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)

When to discontinue emergency coverage?

- 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?