

**The Impact of Medicare Prescription
Drug Part D Coverage on
Dual Eligibles and
Drugs for the Elderly Enrollees
and on the Organizations that Serve Them**

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Executive Summary

Introduction

The Medicare Prescription Drug Coverage benefit (“Part D”) was implemented on January 1, 2006. While the new benefit provided assistance with paying for medications for the 25% of Medicare beneficiaries who did not have drug coverage, many observers predicted that the complex design of the benefit and its tight timeframe for implementation would pose problems for Medicare beneficiaries, their families, their health care providers, and organizations that advocate for the elderly. Preliminary anecdotal news reports and national surveys revealed that the transition to the new benefit for Medicare beneficiaries was complex and in some cases problematic.

The goal of the project described here was to assist the Maine Department of Health and Human Services (DHHS) develop policies to improve the coordination of benefits between MaineCare (Maine Medicaid), the state’s Drugs for the Elderly (DEL) benefit, and Medicare Part D, and to inform the federal government on the impact of Part D on dual-eligibles and other low-income Medicare beneficiaries. We studied the early impact of Part D on older or disabled Medicaid beneficiaries who had prescription drug coverage prior to Part D through MaineCare (“dual eligibles”) or the DEL benefit; local and statewide organizations that work with and advocate for Medicare beneficiaries, which often stepped forward to help make Part D work for the beneficiaries; and Medicare beneficiaries who were not duals or DEL enrollees.

While it is too soon to measure the potential longer-term impact of Part D on beneficiaries’ access to medications and continuity of medication use, it is possible to assess the early effects of Part D implementation and organizations’ responses to it and to identify issues for monitoring and further study.

Data and methods

We surveyed stakeholders to assess the impact of Part D on MaineCare members, on DEL enrollees, on other Medicare beneficiaries, and on the organizations that serve them. The questions focused on

- The activities, resources and funding devoted to implementing Part D
- Stakeholders’ perceptions of the early impact of Part D on dual-eligible MaineCare members, DEL enrollees, and other Medicare beneficiaries
- The challenges stakeholders confronted under Part D and anticipate in the future
- The lessons stakeholders learned and their recommendations for the state and federal government and other organizations

We interviewed members or representatives of key stakeholder groups that work with or represent the interests of MaineCare members and DEL enrollees. We used a purposive sample, chosen to include a broad range of stakeholder organizations. Organizations and individuals were identified by the Muskie School of Public Service project staff, the DHHS leads, and through a “snow ball” sampling process (i.e., asking interviewees to suggest names of others to be interviewed). The groups include Area Agencies on Aging

(AAAs) and State Health Insurance Programs (SHIPs), advocacy organizations, medical provider associations, and pharmacist organizations.

We contacted individuals in 25 organizations. Individuals from 18 organizations responded and agreed to participate. In some organizations we interviewed more than one individual; a total of 20 individuals were interviewed. Twenty percent of the respondents were from AAAs or SHIPs, 35% were from other organizations that represent or advocate for the elderly, and 45% were health care providers or pharmacists and their association representatives. Most of the telephone interviews were conducted during July, August, and September, 2006. A few were conducted in October, November, and December due to scheduling issues and to ensure that all key stakeholder groups were represented. Thus, the interviews span the end of the first year of Part D implementation and the beginning of the second year.

Findings

Impact on MaineCare members, DELs, and Medicare beneficiaries in general

The respondents identified several positive effects of Part D on Medicare beneficiaries. These included reduced out-of-pocket spending on drugs for beneficiaries who previously had no drug coverage or limited coverage; increased screening of beneficiaries for other low-income benefits, such as Medicare Savings Programs, resulting in savings for beneficiaries; and a more active role of beneficiaries in managing their own medications. One respondent felt that some DEL enrollees may be better off under Part D, since DEL only covered drugs for certain conditions. Many felt that other Medicare beneficiaries (i.e., those not in DEL or not duals) are better off under Part D than they were previously, if they had no drug coverage.

Respondents also reported negative aspects of Part D on beneficiaries, including being overwhelmed by the number of plan choices, poor and inconsistent information to pick plans, and gaps in coverage (or the “donut hole”). Almost all the stakeholders mentioned confusion, panic, frustration, and fear experienced by the beneficiaries in the earliest days of the benefit. Many felt that duals were worse off under Part D than under MaineCare, which has a less restrictive formulary than most Part D plans. Some felt that beneficiaries with mental health problems or cognitive limitations and those in assisted living facilities experienced particular problems with choosing plans and enrolling in Part D.

Impact on the organizations

The respondents employed a variety of strategies to prepare for Part D, including adding staff, developing training and informational materials, recruiting volunteers, and purchasing technological tools (e.g., Epocrates).

The respondents reported that their organizations realized unexpected benefits in preparing for Part D, including better partnerships and closer working relationships with other organizations, stronger staff training and teams, increased image and visibility in their organization or with the public, and improved technological capacity (e.g., obtaining and using Epocrates).

On the downside, many organizations were overwhelmed by the level of demand for assistance from beneficiaries and their families. Generally, implementation of the Part D benefit put a significant added burden on these organizations. In addition, many physicians' offices, clinics, and pharmacies devoted hours to counseling beneficiaries on Part D and plan enrollment, and many pharmacies went at risk for prescription costs and experienced lengthy delays in receiving payments under Part D. Most of the time they spent on Part D was supported by temporary support from the State Pharmacy Assistance Program (SPAP), transitional grant dollars provided through the state from the federal government, or their existing budgets.

State involvement

The Maine state government took a number of steps to help MaineCare members and individuals enrolled in the state-funded Drugs for the Elderly (DEL) program. Most of the stakeholders commended the state for its actions. Most thought that "intelligent assignment" of beneficiaries to plans, the emergency safety net, and Part D wrap coverage minimized problems for beneficiaries.

Recommendations

State: Many stakeholders expressed gratitude for the State's responses to Part D and said it was critical to their organization's success with Part D and to making Part D work for beneficiaries. They urged the state to continue these policies. Most stakeholders recommended that the state maintain funding for the safety net and wrap-around coverage. Some suggested that greater integration and communication between the Governor's Office of Health Policy and Finance (GOHPF) and the Office of Medical Services (OMS) on medication-related programs and policies would be helpful to organizations and beneficiaries. Other recommendations included reducing the number of plans with which the state coordinates benefits, informing beneficiaries and advocates of available plans earlier in the enrollment cycle, and minimizing the amount of information sent to beneficiaries. Some interviewees understood that the state may be limited by federal rules in following these recommendations.

Federal government: The key recommendation from the stakeholders is not to rely on the internet or voicemail to provide information to beneficiaries or the people helping them select plans and enroll. Face-to-face counseling is often needed to address their needs.

Stakeholders urged the federal government to simplify the benefit, allow more time for changes to be implemented, recast some of the policies, rules, and cost-control mechanisms, and learn from the experiences of stakeholders like themselves in modifying the benefit. Respondents had many other recommendations for federal policy makers, including eliminating the donut hole, reducing the number of Prescription Drug Plans (PDPs) available, requiring the same enrollment and claims processes across PDPs, and eliminating the legal roadblocks that prohibit pharmacists, physicians, and nursing homes from helping beneficiaries choose a PDP.

Many felt that more standardization would help minimize administrative burdens on clients. Several recommended a single national formulary or restrictions on mid-year

changes in formularies by the PDPs. They also recommended that information be more user-friendly, timely, and accurate. Several recommended that the federal government institute tighter regulations, standards, and monitoring of PDPs. Other recommendations included providing financial incentives and compensation for pharmacists, advocates, and other organizations assisting beneficiaries with Part D, providing emergency prescription fills, making four-day supplies available in long-term care facilities, restricting the level of co-payments/cost-sharing for persons just above Low-Income Subsidy (LIS) income levels, eliminating specialty tiers, counting free or low-cost drugs received through 340b clinics and manufacturer pharmacy assistance program (PAP) assistance toward true out-of-pocket costs (TROOP), and allowing the federal government to negotiate drug prices.

Other organizations: Stakeholders encouraged other organizations to use Part D to develop their internal organizational capacity and external linkages and partnerships. They recommended that in the future other organizations anticipate and plan for the ongoing costs of helping clients with Part D, including staff time and infrastructure or technology costs, while maintaining their routine work for clients, and that they collaborate with other organizations on Part D.

Conclusions

In summary, although Part D is a federal benefit, many local Maine stakeholders expended substantial energy, time, and financial resources to help assist their clients and patients make use of it. Many stakeholders reported being overwhelmed by the level of beneficiaries' need for help in the early implementation phase. Their organizations used their own funds or re-allocated funds or staff from other functions during the early implementation of Part D. In spite of the difficulties some organizations faced in the early implementation stages of Part D, many realized success and reaped unintended benefits.

Although many of the problems and uncertainties with the early implementation of Part D have been resolved, stakeholders and their organizations continue to experience some confusion and pressure due to changes in plan formularies and the short time available for re-enrollment after plans are announced for the following year.

We expect that many organizations and health care providers will continue to use their own resources to help beneficiaries navigate the Part D benefit for a number of reasons: The Part D benefit is complex and by design requires plan selection and enrollment to be repeated each year. Many of the beneficiaries who depend on Part D are fragile, have low incomes, cognitive limitations, physical limitations, or mental health conditions, and few are "internet savvy." Beneficiaries who are not duals or who do not qualify for supplemental support who have high drug expenses will continue each year to face the "donut hole" gap in coverage; they may face difficulty in obtaining needed medications if their plan's formulary changes mid-year. Beneficiaries and the organizations that help them will continue to need accurate, timely information on plans and benefits each year. Pharmacists and advocates for the elderly will continue to spend time helping beneficiaries navigate the Part D benefit and to request reimbursement for their time.

Part D is seen by some of the respondents as an "unfunded mandate" from the federal government to the state and to the organizations that assist Medicare beneficiaries. While it is too soon to measure the potential longer-term impacts of Part D on beneficiaries'

access to medications and continuity of medication use, it is important to continue to track the impact of Part D on the non-governmental organizations that are helping to make it work for Medicare beneficiaries. In addition if, as some observers feel, Part D is a model for initiatives to privatize Medicare in future Medicare reforms, it is important to understand the impact of the new benefit and its implementation on state Medicaid programs, beneficiaries, and stakeholders.

Final Report

I. Overview and aims

The Medicare Prescription Drug Coverage or “Part D” was implemented on January 1, 2006.* While the new benefit provided assistance with paying for medications for the 25% of Medicare beneficiaries who did not have drug coverage, many observers predicted that the complex design of the benefit and its tight timeframe for implementation would pose problems for Medicare beneficiaries, their families, their health care providers, and organizations that advocate for the elderly (Gross, 2007; Kaiser Family Foundation/Harvard School of Public Health, 2005; Kilian & Stubbings, 2007; Laschober, 2005; Moczygemba, 2006). Preliminary anecdotal news reports and national surveys reveal that the transition to the new benefit for Medicare beneficiaries was complex and in some cases problematic (Berenson, 2006; Blethen Maine Newspapers, 2006a; Blethen Maine Newspapers, 2006b; Broder, 2004; Buchsbaum et al., 2007; Cohen, 2006; Edwards, Kramer, & Elam, 2007; Fox & Scholfield, 2006; Gottlich, 2006; Gray, 2006; Hall, Kurth, & Moore, 2007; Kaiser Family Foundation, 2006; Pear, 2003a; Pear, 2003b; Pear, 2006; Smith, Gifford, Kramer, & Elam, 2005; Smith, Gifford, Kramer, & Elam, 2006; Verdier, 2006).

Based on national reports, dual-eligibles encountered the following problems in the early phases of Part D implementation:

- Being charged the wrong co-payment, deductible, or premium
- Not knowing what plan the Centers for Medicare and Medicaid Services (CMS) had randomly assigned them to
- Difficulty in enrolling in or changing a plan
- Inadvertently being enrolled in more than one plan
- Not getting necessary drugs due to inability to pay

Other groups that may have been disproportionately affected include low-income individuals enrolled in state pharmacy assistance programs (SPAPs) such as Maine’s Drugs for the Elderly (DEL) program and persons with cognitive impairments or serious and persistent mental illness.

The implementation of Part D had a spillover effect on the state, beneficiaries’ families and caregivers, health care providers, and advocacy groups. For example, in response to early indications of problems, the state of Maine was one of the first to provide interim emergency “safety net” coverage, amounting to millions of dollars, to cover drugs for MaineCare (Maine Medicaid) members and people enrolled in the DEL program until

*Appendix A has a brief description of Part D, its implications for duals and DEL enrollees in Maine, and the state’s response to Part D. Gross (Gross, 2007) has a general description of Part D. Appendix B has a list of relevant acronyms.

Part D enrollment and cost-sharing problems were resolved. Maine was the only state that elected to re-assign MaineCare members to the Part D plans that best matched their existing drug profiles and pharmacy rather than leaving them in the plans they had been randomly assigned to by CMS. The state developed methods to assign DEL members, who otherwise had to compare plans and enroll voluntarily themselves, to the Part D plans that best fit their drug needs.

The state extended wrap-around coverage to pay for copays for duals and premiums and some cost-sharing for DELs. In addition, in the private sector, some pharmacies experienced difficulty in getting information about Part D plans' coverage or billing policies. In response, they dispensed free medications to tide beneficiaries over until the state safety net was fully in place. Beneficiaries' families and caregivers, physicians, staff in residential care facilities, assisted living facilities and nursing homes, and advocacy groups working with the elderly and people with disabilities helped beneficiaries obtain information and complete the enrollment process.

While it is too soon to measure the potential longer-term impacts of Part D on beneficiaries' access to medications and continuity of medication use, it is important to assess the more immediate affects of Part D implementation and the state's response to it in order to inform future policies. In addition, if, as some observers feel, Part D is a model for initiatives to privatize Medicare in future Medicare reforms, it is important to understand the impact of the new benefit and its implementation on state Medicaid programs, beneficiaries, and stakeholders in the program.

The goal of the project described here is to assist the Maine Department of Health and Human Services (DHHS) develop policies to improve the coordination of benefits between MaineCare, DEL, and Medicare Part D, and to inform the federal government on the impact of Part D on dual-eligible and other low-income Medicare beneficiaries. While it is too soon to measure the potential longer-term impact of Part D on beneficiaries' access to medications and continuity of medication use, it is possible to assess the early effects of Part D implementation and the organizations' responses to it.

In order to learn more about the impact of Part D on healthcare professionals and the organizations they work in, we conducted key informant interviews with a diverse group of stakeholders in Maine. We studied the impact of Part D on older or disabled Medicaid beneficiaries who had prescription drug coverage prior to Part D through MaineCare, ("dual eligibles") or DEL and on local and statewide organizations that work with and advocate for Medicare beneficiaries.

The study was conducted by the Muskie School of Public Service at the University of Southern Maine, with funding from DHHS, and in-kind support from the Muskie School. The USM Institutional Review Board approved the study.

II. Data and methods

A. Sample: The subjects are members or representatives of key stakeholder groups that work with or represent the interests of MaineCare members and DEL enrollees. The groups include Area Agencies on Aging (AAAs) and State Health Insurance Programs (SHIPs), advocacy organizations, and health and medical provider associations (including

pharmacist organizations). This was a purposive sample, chosen to include a broad range of different organizations in the groups of stakeholder organizations. The organizations and individuals were identified by the Muskie project staff, the DHHS leads, and through a “snow ball” sampling process (i.e., asking interviewees to suggest names of others to be interviewed). Potential participants were sent a letter describing the study and the interview, including information on protection of respondents’ confidentiality and on how the results would be reported.

We contacted individuals in 25 organizations. Individuals from 18 organizations responded and agreed to participate. In some organizations, we interviewed more than one individual; a total of 20 individuals were interviewed (see the list of stakeholders at the end of the report). Twenty percent of the respondents were from AAAs or SHIPs, 35% were from other organizations that represent or advocate for the elderly, and 45% were from health care providers or were association representatives. We interviewed executives, managers, and members of the organizations.

Most of the telephone interviews were conducted by the authors during July, August, and September, 2006. A few were conducted in October, November, and December due to scheduling issues and to ensure that all key stakeholder groups were represented. Thus, the interviews span the end of the first year of Part D implementation and the beginning of the second year.

B. Interview questions and analysis: The interview was developed by the Muskie project team in consultation with the DHHS project leads. Questions focused on

- The activities, resources, and funding organizations devoted to implementing Part D
- Stakeholders’ perceptions of the initial and longer-term impact on dual-eligible MaineCare members and DEL enrollees
- The transitional and ongoing challenges stakeholders confronted under Part D and anticipate confronting in the future
- The lessons stakeholders learned and their recommendations for state and federal government and other organizations

The interviews included general, open-ended questions and prompts about specific domains. We tallied the close-ended responses and identified themes from the open-ended responses. The tables present summaries of close-ended questions and the boxes present especially representative or telling quotations from open-ended questions. Due to confidentiality assurances, we have not identified the speakers of direct quotations used.

III. Findings

A. Perceptions of the impact of Part D on MaineCare members, DEL enrollees, and Medicare beneficiaries in general

Almost all respondents (90%) said their organizations worked with dual eligibles and beneficiaries enrolled in DEL, the two groups we focused on in this study. The other 10% work with dual eligibles only. Table 1 summarizes the respondents’ perceptions of the impact of Part D on the beneficiaries, including those with Medicare only, duals, and

DELs. Generally speaking, the most frequently mentioned problems were with accessing needed information, getting enrolled in a plan, and getting drugs previously covered by Medicaid or the SPAP. For each question, respondents from AAAs/SHIPs were more likely to perceive difficulties than respondents from advocacy groups or provider associations.

Table 1. Impacts on beneficiaries by type of organization

Did Medicare beneficiaries experience any difficulties with	Percent of respondents (n=20)
a. Accessing needed information?	75%
b. Getting enrolled in a plan?	55%
c. Getting drugs previously covered by Medicaid/SPAP?	45%
d. Being charged appropriately?	30%
e. Paying out-of-pocket costs?	25%
f. Dissatisfaction with plans once enrolled?	60%
g. Access to their pharmacy of choice?	10%
h. Dealing with paperwork or administrative processes?	35%

Positive impacts on beneficiaries in general: The respondents mentioned several positive benefits for Medicare beneficiaries in general (Box 1). These included reduced medication costs for beneficiaries who did not have drug coverage before Part D; finding out through the Part D screening process about other benefits, such as Medicare Savings Programs, for which they were eligible. One stated that, in her experience, many older people are reluctant to seek state or federal assistance, even if they are eligible for it. In the process of working with Medicare beneficiaries on Part D, case workers in her office often found other programs they qualified for, which they enrolled the beneficiaries in, saving them money. One program documented savings of \$1,000 on average for each person who was screened for other programs. One respondent felt that beneficiaries have taken a more active role in managing their medications as a result of Part D.

Box 1. Positive impacts on beneficiaries in general

- “There is no question that Part D is very good for consumers that had no coverage previously. They have seen a reduction in cost.”
- “I’m in favor of Part D. It’s a good thing. Prior to Part D, the vast majority of my patients did not have drug coverage except the duals. Approximately 35% were on Medicare and had no coverage and now 90% have coverage.”
- “Folks have cut the cost of prescription drug spending as a result of the low-income subsidy. It is good for many people, especially Medicare beneficiaries accessing care at safety net sites in underserved areas.”
- “The added ability to get them connected with other benefits. Through Benefits Check-Up they found other benefits that the beneficiary was eligible for. Because someone got put into a crisis, the system had a chance to find if they qualified for other benefits.”
- “Many people came to the organization who hadn’t heard about it before. They were eligible for SSI, MaineCare and the Medicare Savings Programs. We also linked consumers to tax and rent rebates and food stamps. They didn’t know about them before. One of the volunteers said they saved \$1,000/person for the people helped by the agency. It was a concrete accomplishment. Masses of people and dollars saved.”
- “I’ve had more patients requesting generics than ever before, and I think this is positive. It’s a good thing to counter the manufacturers’ high drug prices.”

The AAAs and other organizations that worked with the beneficiaries helped them avoid potential problems, such as losing private coverage. They also helped them avoid losing access to specific medications by switching from brand name drugs to generics.

Some respondents said that DEL enrollees may have been better off under Part D, since DEL only covered drugs for certain conditions. Duals and DELs in Maine had one advantage over other beneficiaries in the enrollment process. They got assistance from the state in plan selection based on their prior drug use and the pharmacies they used (“intelligent assignment”), whereas Medicare beneficiaries who were not duals/DELs enrolled on their own based on their own plan selection.

Box 2. Positive impacts of Part D on duals and DEL enrollees

- “As long as DELs are in the right plan they are OK. Some have higher co-pays because they chose a plan where the formularies cover their medications but have higher co-pays.”
- “DELs are better off when they reach the donut hole because they revert back to their old low-cost drug benefit.”

Negative impacts on beneficiaries in general: The respondents mentioned negative impacts on beneficiaries (Box 3). These included not having enough time to prepare for Part D (10), being overwhelmed and confused by the number of plan choices (7), poor benefit design overall (4), gaps in coverage (or the “donut hole”), and poor, inconsistent, and outdated information on the plans. (The numbers in parentheses refer to the number of respondents.)

Box 3. Negative impacts on beneficiaries in general

- “State of panic.”
- “Confusion about the Part D benefit in general.”
- “Some clients didn’t get information from the company in a timely manner.”
- “Since it’s been running, we’ve had reports of people who neglected to enroll. They’ll be facing penalties. They couldn’t afford to enroll. It wasn’t clear to them. There was an informational gap.”
- “There are too many plans. The fact that the person was locked into the plan but the formularies kept changing.”
- “I have had patients that had to have all their medications changed because of their Part D plan formulary and I have had to write prescriptions at the last moment. There was very little time to prepare.”
- “If someone doesn’t crusade for someone who is really sick to get the drug they need, they won’t get it.”
- “For people that are really sick when they hit the coverage gap, they used to be able to get help from manufacturers or free pharmacy assistance programs, but now that they are in Part D they may not be eligible and many of those programs are gone.”
- “There have been some inhumane decisions where, for example, narcotic pain medications have been denied for no legitimate reason. The insurance company has denied the claim because they want proof that it is necessary.”

- “Lack of coverage of benzodiazepines is a problem. I do not understand why they will not cover them. Also initially there were problems that they would not cover niacin used for cholesterol, saying that it was a vitamin, but I believe that has since been worked out.”
- “A lot of patients are complaining about the donut hole. My frustration is that patients are not using the savings they got in the initial benefit period toward drugs in the donut hole. Some patients are electing to either switch from a brand that had been covered to a generic during the gap, others may stop taking medications altogether.”
- “The donut hole is a problem. I need to change medicines for patients that have entered the donut hole. We have to renegotiate what medicines they are on based on price. My patients have promised to go on another medicine (the one I think is best for them) after they are through the donut hole.”
- “Patients have to cut back or eliminate medications until they are through the donut hole.”

Negative impacts on some beneficiaries: Three respondents said they were not aware of groups of Medicare beneficiaries that had any problems. The other 17 respondents mentioned several groups with problems. Some of their comments relate to duals and DELs and their transitions to Part D from MaineCare and the DEL program. Others related to the limitations of beneficiaries based on their health condition or their living situation (Box 4).

Box 4. Negative impacts on specific groups of beneficiaries

Duals and DEL enrollees

- “A lot of people aren’t [better off than they were before] – the duals and DELs, since the benefit was not allowed to be as good as before under MaineCare.”
- “...the impact on dual eligibles has not been positive at all. They have been negatively impacted financially and face a lot of confusion getting the medications they are entitled to.”
- “DEL patients faced a real crisis initially because DEL only covers certain drugs at a certain percent, so when they hit the donut hole, if the drug wasn’t covered by DEL, the patient assumed 100% of the costs after only paying 20% up until that point. But by the end of July, the state changed, so now if someone’s on DEL, they are covered for all MaineCare-covered drugs but with the DEL co-payment. This is a big improvement and much simpler to administer. The problem with this is that we still don’t know when they are in the donut hole so we don’t know who to bill.”
- “The DELs have had problems with plans putting drugs in specialty tiers, which increases the cost/administrative burden to get them.”*
- “For the duals and DELs it was a nightmare. The state was slow in getting information to them. They were dually enrolled in different plans. There was conflicting information, changing information.”
- “Of all the groups, the duals and DELs needed more help than others because it was a new benefit from one they had before. [I] don’t think the state did a very good job educating them about the change. There were a lot of complaints, they didn’t understand why their coverage was changing. They complained that drugs that were previously covered were no longer covered.”
- “There were big problems for duals and DELs because of the state and CMS auto-enrolling them into different plans, so sometimes people were in more than one plan or in a different plan than the state had told them they were in.”
- “The more limited formularies of plans and prior authorization requirements have been a problem for the duals, so it’s a back and forth to try to get the drugs they need covered. In particular, they have had problems with narcotics and expensive meds that the plans don’t want to cover. Also we deal a lot with Part B versus Part D issues, where the plan refuses to pay because they say it should be covered under Part B and the pharmacies have to try to bill them first.”
- “Many were enrolled in multiple plans. The feds enrolled them, the state enrolled them, and they enrolled themselves.”

- “There was a lot of confusion about people automatically enrolled in Part D and the role of long term care facilities in selecting plans. [They were] originally told long term care was responsible, then told that state would auto-assign, then right before Christmas told facilities needed to do it. This put a strain on facilities.”
- “Some DELs faced problems with proving eligibility for low-income support.”
- [Getting low-income subsidies] “has been a problem for both DELs and duals, even though they were supposed to be deemed eligible.”
- “DHHS removed the asset test for Medicare Savings Programs – that helped a lot – just the threat of having to reveal their assets is a barrier for people.”

Beneficiaries in assisted living facilities

- [We] “had dual eligibles in assisted living being billed co-pays, but the reason the vast majority did not have problems was because the state stepped in.”
- “Also a lot of people in assisted living were not exempted from the co-payment and, while the state is taking measures to address this, we were previously told to charge co-pays to assisted living residents.”
- [Paying out-of-pocket costs] “is just starting. So far there has not been a huge requirement. A number of assisted living beneficiaries are entering the coverage gap. With prior authorization denials, they have to pick up costs. Costs are shifting onto family members or facilities. Long term care facilities tell us that they have incurred costs because of this coverage gap.”

People with disabilities

- “Overall at the federal level, there was not enough focus on people with disabilities who had Medicare. The feds dropped the ball here. People under 65 with Medicare were able to go to AAAs and SHIPs to get help but they didn’t know about it at first. None of the advertisements or printed materials included folks with disabilities.”

People in prison or correctional facilities

- “People on MaineCare who were supposed to have benefits were suspended. They weren’t auto enrolled because they were in a correctional facility. They got the Social Security payment, it’s an overpayment issue. Not sure the extent of this, only heard it happening in a forensic facility, but it may also be happening in prisons and jails.”

* New rules in 2008 restrict plans’ ability to put drugs in specialty tiers.

None of the respondents said they thought dual eligibles were better off under Part D than under MaineCare drug coverage, because they had more comprehensive coverage under MaineCare, they were previously guaranteed that a drug would be dispensed regardless of their ability to make the co-payments, Part D is more complicated than MaineCare, and duals sometimes were not able to get medications under Part D that they had previously used (10).

B. The organizations' experience with Part D

1. General observations: Almost half of the 20 respondents said that their early experience with implementing Part D had some problems, while about a third said their experience was negative (bad/difficult or very bad/very difficult) (Table 2). Most reported they have had both positive and negative experiences with Part D implementation.

Table 2. Organizations' general experience with implementing Part D

How would you rate your experience so far with the implementation of Medicare Part D?	Percent of respondents (n=20)
Very good/Good	25%
Some problems	40%
Bad/difficult/Very bad/very difficult	35%
Have you had some positive experiences so far with the implementation of Part D?	90%
Have you had some negative experiences so far with the implementation of Part D?	90%

2. Organizations' early responses to Part D: The organizations used a wide variety of strategies to prepare for Part D. They focused on getting and transmitting information, staff training and orientation, staff hiring or re-allocation of staff time, and getting new or using existing technology. In order of frequency, they used the following general strategies:

- Became informed before Part D was implemented (100%)
- Reached out to members, clients or constituents (95%)
- Used any resources or materials that were developed by others that were especially helpful in responding to Part D (85 %)
- Trained or oriented staff (80%)
- Developed informational materials on Part D (75%)
 - ...for clients or patients to use (55%)
 - ...for internal use (50%)
- Held meetings with staff, constituents, clients, and others (75%)
- Addressed the financial implications of Part D (55%)
- Added information technology (45%)
- Worked with new payment, billing, and/or administrative systems or Epocrates (35%)
- Added new staff (20%)

The organizations also did a number of specific things. They connected callers with the appropriate AAA, networked with other organizations, put information on their websites, restructured daily job tasks to be more focused, recruited volunteers, estimated how many of their clients would be affected by Part D without help from the state, assembled formulary information, and got Epocrates.

The respondents developed informational materials for a number of different audiences:

- *Beneficiaries:* Letter to consumers with information on the Part D benefit, deadline to sign up, where to get help, lists of frequently asked questions, resource numbers, and definitions of terms; clinic forms to help clients develop a medication list; tip sheet written at the sixth grade level; information on their website; e-mails, posters, cards, and TV commercials for people seeking help with Medicare payments; charts comparing eligibility time limits; and information to bring to the first appointment
- *Their staff:* CDs and DVDs to use as training for various stakeholders, tools to screen for eligibility for extra benefits, handout sheets on various levels of benefits, PowerPoint presentations, training manuals, websites, outreach materials for use in appeals unit, and a library of form letters to help people with their appeals
- *Providers:* Newsletters and e-newsletters for physicians and office staff to assist patients with questions or issues concerning Part D and training for providers

They also used existing information from a number of different sources:

- *Federal government:* Centers for Medicare and Medicaid Services (CMS) website (6), CMS caregiver materials, “Medicare and You” booklet, and books listing the PDPs and their cost sharing
- *State:* DHHS, Office of Elder Services’ chart with information on the DEL/dual wrap, and state legislation
- *Private organizations:* ABC Coalition web-based software with state specific information, American Association of Retired Persons “Guide to Medicare Part D,” Alzheimer’s Association, American Medical Association, Health Assistance Partnership, Kaiser foundation, Legal Services for the Elderly, Maine Disability Advocacy Coalition, Maine Equal Justice, Medicare Rights Center, National Disability Rights Network, and Senior Law

Many commented that the tight time frame and the slow, inaccurate, or inconsistent information they got from CMS, the state, or the plans made it more difficult to prepare for Part D. “Everything was on the fly,” one said. They noted a number of difficulties during the preparation and early implementation phases. They were overwhelmed by the scope of the need for information and assistance and the number of beneficiaries, family members, and caregivers asking for help. They found it difficult to explain Part D due to the complexity of the benefit, the number of plans, and the lack of timely and reliable information from CMS and the PDPs. Some were able to use technology such as

Epocrates or the CMS website. There were no clear differences among the types of organizations in response to this question.

Some groups were able to get funding for these activities from the state, federal grants, grant ad-ons, or foundations, but many were not reimbursed for the staff time or technology used to respond to Part D.

3. Reflections on the impact of Part D to date on their organizations: In order to put the responses to our study in context, it is important to understand the situation in Maine shortly after Part D was implemented on January 1, 2006. As described above, the state took a number of actions to ensure a smooth transition to the Medicare Part D benefit. These included establishing a Maine Medicare Workgroup comprised of 59 individuals representing the federal government (CMS, the regional Quality Improvement Organization, and the Administration on Aging), the state (MaineCare, Office of Elder Services, DHHS, and the Bureau of Insurance), advocacy groups, providers, and payers; developing wrap-around coverage for duals and DELs; assigning members to the plans that best matched their existing drugs and pharmacies (“intelligent assignment”); contracting with Legal Services for the Elderly to make appeals on behalf of members; and in the early hours of Part D implementation, extending emergency “safety net” coverage to ensure members would get the drugs they needed until the initial problems were resolved.*

Over half the respondents commented positively on the states’ responses to Part D. Twelve respondents mentioned the state’s emergency response to Part D. Eleven respondents indicated that emergency coverage was positive, eight indicated that the state’s assignment of people into plans that best met their needs was positive, and one indicated that the new department to help pharmacies with billing issues was working well. (We suspect that many of the respondents who did not comment on the states’ response were not aware of the nature or extent of its efforts.) Box 5 presents some of their comments.

* Appendix A has further information on the state’s response to Part D.

Box 5. The impact of state interventions on behalf of duals and DELs

- [Emergency assistance] “was lifesaving. There would have been horrible stories to tell without it. Part D plans would have been on a catastrophic course without it. The state made the decision quickly and put it in place quickly. It was great.”
- “The state did *plenty* to help people from missing medications.”
- “State workers were awesome, they couldn’t rescue everyone but they worked night and day to try. Jude Walsh deserves her wings and Doreen McDaniel too.”
- “[Compared to] what I have heard occurred in other states, despite the problems, the state of Maine has tried to make it painless for the consumers.”
- “There has been a valiant effort by the state. They did not leave people in the lurch.”
- “Coordination in Maine was exemplary. It made a big difference.”
- “Maine has done a commendable job and needs to keep it up. The fact that the Governor’s office has been engaged has been commendable. When comparing Maine to other states it is obvious that the Governor’s office involvement has had an impact.”

Positive impacts: We asked the respondents to elaborate on their general experiences with the early phases of Part D implementation (Box 6). They noted several benefits from Part D, some of which they had not expected or intended. They developed better partnerships and closer working relationships with other clinics, providers, state, and advocates (6); strengthened staff training and staff team building; obtained new technology, such as Epocrates, or improved their existing technology; and received recognition within their organizations or from others for their work. The visibility and reputation of the AAAs were strengthened through their outreach to other organizations and the help they provided in the community (4). It is worth noting that several of the respondents who indicated positive experiences qualified their remarks to say they had had “some” positive responses and that most of the respondents with positive experiences work at AAAs/SHIPs or advocacy groups.

Box 6. Positive impacts on the organizations

- “There was a bonding effect because there were so many people affected and the stakes were so high. There was greater collaboration among the agencies. Maine had a much better team approach... may be unique to Maine. Through the Medicare Part D Stakeholders’ Group there was a true sense of partnership. This will be a lasting positive impact.”
- “We built stronger, more respectful relationships with the state. People in MaineCare and DHHS were wonderful – Jude Walsh, OES – all were wonderful. We really partnered at an optimum level. All in this thing together to help seniors. Once we got in the same room and looked at each other... it was coming... no matter what we did. There was no avoiding it. It was not them and us...it was us.”
- “It helped our reputation and knowledge of us as a resource in the community. That was a good part for the agency staff. It increased the familiarity with their mission – doing health insurance counseling for anyone on Medicare or MaineCare.”
- “We finally found a tool (Epocrates) to help find what medicines are on the patient’s plan formulary. The only problem is we have to pay extra for Epocrates.”

Negative impacts: They also noted several negative impacts on their organizations (Box 7). These included difficulties with getting accurate, timely information about Part D and about the available PDPs and their benefits; the overwhelming demand for immediate help with enrollment and selecting a plan for their patients or clients; problems in understanding and interpreting Part D due to its complexity; problems in training staff and allocating their time due to the quick ramp up of the program and the lack of timely information on it before it was implemented; and, due to these problems, general confusion and stress among their staff in responding to Part D. Some respondents felt there was insufficient time to train and educate their staff prior to Part D implementation (4) and said that they had to dedicate staff to respond to Part D or to set up special hotlines, taking away from their other duties (3). Some felt that providers and pharmacies were working harder and getting paid less (4), in what was essentially an unfunded federal mandate. Several said that other activities their organizations usually undertook had to be short-changed or put off to respond to Part D. Several respondents noted the particular problems that pharmacists and pharmacies encountered in terms of trying to get information to help beneficiaries and to get reimbursed for medications they provided when beneficiaries had not enrolled or did not have documentation of enrollment.

Box 7. Negative impacts on the organizations

- “It was difficult – the information from CMS was slow and it kept changing. Information was outdated and wrong (e.g., the annual costs for plans listed on Medicare.gov were wrong, plans were left off the web site). People were angry at us. We were the front line – the person who they could get mad at.”
- “[There are] too many formularies and too many choices.”
- “The entire Part D prior authorization process is awful. It’s cumbersome to providers and to patients.”
- “No respite – people would come to you on the street and ask you to help their mother.”
- “There is no standardization, plans can do their own thing and make their own rules.”
- “There is no standard benefit. Working with 42 different plans and procedures makes it very complex.”
- “It took way more resources than we had. Everything became about Part D. Everything else that we usually do took a back seat.”
- “The phone lines became impossible to get through. We had to purchase software, a mailbox for Part D that routed calls to the computers. It was the first time in 25 years of agency history that we had to use a voice mail, not an operator.”
- [It was] “hard for pharmacists to determine the co-payment level for patients. The state has to get info from the feds and feds to insurance companies and the information is wrong in the system. None of the federal databases (LIS eligibility, TROOP tracking) are working. We cannot depend on it for accurate information. Or even when it’s right it takes weeks or months.”
- “Pharmacists stepped in early to help beneficiaries negotiate the new benefit; they absorbed some of the financial and staff time costs of smoothing the implementation.”
- [Pharmacists] “tried to use the safety net as little as possible because we were afraid the state would later reverse the bill and expect us to go back and collect from the plan.”

- [Pharmacists] “don’t get paid for 60 or 90 days. Rebilling [by pharmacists] post April has required a lot of time. Hannaford Brothers and Shop and Save did a study of the process and found that it took 25 hours to re-bill 1200 prescriptions to the plans and payment was only made by the plans on 25% of these re-billed claims. In our case, I have already spent five hours for 150 [pharmacy] claims.”

4. Ongoing challenges to the organizations posed by Part D: During the course of these interviews, the organizations began to prepare for the second year of Part D enrollment. Their answers about ongoing challenges reflected the situation as they entered the second year. Half the respondents (50%) indicated that most of the problems had been resolved at the time of the interview: 71% of the advocacy group respondents and 56% of the provider association respondents felt that most problems had been resolved. None of the AAA/SHIP representatives felt that this had happened.

The respondents continued to comment on how important the state’s role was in easing the transition, especially for dual eligibles and people qualifying for low-income subsidies. Many reported that several problems had been worked through and that many processes had become easier to navigate (Box 8).

Some problems, however, remained (Box 8). They experienced continuing problems with inaccurate information from CMS or the plans; slow responses on problems from CMS or the plans; the short turn-around time allowed between when the available plans were announced by the state and the enrollees had to decide on which plan to enroll in; the lengthy time needed to assist beneficiaries in selecting plans; the lack of financial support for their work helping beneficiaries select and enroll in plans; and beneficiaries having to cope with the gap in coverage during the “donut hole.”

Box 8. Situation for organizations going into Year 2 of Part D

Problems resolved

- "...if the state override were to go away it would be a lot of work to appeal and get necessary drugs. Now the pharmacy can provide medications and the state pays for the medications if they are not covered."
- "[Negative experiences resolved] primarily because of the state's safety net, which has been there for the duals first as a safety net and now as wrap coverage."
- "I know there have been issues for the duals and DELs but they have been mitigated or masked with the state's transitional coverage."
- "Have been resolved more in pharmacies and at facilities where staff have learned to navigate the system. The system is much better now, the information is more accurate."

Problems remaining

- "Aside from the early bumps and ramp up at CMS and the plans – now the problems are to pair people* with the right plan and there are a wide array of PDPs."
- "Unfunded mandates force providers to provide information and work arounds to make Part D work. There are no provisions for the extra work and costs to providers."
- "Two staff people have been fielding problems. Some people take hours and multiple contacts to explain deadlines, benefits, etc. Appointments now take almost an hour each."
- "It's staff intensive. In physicians' offices, case managers and outreach workers providing assistance takes away from other types of assistance."
- "Deadlines for consumers signing onto the plans, the process to become a plan that happened all over again. At the eleventh hour, most of the plans changed. Medicare Advantage: people trying to get out of them, they are having some problems."
- "Since it's been running, we've had reports of people who neglected to enroll. They'll be facing penalties. They couldn't afford to enroll. It wasn't clear to them there was an information gap."

* Beneficiaries who are not duals or DEL enrollees.

They noted that, even after the early implementation phase passed, because of the complexity of the benefit and the differences among the plans, many problems still need to be addressed individual by individual and plan by plan during each enrollment period, which presents a continuing demand on staff time. In addition, duals and DELS must be re-assigned annually to the plans with premiums below the Low-Income Subsidy benchmark.

IV. Recommendations

A. Recommendations for the state: As noted above, many of the respondents praised the state's response to Part D and expressed the hope that it would continue these responses. Generally, their recommendations for the state fall into two categories – overall strategy and financing and reimbursement issues (Box 9).

Regarding overall strategy, the respondents recommended that the state continue to meet with stakeholders on a regular basis and integrate its response to Part D, specifically by coordinating the work of the Governor's Office of Health Policy and Finance (GOHPF) and the Office of Medical Services (OMS) on medication-related programs and policies. They recommended limiting the number of PDPs the state contracts with for duals and DEL enrollees*, taking out the lower-quality PDPs with limited formularies (2), and listing available PDPs earlier in the re-enrollment cycle. They recommended keeping all processes as simple as possible for beneficiaries and sending them information less frequently (2).

Regarding financing and reimbursement, they recommended letting pharmacists enroll dual eligibles based on their medications; resolving pharmacy billing at the state level (2); maintaining funding for safety net and wrap for duals and DELs (5); and considering aiding beneficiaries who have low incomes and just miss qualifying for Low-Income Subsidies.

* The state has subsequently reduced the number of plans.

Box 9. Recommendations for the state

Overall strategy

- “It would be helpful to gather the best resources for physicians and refer them to those resources as the experts on the subject. It was helpful to publish information from Legal Services for the Elderly in their e-newsletter numerous times.”
- “Don’t wait until the last minute to help because it causes more confusion”
- “Keep it simple.”

Financing and reimbursement

- “Continue to supplement benefits where the federal benefit falls short – for vulnerable Mainers.”
- “Convert all the DELs to the Medicare Savings Programs, which will make them automatically eligible for LIS and can switch plans whenever they need to.”*
- “[I’m] concerned about how the state will pay for eliminating asset tests for MSPs over time. Support helping seniors pay Part B premiums but I’m concerned how the state will sustain this over time.”

* Since our interviews this has been done by the state. In March, 2006, Maine eliminated the Medicare Savings Program (MSP) asset test and effective April, 2007, raised MSP income eligibility to 185% and auto enrolled existing DEL members.

B. Recommendations for the federal government: The respondents had many recommendations for the federal government (Box 10).

Regarding strategy, they urged the government to either reduce the magnitude of planned changes or extend the amount of time allowed for implementation, have tighter regulations, standards, and monitoring of PDPs, eliminate legal roadblocks stopping pharmacists, physicians, and nursing homes from helping beneficiaries make decisions (2), and talk to staff at state-level to see what their experience has been and to get suggestions and ideas (2).

Regarding plan design and plan selection, they recommended reducing the administrative burden on organizations and beneficiaries by simplifying the benefit; reducing the number of PDPs available, having a single national formulary (6), and restricting changes in formularies by the PDPs, especially at mid-year.

Box 10. Recommendations for the federal government

Strategy

- “Implementation was too ambitious for time allotted.”
- “Have real teeth in the penalties for plans. These are real life or death situations for people – or life altering. There should be real consequences for the plans.”
- “Try pilot projects – test [changes] by state.”

Plan design and plan selection

- “Keep it simple. Reduce the number of plans.”
- “There should be uniformity in formularies, policies, procedures, enrollment paperwork, and prior authorization paperwork. Administrative simplification is needed.”
- “All plans need to have the same way of doing business (e.g. enrollment processes, claims submission, medicines covered, prior authorization). Currently we have 12 different processes for each plan. Also need to standardize computer systems so we can receive standard info from the state and federal level.”
- “The feds should not allow plans to change formularies at their whim.”
- “[The annual open enrollment period] is too compressed a time frame for people making choices about plans if they have so many options.”

Information and data

- “The Internet is not the best method to reach this population.”
- “Need better info on annual drug costs and clearer description of the gap and what it is. We counselors didn’t even understand that the plans have much more say in what is counted toward TROOP than we were aware.”
- “Fix the Medicare.gov website. Information on formularies and costs were not accurate, complete or up-to-date.”

Financing and reimbursement

- “It’s not just about paying for the drugs as much as a budgeting issue. They [beneficiaries] don’t know when they hit the donut hole and difficult to plan on a fixed income.”
- “If you don’t take drugs during the donut hole, aren’t you going to use more health services?”
- “Provide information and work arounds to make Part D work. There are no provisions for the extra work and costs to providers.”
- “Now there’s no incentive or encouragement for pharmacists to help beneficiaries. Allow pharmacists to help in a way they are qualified to help. Don’t be suspicious of pharmacists’ motives.”
- “If there weren’t AAAs could DHHS have done everything? The feds didn’t give us any money to do this. Need funding for the people who do the work. If this is going to be ‘look to the local level’ we need funding, assistance and recognition.”

- “Unlike MaineCare PDL where you can dispense a four day supply of medications, Medicare Part D has no such provision in the long term care setting.”
- [Eliminate specialty tiers] “or beneficiaries need the right to appeal the prices of these drugs, which they don’t currently allow.”
- “Pharmacists are not getting timely payments for services.”
- “I prefer the way the VA handles their coverage. The state of Maine and CMS have to be able to negotiate with manufacturers.”
- “Recognize the investment being made on behalf of clients by the subsidies, 340b, and private patient assistance programs – to account for total costs and help person through donut hole.”
- “Its’ difficult, especially in rural safety sites, to align Part D with existing 340b programs so PDPs would have to buy into the 340b plans. It would be a small impact to the market place but a big help to FQHCs and to their beneficiaries.”

Regarding enrollment and beneficiary relations, the key recommendation from the stakeholders is not to rely on the internet to reach Medicare beneficiaries and to reduce the reliance on voice mail to provide information to beneficiaries and to the people helping them select plans and enroll. Face-to-face counseling is often needed to address their needs. They also recommended having fewer PDPs (4), phasing in changes more slowly, providing plan information sooner to allow more time for implementation (2), and having the same enrollment and claims processes across PDPs. They urged CMS to make Part D easier for beneficiaries to understand and use, simplify the program as much as possible, and make resources more user friendly and accurate (3).

Regarding financing and reimbursement, they recommended that the federal government negotiate drug prices (5), mandate timely payments by the PDPs to pharmacists and providers, provide financial incentives and compensation for pharmacists, advocates, and other organizations assisting beneficiaries with Part D, provide for emergency fills pending approval and four-day supplies in long-term care facilities, restrict the level of copayments/cost-sharing for DELs or persons just above LIS income levels, expand coverage under the LIS provision, eliminate specialty tiers, count 340b and SPAP assistance in TROOP, simplify the crosswalk between 340b and Part D, eliminate the “donut hole”, and provide universal health care coverage.

C. Recommendations for other organizations: The respondents had several recommendations for other organizations (Box 11).

Regarding strategy, collaboration, and advocacy, they recommended getting educated as early as possible (5), doing outreach to other organizations (5), networking with partners (4), opening lines of communication with other organizations, and making sure policy makers and legislators, especially the Congressional delegation, know about the problems they encountered (3). They cautioned other organizations to devote enough resources to Part D, while maintaining the same core of services.

Regarding information collection and dissemination, they recommended documenting the problems they encountered (3), having a system to gather data on activities and resources used to respond to Part D, developing common data collection systems and tools among organizations with similar goals and activities so that data can be compared across the state, and purchasing electronic medical record and electronic formulary software such as Epocrates.

Regarding technology, they recommended getting an e-prescribing system, if useful, such as Epocrates.

Box 11. Recommendations for other organizations

Strategy, collaboration, and advocacy

- “You get more in a coalition than working on your own.”

Information collection and dissemination

- “[I] think we could work better at cataloguing the problems we are encountering.”

Technology

- “With Epocrates it is possible to look at the computer screen in your room with patients to find medicines on their plan. Even though it is time-consuming, it is easier in the long run than to go back and forth with the pharmacy and rewrite prescriptions.”

V. Conclusions

In this study of the early impact of Part D on stakeholders, we found that many early predictions about the new benefit proved to be true. The transition was challenging for beneficiaries, their families and caregivers, health care providers, and advocates.

Although Part D is a federal benefit, many local Maine stakeholders expended substantial energy, time, and financial resources to implementing it and assisting their clients and patients to make use of it. Many stakeholders reported being overwhelmed by the level of beneficiaries’ need for help in the early implementation phase. Some organizations were able to secure funds to support their work on Part D, but many dipped into their own funds or re-allocated funds and/or staff from other functions. While this was especially true during the early implementation phase of Part D, many of the stakeholders interviewed said they continue to budget staff time and resources to ongoing implementation issues and to enrolling and re-enrolling beneficiaries. This may be more difficult going forward, since many of these external funding sources, such as SPAP transitional grants, are no longer available. Although many of the early problems and uncertainties have been resolved, they continue to experience some confusion and pressure due to changes in plan formularies and the short time for re-enrollment after the plans are announced for the following year.

In spite of these difficulties, many stakeholders realized success and reaped benefits, some of which were unexpected. Some developed and strengthened working relationships with other local organizations, with staff in DHHS and the Governor's Office of Health Policy and Finance; others, especially the AAAs, increased their visibility in the community; some, especially social workers, got greater visibility and enhanced status in their organizations.

We have documented one aspect of the impact of Part D at the state and local level – the impact on private organizations and providers. There was undoubtedly also an impact on state government agencies. For example, in the first few days of 2006, the entire state telephone system was blocked by Part D calls, so much so that even the Governor could not call out (Jude Walsh, personal communication). Many stakeholders expressed gratitude for the state's response to Part D and said it was critical to their organization's success with Part D and to the beneficiaries' experience. They urged it to continue to support them and Medicare beneficiaries. They encouraged other organizations to use Part D to develop internal organizational capacity and external linkages and partnerships and urged the federal government to simplify the benefit, allow more time for changes to be implemented, recast some of the policies, rules, and cost-control mechanisms, and to learn from the experiences of stakeholders like themselves in modifying the benefit. They conveyed the urgency of the challenge for the beneficiaries, for elders, and for the US health care system.

We expect that many organizations and health care providers will continue to use their own resources to help beneficiaries navigate the benefit, for a number of reasons, Part D is a complex benefit in terms of benefits, formularies, tiers, and the "donut hole" when coverage ends (except for duals). The plans available to beneficiaries can change from year to year, as can the plans the state contracts with for duals and DELS. Although many of the problems with this process have been resolved, beneficiaries and the organizations that help them will continue to face the issues of getting accurate, timely information will be repeated each year. The process of selecting plans and enrolling must be repeated each year, so the issues of informing beneficiaries of the available plans and enrolling that were so problematic during the first year, will be repeated each year (Gross, 2007). Beneficiaries and the organizations that help them will continue to need accurate, timely information each year (Moczygemba, 2006). Pharmacists and advocates for the elderly will probably continue to spend time helping beneficiaries navigate the Part D benefit, and to request reimbursement for their time. Many of the people depending on Part D for prescription drug coverage are fragile, have low incomes, have cognitive limitations, physical limitations, or mental health conditions, and are not "internet savvy." While Part D added or expanded prescription drug coverage to many, for others it restricted the list of drugs covered. For low-income beneficiaries not enrolled in Medicaid or other supplementary programs, the "donut hole," when Part D coverage lapses, can lead to gaps in coverage and, possibly, going without needed medications (Brill, 2007).

Part D is seen by some of the respondents as an "unfunded mandate" from the federal government to the state and to the organizations that assist Medicare beneficiaries. While it is too soon to measure the potential longer-term impacts of Part D on beneficiaries' access to medications and continuity of medication use, it is important to continue to track the impact of Part D on non-governmental organizations that are helping to make it

work for Medicare beneficiaries. In addition if, as some observers feel, Part D is a model for potentially broader initiatives to privatize Medicare in future Medicare reforms, it is important to understand the impact of the new benefit and its implementation on state Medicaid programs, beneficiaries, and stakeholders.

Appendix A. Maine DHHS Actions to Help Facilitate the Transition of Duals to Medicare Part D*

In Maine, there were 45,000 dual eligibles as of December 2005. There are several voluntary actions Maine took to help dual eligibles transition prescription drug coverage from MaineCare to a Medicare Part D plan. One of the key activities was Maine assessing all dual eligibles' randomly assigned plans in relation to the previous medication claims in MaineCare. If the randomly assigned plan covered less than 80% of a person's medications, MaineCare re-assigned them to a plan that covered most, if not all, their medications. For those that had 80-99% coverage through the randomly assigned plan, a plan was recommended that may cover most, if not all, of their medications. Letters about the re-assignment or recommendations were mailed in December 2005. People had the option to "opt-out" of the state's assistance with re-assignment of plans.

In addition to assessing a person's medication needs and the randomly assigned plan, the state has wrapped coverage for dual eligibles by paying 100% of the generic co-payment (co-payment reduced from \$1 or \$2 to \$0) and 50% off brand name drug co-payments (co-payment reduced to \$1.50 to \$2.50). Wrap coverage of brand name and generic drugs were effective January 2006.

Maine has done several activities to inform and educate consumers, providers, and other affected parties about the new Medicare Part D. Maine has a Medicare workgroup that consists of staff from the Department of Health and Human Services, the Area Agencies on Aging, State Health Insurance Program, the State Independent Living Center, Maine Medicare Education Partnership, Legal Services for the Elderly, and others. The group discusses current issues being faced by the roll out of Medicare Part D and how to inform consumers, providers, doctors, and others about this change. This group has worked together to identify potential needs and has collaborated to address these issues. Members of this group were a part of developing two statewide conferences that were held in June and November of 2005. The audience for these conferences was provider organizations and others who work with people who have low incomes. In addition to providing information and awareness to providers and other stakeholders, one-on-one assistance was identified as an additional resource needed to help people with low incomes to transition coverage from their current program to Medicare Part D. Part D Specialist positions were created to assist in these goals and were located at MaineCare Member Services, Office of Integrated Access and Support and the five Area Agencies on Aging. Beyond having Part D Specialists, information on Medicare Part D and how it impacts consumers and providers was also available on the internet. Maine developed a webpage dedicated to posting relevant information and resources on Part D for consumers and providers, and was updated on a regular basis. In addition to these efforts, a MaineCare

*Source: Gray, 2006.

Pharmacy Help Desk was developed to field questions about how this new program would impact dual eligibles and to help with any transition issues. This resource was used by many, as additional staff had to be added to field the number of calls being received. Maine has also used Epocrates to provide information to physicians about the formularies covered under the new Medicare Part D plans. The state of Maine has the highest percentage of Epocrates users of any other state in America.* It was proposed and accepted that CMS would provide the Maine specific Medicare Part D Plan Finder data to Epocrates and designate Maine as the pilot project to demonstrate the effectiveness of its use in assisting people with Medicare who have limited income and assets.

* Maine Medicare Workgroup meeting minutes, September 14, 2005.

Appendix B. Glossary of Acronyms

AAA	Area Agency on Aging
CMS	Centers for Medicare and Medicaid Services
DEL	Drugs for the Elderly
DHHS	Department of Health and Human Services
FQHC	Federally Qualified Health Clinics
GOHPF	Governor's Office of Health Policy and Finance
LIS	Low-Income Subsidy
OMS	Office of Medical Services
PAP	Pharmacy Assistance Program
PDL	Preferred Drug List
PDP	Prescription Drug Plan
SHIP	State Health Insurance Programs
SPAP	State Pharmacy Assistance Program
TROOP	True Out-of-Pocket Costs
VA	Veterans Administration

Appendix C. Stakeholders Interviewed

Area Agencies on Aging/State Health Insurance Programs

- Pam Allen, Senior Plus/Elder Independence of Maine (Area Agency on Aging – Western Maine)
- Steve Farnham and Tammy DeLong, Aroostook Area Agency on Aging
- Betty Jewett, Southern Maine Agency on Aging
- Val Sauda, Eastern Agency on Aging

Advocacy Groups

- Helen Bailey, Disability Rights Center
- Robyn Berry, Alzheimer's Association
- Jack Comart, Maine Equal Justice
- Zahira DuVall, Alpha One
- Brenda Gallant, Long Term Care Ombudsman Program
- Nancy Kelleher, American Association of Retired Persons
- Jaye Martin, Legal Services for the Elderly

Provider Associations

- Rick Erb, Maine HealthCare Association
- Christopher Gauthier, Maine Pharmacy Association
- David Hallbert, Maine Medical Association member
- Thomas Hayward, President, Maine Medical Association
- Andrew MacLean, Deputy Executive Vice President, Maine Medical Association
- Kevin Lewis, Primary Care Association
- Bill Miller, Miller Drugstore
- Courtney Oland, OmniCare
- Susan Rovillard, Home Care for Maine

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