California Dual Eligibles’ Transition to Medicare Part D

Presentation to National Medicaid Congress by
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Dual Eligibles

Nationally, 6.4 million

- 1.074 million (16%) reside in California
  - 937,000 in Medi-Cal fee-for-service
  - 137,000 in Medi-Cal managed care
The Challenges

- **1 day** to transition 1 million dual eligible Californians to Part D

- While choice for duals is good, choice among ten plans is complicated
  - If changed (or selected) plans during December, the information was not available to pharmacists online – caused much confusion
The Challenges (cont)

- If dual eligibles with retirement coverage enrolled in Part D,
  - likely to lose their employer medical coverage.
- Plans not required to share dual eligible data with states
  - California working with 10 different plans to obtain)
- Plans each have different formularies and provider networks
California Actions
(prior to January 1, 2006)

- Outreach
  - multi-language to beneficiaries; interdepartmental coordination; HICAP/SHIP network; advocates, pharmacy orgs)
- 100 day supply (Dec. 05)
- Continued coverage of most Medicare non-covered (excluded) drugs
- Pharmacy claims data to plans
- Extra staffing to handle calls (January)
California could not afford

- Wrap around for Medicare **covered** drugs
- Co-pays for dual eligibles
- Premiums for duals to enroll in more costly Part D plans
- Premiums for Medicare Advantage Plans
January 1, 2006

Many confused, scared, angry Medi-Cal beneficiaries who had trouble obtaining their medications
First two weeks......

- Mass confusion in pharmacies
- Phone and data lines overwhelmed
  - CMS (1-800 Medicare)
  - E-1 transactions (eligibility) not working
  - Many plans unreachable
California Steps In to Help

- **Jan. 12th** – Governor directs CDHS to implement 5-day emergency program
- **Feb 9th** - Legislature gives Governor authority to extend the program until May 16, 2006
- **May 17th** – Legislature modifies and extends emergency program
  - Through January 31, 2007
  - Adds prior authorization requirement
California’s Emergency Program

- Jan. 12 to May 16th
  - Pharmacist self-certified, claim submitted and adjudicated electronically

- May 17th to Jan. 31, 2007
  - Pharmacist must obtain prior authorization from CDHS, claim must be faxed
California’s Emergency Program

- January 12 – May 16, 2006
  - 614,953 claims
  - $58 million
  - 177,732 different people affected
California’s Emergency Program

- May 17 – May 31, 2006
  - 2,370 claims
  - $317,533
  - 1,500 different people affected
Five months later….

- **E-1 transactions (eligibility)**
  - Data in system improved
  - Many pharmacists still not aware of how to use

- **Claims Processing**
  - Inappropriate co-pays returned (various reasons)

- **Wellpoint/Anthem/Unicare (Failsafe)**
  - Only available for “missed” duals
  - Many pharmacists not aware of, or not willing to use, based on experience early on
Five months later…..

- **Prescription Drug Plans (PDPs)**
  - Difficult to train customer service reps on this complex benefit
  - Transition Plans
    - not always clear how to access
  - Exceptions Process
Five months later….

- **Long Term Care**
  - In many cases, residents not identified correctly in system, therefore incorrect co-pays returned

  - If dual eligible had a “representative payee”, CMS auto-enrolled them in a plan in the representative payee’s region (rather than where the dual resides)
Five months later….

- **Enrollment issues**
  - People who change plans lose LIS
  - New enrollees don’t get auto-assigned until mid-month and may not show up in plan’s electronic systems until late in month (ongoing system issue)
Five months later….

- **Home Infusion**
  - Now requires split billing
    - *Medi-Cal*
      - supplies and “excluded” drugs
      - Seeking clarification from CMS on dispensing fees/compounding fees
    - *Part D*
      - Part D coverable drugs only
  - Plans not used to dealing with home infusion providers
Five months later….

- **Long Term Care**
  - In many cases, residents not identified correctly in system, therefore incorrect co-pays returned
  - If dual eligible has a “representative payee”, CMS auto-enrolled them in a plan in the representative payee’s region (rather than where the dual resides)
Five months later….

- **Prescription Drug Plans (PDPs)**
  - Phone line response times have improved, but quality of info still an issue
    - Difficult to train customer service reps on complex benefit
  - **Transition Plans**
    - Even though extended, not always clear how to access
  - **Exceptions/Prior Authorization process**
    - Every plan is different
    - Not clear to pharmacist if this process has been completed
    - In California, physicians who serve Medi-Cal are not used to having to call plans for prior authorization (pharmacist handles)
Key problems still exist that are not addressed

- Ability of plans to respond to CMS’s direction for key new functions (e.g. transition policies, exceptions process)
- Physicians and pharmacists completely discouraged
  - Maze of procedures, contact numbers, requirements creates barrier to use
  - Almost total lack of activity may signal obstacles
When to discontinue emergency coverage?

- CMS data often too general to be conclusive – need more quantifiable data

- **Plan phone lines**
  - Wait times are down
    - For what time periods?
    - Quality of the information provided?

- **Results of CMS case work**
  - How many received?
  - Resolved?
  - Days to resolve?
The Transition to Part D Has Been Rocky for Many

- Even with auto-enrollment process, some duals were missed
- Plans did not always follow transitional protocols required by CMS
- Some duals were overcharged for drugs
- People with cognitive impairments have been particularly vulnerable
Challenges After Enrollment

- Once enrolled, dual eligibles need time to understand their new coverage
  - Learning how Medicare drug plans work in ways that may be different from Medicaid
  - Adjusting to new formularies and co-payments
  - Securing exceptions if they need non-formulary drugs

- Care for dual eligibles may become more fragmented as Medicaid, Medicare, and Part D plans must coordinate
Observations

- Dual eligibles’ high rates of chronic illness, including mental disorders, makes management of their cases complicated and expensive.

- In addition to their poor health status, dual eligible beneficiaries have very low incomes.

- Dual eligibles require extensive health care services and many are reliant on prescription drugs.
  - Medicare Part D transition has been difficult and requires ongoing monitoring.
Conclusion

- Most people are getting their medications
- CMS is working to resolve remaining problems
- Situation is improving - but some issues will likely take a long time to fix (e.g. system issues)
QUESTIONS?