

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

Legislative Budget Committee

September 9, 2004

Medicare Modernization Act

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Chairman Morris and members of the committee, thank you for this opportunity to appear before you today to provide information relevant to the state in regard to the Medicare Prescription Drug, Improvement and Modernization Act. I am Scott Brunner, Director of Medical Policy and Medicaid for the Department of Social and Rehabilitation Services.

Background

The Medicare Prescription Drug, Improvement and Modernization Act, also known as the MMA, was signed into law on December 8, 2003. The new law, most well-known for the creation of Medicare Part D - a voluntary drug benefit, will provide seniors and people with disabilities access to prescription drug coverage beginning January 2006. To assist beneficiaries with prescription drug coverage until Part D is implemented, an interim Medicare-endorsed drug discount card and transitional assistance program were implemented in June, 2004.

While the prescription drug benefit provisions have been extensively publicized, the MMA contains a number of changes to the current Medicare law. Key provisions that are Medicaid related include the following:

- Dual eligibles will receive drug coverage through the new Medicare Part D; however, the new law requires a significant portion of the savings realized from the reduction in Medicaid drug costs be returned by the states to Medicare.
- States will have new administrative responsibilities including determining who qualifies for low-income assistance.
- States will receive an increase in Disproportionate Share Hospital (DSH) payments in 2004.
- Medicaid expansions will not be allowed to fill in the gaps of the Medicare drug benefit. This means that if states choose to provide additional prescription drug assistance, they will have to use their own funds exclusively.

Other key provisions include:

- For 18 months (following the December 8, 2003 enactment), physicians will not be able to own an interest in a specialty hospital, unless the hospital was in operation or under development as of November 18, 2003. During this moratorium, preexisting specialty hospitals cannot exceed a 50% increase in the

number of hospital beds, increase the number of physician investors, nor change their areas of specialization.

- Tax-free “Health Savings Accounts” may be established that can be used in conjunction with high deductible health insurance plans.
- State and local governments may be eligible to receive incentive payments of 28% of costs between \$250 and \$5,000, tax-free, for drug coverage to retirees.
- Qualified providers who provide care to undocumented immigrants may receive a capped payment from The Department of Health and Human Services for any un-reimbursed care from 2005 to 2008.
- The Medicare Advantage program (MA) will replace the Medicare + Choice Program. The MA program creates regional and local MA plans starting January 1, 2006, and will require a competitive bidding process to execute a Medicare contract. Regional plans will consist of preferred provider organizations (PPOs) that cover large regions (possibly across state borders). Local plans will be similar to current Medicare+Choice HMO plans, typically operating in the area the size of a county.

Dual Eligibles and the “Clawback”

One of the primary provisions of the MMA is prescription drug coverage beginning in January 2006. The coverage – known as Medicare Part D – will pay for prescription drugs for low-income seniors and persons with disabilities who are eligible for both Medicare and Medicaid. This group is referred to as dual eligibles. Currently, the Kansas Medicaid program pays for the drug costs of this group.

When the Medicare Part D coverage begins in January 2006, the cost of prescription drug coverage for dual eligibles shifts to the Federal government; however, the states are expected to continue to contribute to the cost of this coverage through a phased-down state contribution – commonly referred to as the “clawback.” This is a payment each state will make monthly to the federal government, starting in January 2006. The formula includes a phased-down percentage for each year, beginning with 90 percent in 2006 and decreasing to 75 percent in 2015. The actual formula is outlined in the attached document from the Kaiser Foundation.

The concept of the clawback is that because states will no longer be paying for pharmacy expenditures for Medicare-eligible individuals, a portion of the states’ savings should be paid to Medicare. The clawback will be calculated using the State share of Medicaid per capita spending for prescription drugs for dual eligibles in calendar 2003 and inflated forward to 2006. The calculation makes adjustments for manufacturers’ rebates and excludes any amount spent on drugs not covered under Part D.

Our estimate of the amount of the clawback Kansas will be expected to pay is significantly lower than the amount estimated by the Centers for Medicare and Medicaid

Services (CMS). The primary reason for the difference is that CMS used data from a national reporting system which assumed 100 percent of all aged and disabled persons receiving Medicaid are eligible for Medicare. While SRS considers this an incorrect assumption, SRS remains unsure of the methodology CMS will use to calculate the final payment required by the state.

The data in the attached table is based upon actual pharmacy expenditures incurred only by Medicaid eligible beneficiaries who were also eligible for Medicare. All figures show only the State General Funds. The amounts shown in the “gain” column do not include consideration of additional administrative costs that would be incurred by the State.

Eligibility for Subsidies

The MMA establishes subsidies for low income Medicare beneficiaries to help meet the cost of premiums, deductibles, and co-insurance connected with Part D coverage as well as provide continuous coverage above the initial coverage limit. Full subsidy eligibles will pay no premiums or annual deductibles. Co-payments for drugs will be minimal and vary based on whether the individual is above or below 100 percent of poverty. Those eligible for full subsidies include persons who receive full Medicaid coverage including SSI recipients, persons receiving institutional services, and persons who qualify by meeting a medically needy spenddown. It also includes individuals who receive coverage through the Medicare Savings Programs, Qualified Medicare Beneficiaries (QMB), and Specified Low Income Medicare Beneficiaries (SLMB).

A primary impact on states is the requirement that subsidy applications be filed with either the State or the Social Security Administration. States must be prepared to accept subsidy applications for any Part D beneficiary regardless of whether the person is, or could be, eligible. Information regarding the outcome of this determination must then be shared with CMS so that the information is made known to the drug plan sponsors. The income and resources that must be considered in this determination differ from what states may be applying in the Medicaid program. The regulations prohibit use of more liberal income rules that many states have adopted. They impose different requirements for the family size used to determine the poverty level standard. For resource purposes, only liquid assets such as savings, bank accounts, and other real property are to be considered.

Because of the special determination rules, states will be required to make extensive system and administrative changes and will be unable to use current system logic that exists for regular Medicaid determinations. In addition, data exchanges will need to be developed for purposes of conveying determinations to CMS. States must also do annual re-determinations of subsidy eligible individuals and offer enrollment for any Medicaid program for which the individual qualifies. Subsidy determinations will be

required not only for current Medicaid beneficiaries but also any other Part D eligible individual thus potentially increasing workload and the costs associated with those determinations. States must be prepared to begin accepting subsidy applications as of July 1, 2005. Substantial coordination, as well as educational efforts, will need to take place with SSA since applications can be filed with either SRS or SSA.

Potential “Woodwork Effect”

The woodwork effect refers to the idea that this new program will result in persons enrolling in Medicaid who are not currently enrolled. It is anticipated that virtually all of these persons would be Qualified Medicare Beneficiaries and the primary expenditure for Medicaid would be the Medicare Buy-In premium. Kansas also would be paying for any coinsurance and deductibles these beneficiaries incur on non-pharmacy expenditures.

It is generally believed that only about 50 percent of all Qualified Medicare Beneficiaries are enrolled in Medicaid, so there may be a significant number of new persons who could enroll in Medicaid. The potential costs of the woodwork effect likely would result in net costs to Kansas for at least the first three years of the Medicare Part D program. There is the possibility for a net savings in subsequent years, depending upon the number and cost of the persons who choose to come into Medicaid as a result of this program.

Restrictive Formularies and Wrap-Around Coverage

Beginning January 1, 2006, dual eligibles will not be able to continue Medicaid coverage for any prescription drugs covered by Medicare Part D; they must choose a Part D plan or lose prescription drug coverage. There is concern about what drugs Part D plans will cover and whether dual eligibles will be able to receive the specific drugs they need. This population is often sicker and in need of more medications than the rest of either the Medicare or Medicaid populations. Part D plans must cover at least two drugs in every class, but the plans have much flexibility in the determination of drug classes, and they can establish closed formularies.

CMS will review any formularies proposed and has contracted with the U.S. Pharmacopeial Convention to develop model guidelines for classifying drugs and drug categories; however, dual eligibles with HIV/AIDS, epilepsy, or mental illness may be vulnerable if Part D plans cover only a limited number of newer, more effective drugs. States may continue to cover specific drugs that are not covered by Part D plans, but no federal match will be available. SRS staff are researching the types of medications Kansas dual eligibles take to determine the potential impact of closed formularies on this population.

Coordination Activities

Since the signing of the MMA, a team composed of relevant SRS and Department on Aging staff are working to make certain Kansas meets the requirements for states in the Act, and to ensure a smooth transition for dual eligible beneficiaries from Medicaid to Medicare drug coverage. A multi-department Steering Committee has been established to assist the MMA Work Team by making policy decisions and securing necessary resources for the Work Team.

Recently, CMS published the proposed regulations for the Medicare Prescription Drug Coverage, but some implementation details continue to be undefined. SRS and the Department on Aging staff participate in periodic conference calls with CMS to obtain guidance and clarification on our roles and responsibilities in implementing this coverage.

That concludes my testimony. I am happy to answer any questions the Committee has at this time.