A Real Y2K for Medicaid P&T Committees

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Many of us in the health care field still remember midnight on December 31, 1999, because we were up well past our bedtimes waiting for massive computer failures and utter chaos to befall our health systems—an event that, thankfully, never occurred. Unfortunately, those of us who are involved with Medicaid P&T committees will not experience the same “non-event” at midnight on December 31 of this year. At this predetermined time and date, beneficiaries whose costs for prescription drugs were covered by both Medicaid and Medicare (“dual eligibles”) will be moved from their Medicaid program to newly formed Medicare Prescription Drug Plans (PDPs).

This change is the result of the Medicare Modernization Act (MMA), which terminates federally funded Medicaid prescription drug coverage for all dual eligibles, whether or not these individuals obtain coverage through a Medicare Part D plan and whether or not their new Medicare coverage is as broad as their state’s Medicaid coverage. This effect will be felt well after the clock strikes midnight this New Year’s Eve.

The main effect of this massive shift will be felt directly by those individuals who are dually eligible. To be classified as a dual eligible, an individual must qualify for both Medicare and Medicaid separately. For Medicare, the person must be 65 years of age or older, disabled, or with end-stage renal disease. For Medicaid, the person’s income must be below the poverty line and the person must have minimal assets. As a result of these qualifications, the dual eligibles tend to have more extensive health care needs than other Medicare beneficiaries:

- More than 70% of dual eligibles have annual incomes below $10,000, compared with 13% of all other Medicare beneficiaries.
- Dual eligibles are more than twice as likely to be in fair or poor health (52%) as other Medicare beneficiaries (24%).
- Nearly 25% of dual eligibles reside in long-term care facilities; only 2% of other Medicare beneficiaries live in such facilities.
- Dual eligibles are more than twice as likely to have Alzheimer’s disease as other Medicare beneficiaries (6% vs. 3%), are substantially more likely to have diabetes (24% vs. 17%), and are more likely to have had a stroke (14% vs. 11%).

Because of these characteristics, dual-eligible beneficiaries are more likely to suffer adverse health consequences if they cannot obtain medications in a timely manner.

These concerns were raised early in this process; just before the MMA’s completion, the Kaiser Commission convened Medicaid directors from eight states in a focus group conducted on October 26, 2003. The group identified the following problems:

- limited fiscal relief
- major new responsibilities for administering Medicare’s low-income subsidies
- a loss of control over prescription drug benefits for dual eligibles
- a possible prohibition on using Medicaid to supplement the Medicare drug benefit

Although some of these issues (such as the prohibition on using Medicaid to supplement the Medicare drug benefit) have been clarified, significant problems remain. Medicaid programs and their P&T committees will need to refocus their efforts for this frail population. This renewed focus should concentrate on the areas outlined in Table 1.

ENSURING PRESCRIPTION COVERAGE IN 2006

To assure dual eligibles of uninterrupted drug coverage after December 31, 2005, the Centers for Medicare and Medicaid Services (CMS) will automatically enroll them into a freestanding PDP that is at or below the low-income subsidy amount. This ensures that beneficiaries will not be without coverage on January 1, 2006, when the Medicaid prescription benefit—as it currently exists—ends.

The “auto-enrollment” started in October 2005 and continues every month thereafter, with the CMS auto-enrolling and notifying full-benefit dual eligibles of their assignment into a

Table 1: Focus of Medicaid Programs for Dually Eligible Beneficiaries

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<th>Focus of Medicaid Programs for Dually Eligible Beneficiaries</th>
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<td>1. Ensure continuity of health care through enrollment in a</td>
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<td>Medicare drug plan.</td>
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<td>2. Supervise Medicare drug plans in which the dual eligibles</td>
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<td>are enrolled to ensure access and adherence to all</td>
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<td>medically appropriate medications to avoid shifting of</td>
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<td>expenses.</td>
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<td>3. Provide coverage of medications excluded by Medicare</td>
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The MMA, Medicaid, and P&T Committees

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low-premium PDP. This notice includes the following information:

• an explanation of how to choose a Medicare PDP
• the name of the Medicare PDP in which beneficiaries will be enrolled if they do not choose a plan by December 31, 2005
• the plan’s Web site and toll-free telephone number for members (1-800-MEDICARE)
• reminders that Medicaid drug coverage ends on December 31, 2005
• a notice that enrollees qualify for extra help with their drug plan costs
• a note that enrollees can change plans at any time
• an explanation of the right to decline Part D. (If Part D is declined, beneficiaries may be subject to a late enrollment penalty if they eventually enroll at a future date.)

Although the auto-enrollment is in place to ensure that the dual eligibles have a replacement for their Medicaid drug coverage as of January 1, it does not ensure access to the same level of coverage that these frail individuals might have enjoyed previously.

ACCESS TO MEDICATIONS

For several reasons, access to medications for dual eligibles will be more limited under the new plan than under their state’s Medicaid program. For instance, under federal law, states that provide prescription coverage are required to cover “most” FDA-approved drugs for all manufacturers that have entered into an agreement with the Secretary of the Department of Health and Human Services (DHHS) to pay rebates to states for the products they purchase. This stipulation allowed dual eligibles access to a more “open” formulary than is commonly available from most Medicare plans. Although states have been implementing tools to control utilization (such as prior authorization requirements, limiting the number of prescriptions, and charging nominal co-pays), Medicaid formularies are considered open formularies.

With regard to charging a nominal co-payment, the burden is on the provider, for providers are not allowed to deny services to Medicaid beneficiaries who cannot make these payments. This is not true under Medicare Part D, in which plans can withhold prescriptions to any beneficiary, including the dual eligibles, for failure to pay $1.00 for their generic prescriptions and $3.00 for brand-name prescriptions. This change will certainly result in some dual eligibles not receiving needed medications.

Pharmacies can choose to waive co-pays and dispense medications if the patient cannot pay and if the following conditions are met:

• The pharmacy does not advertise that it will waive co-payments.
• The pharmacy does not routinely waive co-payments.
• The pharmacy waives the co-payment only if the patient is in financial need.

Fortunately, patients who are fully dual-eligible beneficiaries and who reside in long-term care facilities will not be required to pay any co-insurance for formulary prescription drugs. The critical word is “formulary,” because not all prescription drugs will be included on a plan’s formulary. Some medications will be restricted by the plan; still others are not covered by the MMA legislation because they are not available under Medicare Part D.

These medications were excluded because the MMA’s drafters relied on a definition of Medicare Part D drugs from the list of medications that state Medicaid programs offering prescription drug coverage are required to cover. Although all 50 states now cover these medications to some degree, they are not required to do so under the current Medicaid law. As a result, Medicare PDPs are not being required to cover these medications either, nor can they cover them using Medicare Part D funds because of the way in which the law was drafted.

States can decide to cover those medications that are excluded by the MMA rules because of their classification as non-Medicare Part D medications, and although some states (e.g., Delaware, Colorado, Illinois, and Maryland) have passed bills to provide funding for these excluded medications, some states may choose not to provide such coverage.

The MMA excludes certain medications from Medicare Part D coverage according to their drug class and use:

• Specific excluded uses:
  • weight enhancement or reduction (except when the medication is used to treat obesity or weight enhancement in patients with acquired immunodeficiency syndrome (AIDS)
  • fertility
  • cosmetic enhancement (e.g., minoxidil [Rogaine®] and isotretinoin [Acutane®])
  • symptomatic relief of cough or colds

Of these medications excluded under MMA, the drug class most commonly utilized by dual eligibles is the benzodiazepines. Because of this need, a bipartisan bill was introduced to strike the exclusion of benzodiazepines that currently exists in the MMA. Representative Benjamin Cardin (D-Md.) introduced H.R. 3151, which has been referred to the Committee on Energy and Commerce and to the Committee on Ways and Means for consideration. Obviously, this would remove this burden not only from states but also from individual Medicare beneficiaries, who would be forced to cover this excluded medication on their own if they needed it.

An additional concern regarding excluded medications is that the exclusions will force a shift to drugs covered under Medicare Part D. This change might not always be appropriate and might result in adverse drug reactions and increased expenditures.
SUPERVISION OF MEDICARE DRUG PLANS

Under the MMA, state Medicaid programs are likely to lose their clinical responsibility for the prescription management of their dually eligible members. Some states are pushing to have continued access to their clinical information through a relationship with the Medicare PDPs. This information is required to determine adherence as well as appropriate medication usage. The MMA has provided a process for Quality Improvement Organizations (QIOs) to oversee the Medicare PDPs. This is important because Medicare PDPs are solely responsible for Medicare Part D, not Medicare Part A or B. Consequently, there would be a financial incentive to move toward underutilization of medications within this population; the result would be an increase in expenditures for Medicare Part A and B as well as for state Medicaid programs. These increased expenditures could come from the underuse of cholinesterase inhibitors, resulting in premature placement of dual eligibles in nursing homes.

While the states are losing the clinical responsibility for the management of prescription utilization, they maintain direct financial liability for these 6.5 million Americans who are covered by Medicare plus Medicaid. The phased-down state contribution payment (“the Clawback provision”) represents each state’s financial responsibility for the care of the dual eligibles under Medicare’s prescription drug coverage. The phased-down state contribution payments are defined in the MMA to be the product of the annual per capita dual-eligible drug cost and monthly state enrollment of full dual eligibles times the monthly adjustment factor.

The baseline from which the per capita costs have been derived is the enrollment and drug payment information reported by the state in calendar year 2003. This payment is phased down over time, starting at 90% in calendar year 2006 and decreasing by 1 2/3% until the reimbursement reaches 75% in 2015. These payments are designed to return to the federal government a significant share of the amount that the states would have spent on prescription drug coverage for dual eligibles under Medicaid if the MMA had not been enacted.

CONTROLLING COSTS

The Medicaid Commission, formed by provisions of the Congressional budget resolution as a way to achieve consensus on reducing federal Medicaid expenditures, issued its report in September 2005. Among the major proposals was a plan to reduce Medicaid pharmacy reimbursement by basing reimbursement on the average manufacturer price (AMP), which is the benchmark by which drug manufacturers pay Medicaid rebates. This plan differs from the Bush administration proposal, which endorsed the average sales price (ASP) as a reimbursement standard.

The Commission’s proposal is in line with the plan suggested by the National Governors’ Association. The net difference to pharmacy between the ASP and the AMP is believed to be about $1 billion over five years; the AMP saves less money than the ASP. Congressional appropriators will be examining all options and will make their own recommendations. In any event, it appears that Medicaid’s pharmacy reimbursement is headed downward.

FUTURE DIRECTION OF MEDICAID PROGRAMS

Medicaid now consumes more resources than any other state program; this is a significant point, because education expenditures have been surpassed for the first time in many states. This is occurring at the same time that the U.S. Congress has established the Medicaid Commission to examine and recommend policy changes to reduce the federal government’s Medicaid bill by $10 billion over the next five years. Previous efforts had focused on pharmacy reimbursement through cuts in dispensing fees and product reimbursements. Additional measures to curb expenditures include restricting access to certain medications, although this will probably reduce prescription expenditures through shifting costs to other areas, such as Medicare Part A and Part B programs.

The state of Florida is experimenting with a Medicaid preferred drug list that includes only the two lowest-cost products for each therapeutic category. Access to medications that are not on this list will be significantly restricted.

Other approaches to easing the financial burden include moving Medicaid beneficiaries to managed care organizations—which includes a unique option available under the MMA of special needs plans (SNPs) for the dually eligible. These plans appear to be ideal from an integrated approach because of their responsibility not only for Medicaid but also for Medicare Parts A, B, and D.

Another approach includes the expansion of group-purchasing organizations. The second multistate purchasing pool was approved by DHHS, Louisiana, Maryland, and West Virginia have established their pool, as have Alaska, Hawaii, Michigan, Minnesota, Montana, Nevada, New Hampshire, and Vermont. It is hoped that these pools will reduce prescription costs through volume purchases.

In the future, Medicaid programs are likely to be under increased pressure to reduce prescription expenditures within the Medicaid-only population, which will comprise mainly women and children, because the elderly, the disabled, and patients with end-stage renal disease are removed from this group.

States will find themselves in the difficult situation of either moving toward relinquishing control of their dual eligibles or pushing to regain some of the control that they have lost as a result of the MMA—while at the same time refocusing their Medicaid pharmacy program on the needs of the Medicaid-only beneficiaries. Some level of control over the dual eligibles is essential to ensure that Medicare PDPs are delivering optimal outcomes not only for dual eligibles but also for the state Medicaid program overall by not shifting costs to the state’s side of the ledger. Only time will tell which direction states will take, but clearly this is a very important milestone.

REFERENCES