

California Medicare Part D: Dual Eligible Rx Implementation



POLICY BRIEF / APRIL 2005

SOLUTIONS-ORIENTED CONVERSATIONS IMPROVING HEALTH POLICY

New Rx Benefit Affects 4.3 Million Californians

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) represents the largest reorganization of a government health program in 40 years. Under MMA, Medicare will begin to provide outpatient prescription drug benefits to beneficiaries and people with disabilities starting in 2006.

Nearly one-quarter of California's 4.3 million beneficiaries will be eligible to receive drug coverage for the first time.¹ About 1.1 million low-income beneficiaries, called "dual eligibles" because they qualify for both state Medi-Cal and federal Medicare benefits, will need to transition from their current state drug coverage to the new Medicare benefit.² This medically vulnerable population could encounter challenges with new formularies, statutory limitations and appeals processes. The remaining 2.2 million beneficiaries who currently have subsidized, or private coverage—such as former state workers who receive prescription drugs through CalPERS—may or may not transition to the new Medicare program.

Medicare will contract with private plans to provide outpatient prescription drugs. The Centers for Medicare and Medicaid Services (CMS) is relying on market competition among prescription drug plans (PDPs) to keep quality high and costs low for beneficiaries and the program. Because California has the largest number of people in Medicare, CMS has deemed the state its own region for purposes of creating PDP competition.

California's Most Vulnerable Population Affected

Californians comprise one-sixth of all dual eligible persons in the nation. Because dual eligible persons typically have incomes of less than \$10,000 a year and face severe chronic illnesses and conditions such as diabetes, heart disease, dementia or a serious mental illness, there are significant issues related to how they will transition from Medi-Cal to Medicare drug coverage without any disruption to services. Nearly one-quarter reside in long-term care facilities and many receive services through the California Department of Developmental Disabilities or the Department of Mental Health. Medi-Cal's pharmacy expenditures for dual eligible individuals in fiscal year 2002–03 accounted for 57% of all Medi-Cal pharmacy fee-for-service expenditures, although they represent fewer than 20% of enrollees.³

Plan for Outreach and Communication

In October 2005, dual eligible individuals will receive information on the different Medicare prescription drug plans available to them, as well as notification of the default plan they will be enrolled in if they do not make a choice. For this population, the enrollment period runs from November 15, 2005 through December 31, 2005. If a prescription drug plan is not chosen, a dual eligible beneficiary will be automatically and randomly enrolled into a default plan that has an average or below-average monthly premium so that the individuals will not be liable for any out-of-pocket premium costs.⁴ Approximately 137,000 dual eligible individuals are currently enrolled in Medi-Cal managed care plans; these individuals may not be auto-enrolled by CMS in the same manner as others.⁵ To minimize the potential problems with random automatic enrollment, dual eligible beneficiaries will be able to switch prescription drug plans at anytime.⁶

In order to coordinate the transition of this population, four state Health and Human Service Agency Departments have formed an MMA Implementation Team: Aging, Developmental Services, Health Services, and Mental Health. The Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP) will assist with disseminating information. The MMA Team is also coordinating with counties, which will be responsible for determining whether other low-income persons (partial dual eligibles), qualify for subsidies under the Part D benefit.

“This is the most significant change in a government health care program in 40 years.”

—Stan Rosenstein, MPA
California Department of Health Services, 2005

ISSUES	CURRENT STATUS 2005	MMA CHANGES	STATE ACTION	GENERAL FUND IMPACT
Dual Eligible Beneficiaries	<ul style="list-style-type: none"> Currently covered under Medi-Cal fee-for-service or managed care. Interaction is with county welfare workers, HICAPs, pharmacists, doctors, long-term care facilities and caregivers. 	<ul style="list-style-type: none"> Reduction in drug categories and classes covered. Private plan selection or automatic enrollment. Private plans need to produce materials in multiple languages. No planned outreach to possible caregivers and relatives of beneficiaries. 	<ul style="list-style-type: none"> MMA Implementation Team in place (DHS, DoA, DDS, & DMH) using current redirected state resources. State may choose to augment funding of the MMA Implementation Team. 	<ul style="list-style-type: none"> Coordination efforts are currently not funded by the state or federal government. HICAPs are funded through Medicare. Possible IT system changes may be necessary, costs unknown.
Base Year Formula Payments “Clawback”—based on per capita drug spending for 2003	<ul style="list-style-type: none"> Cost sharing between Medi-Cal and Medicare. In calendar year (CY) 2003, dual eligibles accounted for 56.85% of total expenditures within the Medi-Cal fee-for-service program. (Most recent year with complete data).⁷ State Medicaid spending for Part D covered prescription drugs for full-benefit dual eligibles, net of rebates, in calendar year (CY) 2003 was \$877 million.⁸ 	<ul style="list-style-type: none"> State will submit subsidy/“clawback” payments to the federal government to help pay for Medicare Part D. LAO estimates \$107 million monthly payment to the federal government, starting in January 2006. 	<ul style="list-style-type: none"> State has approached CMS to readjust formula to include rebates paid in 2004 for the 2003-year. <i>(Requires federal regulatory change)</i> State may choose to challenge the Federal government on the grounds that the Federal law is unconstitutionally coercive under the “doctrine of federalism”.⁹ <i>(Requires legal action)</i> 	<ul style="list-style-type: none"> LAO estimates show an initial net savings of \$17 million in the first 18 months; cumulative net losses to the state thru 2008-09 of about \$758 million. Funded 100% by the General Fund. Additional unfunded costs are unknown (e.g. increased Medi-Cal enrollment).
Wrap-Around Coverage for Dual Eligibles to Supplement Medicare Drug Plan Rx Formularies	<ul style="list-style-type: none"> Dual eligible individuals receive extensive prescription benefits under Medi-Cal. Medi-Cal covers most of the 178 drug categories and classes as defined by the United States Pharmacopeia (USP).¹⁰ 	<ul style="list-style-type: none"> Drug formularies are not specified. Coverage will be determined by private plans and approved by CMS. CMS floor to PDPs requires at least two drugs be covered in 146 listed categories and classes. Most or all FDA-approved drugs in 6 highly sensitive classes will be covered.¹¹ (e.g. HIV, mental health) Appeals process available for beneficiaries seeking coverage of a drug not covered by their Rx plan. 	<ul style="list-style-type: none"> State must terminate “wrap-around” coverage in CA beginning January 1, 2006 or be liable. <i>(Requires CA statutory change)</i> State has approached CMS to grant 6-month to 1-year transition period to maintain continuity of care. <i>(Requires federal regulatory change)</i> State may approach CMS for “clawback” reduction to eliminate the possibility of a dual payment for Rx drug coverage for dual eligible individuals during transition period. <i>(Requires federal statutory change)</i> 	<ul style="list-style-type: none"> Wrap-around coverage funded 100% by the General Fund. If CA does not terminate wrap-around coverage then CA will make a double payment starting on January 31, 2006 from the General Fund.
Excluded Drug Coverage	<ul style="list-style-type: none"> Cost sharing between Medi-Cal and Medicare for several drugs categories (weight loss drugs, barbiturates, benzodiazepines and over-the-counter medications.) 	<ul style="list-style-type: none"> These drugs (weight loss drugs, barbiturates, benzodiazepines, and over-the-counter medications) will be excluded from Medicare Part D. 	<ul style="list-style-type: none"> State may choose to enact legislation that would cover these excluded drugs for dual eligible individuals. <i>(Requires CA statutory change)</i> 	<ul style="list-style-type: none"> Federal matching funds possible if CA chooses to cover excluded drugs for dual eligible individuals.
Administration/Other Programs	<ul style="list-style-type: none"> Medi-Cal determinations are solely made at the county level by county welfare departments. Regional Center case managers can assist in getting families to apply for Medi-Cal, but cannot make actual determinations. The federal government and the state provide funding to the counties to carry out these duties. 	<ul style="list-style-type: none"> Requires the (federal) SSA offices to evaluate and determine if beneficiaries are eligible for Medicare Part D. SSA offices are not required to provide screening for other programs. County welfare offices are required to screen for eligibility for the Medicare cost-sharing programs. Current federal and state budget cycle differences may cause timing and funding problems for HICAP outreach efforts. 	<ul style="list-style-type: none"> Coordinate with the SSA to create an eligibility and determination process that will be seamless and will not place an undue burden on beneficiaries. <i>(Requires federal and CA programmatic change)</i> State may choose to hold staff briefings for federal and state legislative district offices, as well as for local county staff with new administrative responsibilities. Approach the federal government for financial support for new administrative duties. <i>(Requires federal statutory change)</i> 	<ul style="list-style-type: none"> Administrative costs are unknown. Required screening for other cost-sharing programs could be potentially costly for Medi-Cal.

“CMS intends for this program to be revenue neutral for the states.”

—Centers for Medicare and Medicaid Services. (2005).

“[Part D]...will result in cumulative additional General Fund costs to the state through 2008–09 of about \$758 million.”

—Legislative Analyst's Office. (2005).

References

¹ Centers for Medicare and Medicaid Services. (2003). *Medicare Modernization Act: Region Specific Fact Sheet*. Retrieved March 1, 2005 from the CMS website <http://www.cms.hhs.gov/medicarereform/mmregions/pdp32.pdf>

² Legislative Analyst's Office. (2005). *Analysis of the 2005-06 Budget Bill, Health and Social Services, Part "D" Stands for "Deficit": How the Medicare Drug Benefit Affects Medi-Cal*. Retrieved February 24, 2005 from the LAO website <http://www.lao.ca.gov>

³ Legislative Analyst's Office. (2005).

⁴ The Kaiser Commission on Medicaid and the Uninsured. (2005). *Implications of the MMA for States: Observations from a Focus Group Discussion with Medicaid Directors*. Retrieved March 1, 2005 from the Kaiser website <http://www.kff.org/medicaid/7248.cfm>

⁵ Rosenstein, S. (2005, March, 16). *Implementing the Medicare Modernization Act State Perspective: Medi-Cal*. Presentation conducted at The Federal Medicare Prescription Drug Act: State Readiness, Implementation, and Consumer Issues, a joint informational hearing of the CA State Senate and Assembly, Sacramento, CA.

⁶ Office of the Federal Register. (2005, January 28). *Rules and Regulations*. Vol. 70, No. 18, 4204. Washington, DC: Government Printing Office.

⁷ California Department of Health Services. (2005). *Medi-Cal Policy Division*. Sacramento, CA. Author.

⁸ California Department of Health Services. (2005). *Fiscal Forecasting and Data Management Branch*. Sacramento, CA. Author.

⁹ Gardner, J. (2005, March 1). *Winter meeting of the National Governors Association*, Washington, D.C.

¹⁰ California Department of Health Services. (2005). *Medi-Cal Policy Division*. Sacramento, CA. Author.

¹¹ Kelman, J. (2005, April 12). *Personal communication with Centers for Medicare and Medicaid Services, Center for Beneficiary Services*. Washington, DC.

¹² The Kaiser Commission on Medicaid and the Uninsured. (2005).

¹³ Legislative Analyst's Office. (2005).

¹⁴ Legislative Analyst's Office. (2005).

¹⁵ Smith, V. & Moody, G. (2005, February). *Medicaid in 2005: Principles & Proposals for Reform*. Paper presented at the winter meeting of the National Governors Association, Washington, D.C.

State Payments to Medicare and Other Incurred Costs

The MMA requires all states to send a monthly payment (“clawback”) to the federal government to help finance the Medicare drug benefit. The formula used to generate the monthly payment estimates the amount the Medi-Cal program would have spent on dual eligible individuals’ drug coverage if the MMA were not enacted, and then bills the states for their share of this amount starting at 90 percent in 2006 and slowly reducing to 75 percent by 2015.¹² Although the Legislative Analyst’s Office estimates an initial net savings of \$17 million in the first 18 months of the program, they calculate cumulative net losses to the state through 2008-09 of about \$758 million.¹³ This is primarily attributed to the CMS formula for calculating the clawback.

The formula accounts for drug rebates paid only within a calendar year and excludes rebates incurred in that same year but paid for in the subsequent year. The clawback payment is funded 100% by the state General Fund.¹⁴

Unknown costs to the state include the ripple effect of California’s reduced Rx purchasing power for the remaining Medi-Cal enrollees. Other unidentified costs to the state are associated with a projected influx of new eligible low-income enrollees attracted to Medi-Cal by the new Medicare prescription drug benefit, and additional administrative duties relating to implementation. The National Governors Association reports that the required state contributions will cause many states to spend more on Medicaid than they would have in the absence of the law.¹⁵

The California Health Policy Forum (CAHPF) provides an independent platform for education, idea sharing, and conversations among legislative and executive branch health policy staff about the complex and vast array of health issues facing the state today.

CAHPF is an initiative of the Center for Health Improvement (CHI). CHI is an independent, nonprofit health policy center dedicated to improving population health and encouraging healthy behaviors.

Steering Committee

- Center for Health Improvement—Patricia E. Powers, President
- Department of Health Services—Sandra Shewry, Director
- Legislative Analyst’s Office—Elizabeth G. Hill, Legislative Analyst
- Public Health Institute—Joseph M. Hafey, President
- Senate Office of Research—Donald B. Moulds, Director

This publication was supported by grants from the California HealthCare Foundation, based in Oakland, California, and The California Endowment based in Woodland Hills, California.

CAHPF would like to thank the following reviewers of this policy brief:

Bonnie Burns

California Health Advocates/HICAP

Julie James

Health Policy Alternatives, Washington DC

Teresa Miller, Pharm.D.

Medi-Cal Policy Division, California Department of Health Services

Chuck Milligan, MPH, JD

Former Medicaid Director, New Mexico

Stan Rosenstein, MPA

Deputy Director, Medi-Cal Services,

California Department of Health Services

Alan Weil, MPP, JD

Executive Director,

National Academy of State Health Policy, Portland ME

Key Policy Considerations as of April 2005

Enact Wrap-Around Benefit Coverage

Policymakers and advocates have expressed concern that dual eligible beneficiaries may have fewer outpatient prescription drug choices under the Medicare program than they currently receive through Medi-Cal. Mental health advocates are especially concerned that there may also be disruption in continuity of care because of a change in drug formularies. The Legislature may consider whether or not to offer wrap-around coverage in either the short or long term for dual eligible individuals to supplement the Medicare formulary.

Approach CMS Regarding Clawback Formula and Flexibility in Transition

California may choose to team with other states to request that all incurred rebates along with any state cost saving innovations for a given year are included in the clawback formula.

Formally Terminate Medi-Cal Current Outpatient Rx Benefits

If the Legislature does not formally terminate current outpatient prescription drug benefits as of January 1, 2006, Medi-Cal will be paying both for these benefits and the clawback to the federal government.

Monitor Transition

The MMA Team is working closely with CMS to ensure a smooth transition for dual eligible persons. Given the size and complexity of this change, the Legislature may want to closely monitor what is happening and provide augmented funding to the Team where warranted. The state may choose to hold staff briefings for federal and state legislative district offices as well as for local county staff with new administrative responsibilities.

Plan For Outreach to Families and Caregivers

At this time, there is no planned outreach to the families and caregivers of dual eligible persons. The MMA Implementation Team and/or the Legislature may consider options to engage their participation during the transition.

Timeline:

- October 13, 2005: Prescription drug plan details will be made available to beneficiaries. Marketing by private plans can begin.
- November 15, 2005: Enrollment for all beneficiaries begins.
- December 31, 2005: Medi-Cal drug benefit ends for full benefit dual eligible individuals.
- January 1, 2006: Part D coverage begins for all beneficiaries enrolled in a plan. Random auto-enrollment of dual eligible individuals takes effect. CA begins to make monthly “clawback” payments to the federal government for dual eligible individuals.
- May 15, 2006: Last day for beneficiaries to enroll in Part D without facing a penalty.
- May 16, 2006: Beneficiaries that enroll after this date or seven months after their 65th birthday must pay penalties.



CALIFORNIA
Health Policy Forum

Project Director—Vonnice Madigan
Research Analyst—Nicole Kimbrough, MPPA

1330 21st Street, Suite 100
Sacramento, CA 95814
Phone: 916 930.9200, Fax: 916 930.9010
<http://www.cahpf.org>
<http://www.chipolicy.org>