharmacy benefit managers (PBMs)/processors on October 20, 2006 to discuss testing the process for submitting claims.* How many PBMs/processors participated in the call?
    - i) Were all PBMs' systems ready by December 31, 2006? **If not**, what caused the delays?
    - ii) Were all of the tests and Attestation of System Readiness documents returned by February 15, 2007? **If not**, what caused the delays?
  - b) *We understand that Part D sponsors were directed by CMS not to reject claims for eligibility/coverage reasons since CMS and PCG had already screened the claims for eligibility and coverage.* Did Part D plans reject any claims for eligibility or benefit coverage issues even though CMS already verified these claims as eligible for reimbursement? **If so**, why were the claims rejected?

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- i) How frequently did this occur?
  - ii) How were these problems resolved?
  - c) *As part of the claims adjudication process, PBMs had to program their system to avoid triggering payments to pharmacies. Were there any problems with PBMs fulfilling this requirement?*
  - d) *We understand that in some cases, PCG could not submit the original provider's NCPDP number on a claim so PCG had to assign an NCPDP number. Were there any problems implementing this change? How many claims did not have the NCPDP ID of the original provider?*
  - e) Can you describe any ways claims processing could have operated more efficiently?
- 4) What types of input did you receive from the states regarding the S2P demonstration?
- a) Did the states express any difficulties regarding the process of submitting claims for reimbursement? ***If so***, what types of problems did the states encounter?

#### **IV. Conclusion**

- 1) Are there any topics we have not yet covered (or questions that we have not asked) that we should now discuss?
- 2) If, in the near future, we have any future questions regarding answers provided during this interview or if any other future questions arise, may we contact you? **If yes**, what would be the most appropriate way to reach you?

*Thank you very much for your help today. Good bye.*

## APPENDIX D

**DRAFT INTERVIEW GUIDE: PHARMACIES  
(NATIONAL COMMUNITY PHARMACISTS  
ASSOCIATION, NATIONAL ASSOCIATION  
OF CHAIN DRUG STORES, LONG TERM  
CARE PHARMACY ALLIANCE, INDIVIDUAL  
PHARMACISTS REPRESENTING CHAIN AND  
INDEPENDENT DRUG STORES)**



## I. Introduction and Project Background

Hello, this is \_\_\_\_\_ from Mathematica Policy Research. We scheduled this time to talk with you about your knowledge and experience regarding the Point of Sale Facilitated Enrollment process for enrolling dual eligible and low-income Medicare beneficiaries in a Part D plan. Is this still a good time for you? Are there any particular time constraints we should know about before we start?

As I said, my name is \_\_\_\_\_, and I'm a [title] here at MPR, and I'm joined by \_\_\_\_\_, [title]. During this interview, I'll be asking most of the questions. \_\_\_\_\_ will be mostly listening and taking notes, or following up on some points that I may have missed. Please let us know if any of the questions we ask are not within your realm of knowledge or experience and we can move on to the next question. Also, please note that this set of questions is meant to serve as an interview guide; if there are any topics not addressed in our discussion that you believe would contribute to our understanding, please feel free to raise them.

Do you have any questions at this time?

Before we start our questions, can each person participating in the call please tell us your name, your title, and your role in the organization. (Note: Not relevant to individual pharmacists)

## QUESTIONS FOR INDIVIDUAL PHARMACISTS

### II. Recent Experience with Part D

- 1) Thinking about the past six months, about what percentage of the low-income Medicare beneficiaries you have served have required assistance with some aspect of their Part D drug benefit?
  - a) With the exception of the POS facilitated enrollment process (*also known as the WellPoint/Anthem or WellPoint/NextRx POS process*), what types of assistance have these beneficiaries needed? (*see below for some examples*)
    - i) Resubmission of denied claims
    - ii) Obtaining drugs not covered in plan's formulary
    - iii) Assistance with understanding their co-payments
  - b) About how much time have you spent, per beneficiary, assisting with Part D-related questions?
- 2) About what percentage of the low-income Medicare beneficiaries you have seen in the past six months were not enrolled in a Part D plan at the time they appeared at the pharmacy counter?
  - a) What were the primary reasons these beneficiaries were not enrolled in a Part D plan prior to their visit to the pharmacy? Probe: *reasons may include beneficiary didn't realize they needed to enroll after applying for low-income subsidy, beneficiary affirmatively declined autoenrollment and did not enroll in alternate plan, technical problems in data exchange between State and CMS indicated beneficiary was not enrolled, etc.*
  - b) Are there specific subgroups of beneficiaries who are more likely to arrive at the pharmacy needing assistance with enrolling in a Part D plan?
- 3) What more do you think could be done to ensure that all eligible individuals are enrolled in a Part D plan before they appear at the pharmacy?

### III. Point of Sale Facilitated Enrollment

- 4) Over the past six months, about how many claims have you submitted at the point of sale to WellPoint/Anthem or WellPoint/NextRx under the facilitated enrollment process?
  - a) What has been the outcome of those claims?

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- b) How does the number of claims compare with the first six months after implementation of Part D, which was January 1 to July 1, 2006 (i.e., has there been a significant increase or decrease in the number of claims submitted to WellPoint or has there been no change)?
- 5) Please describe how the Point of Sale system works, from a pharmacists' perspective.
- a) How well does the system work? Probe: What changes would you recommend?
- i) How have changes in the edits (for prior drug coverage, eligible HICN, and date of service) affected claims processing?
- ii) How well does the E1 query work? (This is the electronic system CMS has developed with the TRooP Facilitator, Relay Health [previously Per-Se Technologies], to allow pharmacists to check for effective dates of Part D enrollment. The E1 query can also be used to check for Medicare Part A eligibility and/or Part B enrollment.)
- iii) Do you use the enhanced E1 query? If so, how well does the enhanced E1 query work? (The enhanced E1 query provides effective dates for Part D plan enrollment within 90 days and was introduced in 2007).
- 6) What has been your experience regarding the use of other steps available to verify whether an individual was dual or other LIS eligible and therefore, eligible for POS FE, such as:
- a) Requesting a Medicaid ID Card
- b) Request a copy of a current Medicaid award letter
- c) Using a state eligibility verification system (EVS) query
- d) Utilizing recent history of Medicaid billing in patient profile
- e) Requesting a Medicare ID Card
- f) Requesting a copy of a Medicare Summary Notice
- g) Calling the Medicare pharmacy eligibility line or 1-800-MEDICARE

## QUESTIONS FOR PHARMACY ASSOCIATIONS

### II. Recent Experience with Part D

- 1) Thinking about the past six months, about what percentage of the low-income Medicare beneficiaries that have been served by your member pharmacists have required assistance with some aspect of their Part D drug benefit?
  - a) With the exception of the POS facilitated enrollment process (*also known as the WellPoint/Anthem or WellPoint/NextRx POS process*), what types of assistance have these beneficiaries needed? (*see below for some examples*)
    - i) Resubmission of denied claims
    - ii) Obtaining drugs not covered in plan's formulary
    - iii) Assistance with understanding their co-payments
  - b) About how much time do your members report spending, per beneficiary, assisting with Part D-related questions?
- 2) About what percentage of the low-income Medicare beneficiaries your members have seen in the past six months were not enrolled in a Part D plan at the time they appeared at the pharmacy counter?
  - a) What were the primary reasons these beneficiaries were not enrolled in a Part D plan prior to their visit to the pharmacy? Probe: *reasons may include beneficiary didn't realize they needed to enroll after applying for low-income subsidy, beneficiary affirmatively declined auto-enrollment and did not enroll in alternate plan, technical problems in data exchange between State and CMS indicated beneficiary was not enrolled, etc.*
  - b) Are there specific subgroups of beneficiaries who are more likely to arrive at the pharmacy needing assistance with enrolling in a Part D plan?

### III. Point of Sale Facilitated Enrollment

- 3) What percentage of pharmacies participate in CMS' Point of Sale facilitated enrollment process through WellPoint? (*This is the process through which pharmacists can fill prescriptions by temporarily enrolling a dual eligible or other low-income Medicare beneficiary in WellPoint's UniCare plan*).
- 4) Please describe how the Point of Sale system works, from a pharmacy's perspective.
  - a) How well does the system work? Probe: What changes would you recommend?

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- i) How have changes in the edits (for prior drug coverage, eligible HICN, and date of service) affected claims processing?
    - ii) How well does the E1 query work? (This is the electronic system CMS has developed with the TRooP Facilitator, Relay Health [previously Per-Se Technologies], to allow pharmacists to check for effective dates of Part D enrollment. The E1 query can also be used to check for Medicare Part A eligibility and/or Part B enrollment.)
    - iii) Do most of your members use the enhanced E1 query? If so, how well does the enhanced E1 query work? (The enhanced E1 query provides effective dates for Part D plan enrollment within 90 days and was introduced in 2007).
  - 5) What have been your members' experiences regarding the use of other steps available to verify whether an individual was dual or other LIS eligible and therefore, eligible for POS FE, such as:
    - a) Requesting a Medicaid ID Card
    - b) Request a copy of a current Medicaid award letter
    - c) Using a state eligibility verification system (EVS) query
    - d) Utilizing recent history of Medicaid billing in patient profile
    - e) Requesting a Medicare ID Card
    - f) Requesting a copy of a Medicare Summary Notice
    - g) Calling the Medicare pharmacy eligibility line or 1-800-MEDICARE
  - 6) Over the past six months, about how many claims have your members submitted at the point of sale to WellPoint/Anthem or WellPoint/NextRx under the facilitated enrollment process?
    - a) What has been the outcome of those claims?
    - b) How does the number of claims compare with the first six months after implementation of Part D, which was January 1 to July 1, 2006 (i.e., has there been a significant increase or decrease in the number of claims submitted to WellPoint or has there been no change)?
  - 7) What more do you think could be done to ensure that all eligible individuals are enrolled in a Part D plan before they appear at the pharmacy?

#### **IV. Conclusion**

- 1) Are there any topics we have not yet covered (or questions that we have not asked) that we should now discuss?
- 2) If, in the near future, we have any future questions regarding answers provided during this interview or if any other future questions arise, may we contact you? If yes, what would be the most appropriate way to reach you?

*Thank you very much for your help today. Good bye.*