

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, February 16, 2005

Members in Attendance: Ray Maxim, MD, Chair; Munawar Azam, MD; Stanley Block, MD; Mark Braun, MD; Michael Fine, MD; Ellen Gurney, MD; William Hollinshead, MD, MPH; Victor Lerish, MD; Sharon Marable, MD, MPH; Richard Wagner, MD; John Young. Guests: Sandra Boehlert, MD; Kerrie Jones Clark; Celia Gomes McGillivray. HEALTH Staff: Deborah Pearlman; Anne Marie Silvia. PCPAC Staff: Carla Lundquist, Mary Anne Miller, RN, MPH.

Members not in Attendance: Jeffrey Borkan, MD, PhD; Herbert Brennan, DO; L. Anthony Cirillo, MD; Herbert Constantine, MD; Charles Eaton, MD; Sarah Fessler, MD; Deidre Gifford, MD, MPH; Arnold Goldberg, MD; Omar Meer, MD; John Murphy, MD; Donya Powers, MD; Mark Schwager, MD.

- *The Medicare Part D Prescription Drug Benefit is likely to be very confusing to the Medicare eligible population, many of whom will need to consult their primary care physician regarding their choice of Prescription Drug Plan.*
- *Implementation of Medicare Part D will negatively impact the state both fiscally and through the loss of drug utilization review data critical for disease and clinical management.*

Dr. Maxim opened the meeting at 7:37 AM. Minutes of the January 19, 2005 meeting were approved as written.

John Young, Associate Director, Division of Healthcare Quality, Financing & Purchasing, Department of Human Services, provided a presentation on Developments in Medicaid and Medicare. Four topic areas were covered; see the attached presentation slides. Discussion highlights:

1. Medicare Modernization Act: Medicare Part D: Beginning January 1, 2006, new Medicare prescription drug plans [Medicare Part D] will be available to Medicare beneficiaries (~173,000 in RI). Persons entitled to Medicare Part A (Hospital Insurance) and enrolled in Part B (Medical Insurance) are eligible to participate in Part D. Enrollment in Medicare Part D will be voluntary (except for those dually eligible for Medicaid, ~30,000 in RI). Beneficiaries will pay an average monthly premium of \$35 for Part D in addition to their monthly Part B premium, and an annual deductible of \$250 for prescription drugs. Between \$250 and \$2,250, Medicare pays 75 percent of drug costs. The beneficiary pays a 25 percent co-insurance. Between \$2,250 and \$5,100, [the "coverage gap"] the beneficiary is responsible for 100 percent of their drug costs. When a beneficiary has spent \$3,600 out-of-pocket (OOP), the Medicare "catastrophic limit" coverage provision kicks in. (OOP expenses include the annual deductible of \$250 and all co-payments and co-insurance, but not the Part D premiums or payments made for any off-formulary medications. Including the Medicare contribution, the \$3,600 OOP expense level equates to \$5,100 total point of service cost of medications.) Under the "catastrophic limit" coverage provision of Part D, Medicare pays 95 percent of prescription drug costs for the remainder of the year. Assistance will be available for lower-income beneficiaries. Dual eligibles living in the community will be exempt from cost sharing in general, but will be responsible for nominal point-of-service co-pays of \$1-\$3. A key aspect of Part D's financing is the use of state funds previously expended by Medicaid for dual-eligibles to finance the new federal benefit (the reverse payment or "clawback"), calculated from the FY2003 level of state expenditure. Areas of concern include:

Prescription Drug Plans (PDPs) PDPs will be offered by insurance companies and other private vendors, such as pharmacy benefit managers, drug store chains, or drug manufacturers. It is estimated there will be approximately 12 PDPs in our region. Medicare is prohibited from negotiating best price for pharmaceuticals, unlike Medicaid. Marketing is the only incentive for PDPs to pursue aggressive pricing. PDPs are not obligated to offer a full formulary; they are required only to have at least one medication per therapeutic class. Some types of drugs (lifestyle) may be excluded. PDPs may change their formularies monthly but enrollees will be locked into a PDP for at least one year. It is not defined whether existing prescriptions will be honored or if there will be any formulary override privileges. Enrollment may mean changes in pharmacy network; freedom of choice is not guaranteed.

State Impact The ability of Medicaid to negotiate discount bulk drug purchase pricing will be diminished. The reverse payment (clawback) is calculated using factors disadvantageous to RI; the state will see an initial net loss of several million, probably growing to \$10-12M over the next few years. RI will lose the drug utilization review data critical for disease and clinical management. Mandatory take-up of Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) members for the coverage gap (if implemented) would be ruinously expensive for the state.

Timeline Application for Part D will start in July 2005, but the PDPs, their formularies, and price structure will not be announced until September. Dual eligibles will be auto-enrolled in early fall with less choice of plans. Seniors who apply but do not enroll before the end of May 2006 will be auto-enrolled in a plan without choice. Seniors who do not apply in the first year will receive less favorable benefits in subsequent years.

General OOP expenses for the consumer are considerable and the cost savings are modest until the catastrophic limit is reached. Part D is likely to be of most benefit to middle-income seniors with exceedingly high pharmacy expenses. There are

legal liabilities for persons counseling seniors on their choice of plan, except for MDs and volunteers (e.g., at a senior center). CMS has deferred the operational decisions of most interest to states until "later guidance". There are no tracking mechanisms to know when a beneficiary enters the coverage gap. CMS's online tool for matching a patient's medications/conditions to a PDP is incredibly difficult to use.

2. Supplemental Pharmacy Rebate: Pharmacy is a leading driver of overall expense in Medicaid. RI has implemented cost-containment efforts including prior authorization and drug utilization review to save ~\$25M over the last two years. The Governor's FY2006 Budget includes a proposal to sign on to the Multi-state Consortium for the purpose of acquiring supplemental pharmacy rebates (~\$1.8M in general revenue savings). These negotiated rebates would apply to fee-for-service Medicaid, not Rite Care.

3. Expansion of Medicaid Managed Care: In addition to the populations currently enrolled in Rite Care [125,926 TANF-eligible parents and children, 2,158 children in foster care, 3,858 Children w/ Special Health Care Needs, 207 Adults with Disabilities in Connect CARRE], three additional populations that may benefit from managed care are under consideration for expansion [~4,000 SSI parents of Rite Care children, CSHCN's who age out of Rite Care but remain eligible for Medicaid (~200/year), 6-8,000 adults with disabilities or chronic care needs]. Enrollment options, sequencing, and service/risk options for these populations need to be developed, and the value, savings, and ability of the Rite Care service delivery system to take on these complex cases need to be analyzed. Due to the time needed for implementation, fiscal benefits of this expansion would not be seen until FY2007.

4. Emergency Department Utilization: Rite Care: As many as 25% of the emergency department visits in Rite Care are for conditions that could have been treated in a primary care setting. The new health plan contracts create an incentive payment for plans that implement strategies that demonstrate reduced ED utilization. Under upcoming contract amendments, DHS payment rates will be adjusted to reflect the appropriateness of the treatment setting. Savings to the state will come out of capitation rates. The new contracts reflect assumptions around increased PCP reimbursement; Dr. Fine voiced concern that due to the all products clauses, the ability of PCPs to negotiate increased reimbursement [for expanded evening/weekend/holiday hours, urgent visits] with health plans for Rite Care is virtually nonexistent.

Dr. Maxim urged PCPAC members to review the conference announcements included in the meeting packets, especially for the Health Information Technology Fair. The meeting was closed at 8:55 AM.

NEXT PCPAC MEETING WEDNESDAY, MARCH 16, 2005

Developments in Medicaid and Medicare

Presentation to
Primary Care Physician Advisory Committee
February 16, 2005

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TODAY'S DISCUSSION

- Medicare Modernization Act: Medicare Part D
- Expansion of Medicaid Managed Care
- Emergency Department Utilization: Rite Care
- Supplemental Pharmacy Rebate

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MEDICARE PRESCRIPTION DRUG PLAN: MEDICARE PART D

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THE BASICS

- Beginning January 1, 2006, new Medicare prescription drug plans will be available to 41 million Medicare beneficiaries-Medicare Part D. Rhode Island has approximately 173,000 Medicare beneficiaries.
- Persons entitled to Medicare Part A (Hospital Insurance) and enrolled in Part B (Medical Insurance) are eligible to participate in a Medicare Part D prescription drug plan.
- Enrollment in Medicare Part D will be voluntary (except for those dually eligible for Medicaid).
- Prescription drug plans will be offered by insurance companies and other private vendors, such as pharmacy benefit managers, drug store chains, or drug manufacturers.
- Assistance will be available for lower-income beneficiaries.

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HOW MEDICARE PART D WORKS

- Beneficiaries will pay an average monthly premium of \$35 for Part D. This is in addition to their monthly Medicare Part B per month premium (currently \$78.20).
- Beneficiaries pay an annual deductible of \$250 for prescription drugs.
- Between \$250 and \$2,250, Medicare pays 75 percent of the beneficiary's drug costs. The beneficiary pays a 25 percent co-insurance.
- Between \$2,250 and \$5,100, the beneficiary is responsible for 100 percent of their drug costs. This is called the "coverage gap" or "donut hole."
- When a beneficiary has spent \$3,600 in out-of-pocket prescription drug costs, the Medicare "catastrophic limit" coverage provision kicks in.
- Under the "catastrophic limit" coverage provision of Part D, Medicare pays 95 percent of prescription drug costs for the remainder of the year. The beneficiary pays five percent.
- Out-of-pocket expenses include the annual deductible of \$250 and all co- 5 payments and co-insurance.

Enrollee Drug Spending Estimates under Part D

	<u>Total Cost</u>	<u>Consumer</u>	<u>Medicare</u>	<u>State</u>
• Annual Premium @ \$35/month	\$420	\$420	\$0	NA
• Annual Deductible	\$250	\$250*	\$0	NA
• Co-insurance	\$2,000	\$500*	\$1,500	NA
• Coverage Gap	<u>\$2,850</u>	<u>\$2,850*</u>	<u>\$0</u>	NA
Total Cost	<u>\$5,520</u>	<u>\$4,020</u>	<u>\$1,500</u>	NA

- Counts towards \$3,600 out-of pocket "catastrophic limit"

So, if a Medicare consumer (non-dual eligible) has a total annual point of service cost of medication of \$6,000, their obligation (including premium) would be \$4,065, and Medicare's share would be \$1,500 (offset by the \$20 premium)

Enrollee Drug Spending Estimates under Part D

- Dual eligibles living in the community will be exempt from cost sharing in general, but will be responsible for point-of-service co-pays of \$1 (generic) and \$3 (brand) – average cost/month for the consumer will be approximately \$7.62

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Enrollee Drug Spending Estimates under Part D

- Estimates were calculated last year using the Kaiser Family Foundation benefits calculator
- Estimates assume that consumer is enrolled in standard Part D plan, does not have Medicaid, and has income < 150% FPL (\$13,965 individual/\$18,735 couple)
- Estimates vary widely between sources:
 - CBO estimated that *median* per capita drug spending for a senior would be \$1,891 in 2006
 - Kaiser estimated that the *average* senior would have \$3,160 in total drug spending in 2006

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RIPAE/MEDICAID PROGRAM INFORMATION

<i>RIPAE</i>		<i>Eligibility</i>		<i>Cost of RIPAE</i>	
Groups	Members	Annual Income Limits	Assets Limits	Member Copay	DEA Cost FY04
RIPAE 1	30,383	\$17,515 (S) \$21,895 (M)	N/A	40% copay up to a maximum of \$1500 OOP, then \$0	\$14,554,929.88
RIPAE 2	3,459	\$21,987 (S) \$27,484 (M)	N/A	70% copay	
RIPAE 3	4,366	\$38,478 (S) \$43,974 (M)	N/A	85% copay	
RIPAE 4 (SSDI 55--64 yrs)	574	\$37,687 (S) \$43,070 (M)	N/A	100% copay (state discounted rate)	

<i>MEDICAID</i>		<i>Eligibility</i>		<i>Cost of MEDICAID</i>	
Groups	Members	Annual Income Limits	Assets Limits	Member Copay	DHS Cost FY04
N/A	29,176	\$9,310 (S)	\$2,000	\$0	\$104,500,000.00
		\$12,490 (M)	\$4,000	\$0	

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WHAT HAS CMS TOLD US?

- Final rules (363 pages) were released in the Federal Register on January 28, 2005
- Analysis of the new rules is underway, but will not be complete for several weeks
- In general, decisions on many of the issues that are important to states for implementation have been deferred to "later guidance"
- Of prime concern are the details around the "Clawback" (now officially referred to as the "Phased-down Contribution")

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WHAT'S THE CLAWBACK?

- A key aspect of Part D's financing is the use of state funds previously expended by Medicaid for dual-eligibles (in Rhode Island: 29,000 people) to finance the new federal benefit (inflated forward using a national inflation factor)
- In general, states that have a significant low-income elderly population, a low FMAP rate, and/or have been aggressive in controlling pharmacy costs will be disadvantaged – at least in the early years
 - In Rhode Island, Medicaid cost-containment efforts have netted \$25 million over two years (ignored by the Clawback calculation)
- CMS may not negotiate “best price”, so the gap between Medicaid's historical spending trend and the Part D projection will grow over time

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MEDICAID CLAWBACK CALCULATION

- Fiscal Year 2003 expenditures will be used to calculate a base rate
- A National Health Expenditure (NHE) inflator is applied:
 - CMS estimated to be **38.3%** compared to RI price inflator of **29.3%**
- Rate is adjusted by the rebate:
 - CMS estimated to average **20%** compared to a RI rebate average of **22.7%**
- States will pay 90% of rate calculation (declining yearly over ten years)

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FEDERAL TIMELINES FOR START-UP

- Spring-2005: Start of outreach & public awareness campaign
- July 1, 2005: SSA & states begin accepting low-income subsidy applications
- September 2005: Part D Plans (PDP's) announced, and their formularies and price structures become known
- Early Fall 2005: CMS auto-enrollment of dual eligibles in PDP's
- November 15, 2005 – May 15, 2006: Part D open enrollment period for 2006
- November 2005: PDP's can begin marketing and enrollment
- December 31, 2005: Medicaid coverage for dual eligibles ends

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POLICY ISSUES

- **Consumers will be confused:** vendors, formularies and pricing won't be known until AFTER they're asked to apply
- Enrollment (when it happens) may mean **changes in pharmacy network**
- Enrollment is voluntary (for some) but mandatory for dual-eligibles
- Enrollees are not guaranteed that their existing prescriptions will be honored (**continuity of coverage**)
- For all, there will be **formulary changes** (RIPAE members have more drug choice, dual-eligibles less)
- Medicaid may **lose data** critical to disease and clinical management
- Dual-eligibles will be subject to **co-pays** – can/should they be held harmless?
- Who covers the “**doughnut hole**”, and should there be a **mandatory take-up** for RIPAE members?

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Supplemental Pharmacy Rebate

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Pharmacy Expense in Medicaid

- Pharmacy is a leading driver of overall program expense in Medicaid, inflating at 15-20% per year over the past several years.
 - In Rhode Island, our experience over the past two years has been at just under 15% per year, based on a series of cost containment initiatives.
 - FY2004 spending (post-rebate) totaled \$116.9 million
- In general, states benefit from the Medicaid “best price” provision if they cover all FDA-approved drugs (with certain limited exclusions).
- Cost containment strategies available to states include:
 - Prior authorization
 - Generic substitution
 - Nominal consumer co-pays
 - Disease management
 - Drug utilization review (DUR)
 - Negotiation of supplemental rebates
- Rhode Island has implemented, or considered implementing, all of these strategies with the exception of consumer co-pays and negotiation of supplemental rebates

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Current and Recent Initiatives

- Over the past two years, Rhode Island's cost containment efforts have netted nearly \$25 million, from:
 - Implementation of SmartPA®, and
 - Expanded point-of-service DUR
- These efforts are clinically-driven, electronically-supported, and essentially transparent to consumers and clinicians
- Additionally, we have used our pharmacy claims data to support chronic care management and other prevention strategies, including fall prevention

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Supplemental Rebates

- States may negotiate rebates in addition to those already received under the national drug rebate agreement (more than 33 states already realize some level of supplemental rebate)
- States may negotiate state-specific rebates, or participate in multi-state pooling arrangements
- Florida, for example, began collecting supplemental rebates on a state-specific basis in 2001
- In April 2004 CMS approved the first-ever multi-state purchasing consortium for this purpose. Member states now include Michigan, Vermont, Alaska, Nevada, New Hampshire, Minnesota, Hawaii, and Montana

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How Do They Work?

- Supplemental rebates typically utilize Preferred Drug Lists (PDL's) to leverage dispensing volume
 - Usually, one drug per therapeutic class is considered to be “preferred”, and all others require prior authorization
 - A Pharmacy and Therapeutics (P&T) Committee determines which classes of drug will be included on a PDL, taking into account clinical factors and therapeutic evaluations
 - Once the class has been narrowed to include only those that are therapeutically equivalent, negotiations begin with manufacturers of the products within that class

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The Current Proposal

- The Governor's proposed FY2006 Budget includes a proposal to sign on to the Multi-state Consortium for the purpose of acquiring supplemental rebates (\$1.8 million in general revenue savings).
- Rhode Island wanted to maximize the benefits available from SmartPA[®] and expanded DUR, both to develop enhanced data extract capability, and to refine clinical standards prior to engaging in this strategy.
- Joining the multi-state effort makes sense, because the advent of Part D lessens Rhode Island's critical mass to negotiate on its own.

SAVINGS: \$1,848,044 gen. rev./\$4,078,557 All Funds

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Expansions of Managed and Coordinated Care

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Medicaid Managed Care in RI

- As of December 2004, the following populations were enrolled in RIte Care:
 - 125,926 parents and children who are TANF-eligible, with incomes under 185% FPL (parents) and 250% FPL (children) - in NHP, United, and CHP
 - 2,158 children in substitute (foster) care - all in NHP
 - 3,858 Children w/ Special Health Care Needs (SSI, Subsidized Adoption, Katie Beckett) – all in NHP
- Additionally, 207 Adults with Disabilities were enrolled and active in Connect CARRE

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Potential for Expansions of Managed or Coordinated Care

- Other than those dually eligible for Medicare, there were the following populations who might benefit from some variety of managed or coordinated care:
 - ~4,000 SSI parents of RItE Care children
 - CSHCN's who age out of RItE Care but remain eligible for Medicaid (~200/year)
 - 6-8,000 adults with disabilities or chronic care needs (not including persons in the DD Waiver or the SPMI in Medicaid)
- Options:
 - Enrollment in full risk, comprehensive health plan, such as RItE Care
 - Enrollment in a system of Primary Care Case Management or Collaborative Care Model
 - Enrollment in a Disease Management/Chronic Care Management Model with Intensive Case Management

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Planning

- Phased in roll-out, over the next 18-24 months, with program and financial assessments refined over the next 6 months
- Basic Decisions:
 - Mandatory or voluntary?
 - Service/Risk option(s) to be developed and proposed
 - Enrollment Sequencing
- Considerations:
 - What's the value of a *larger* RItE Care?
 - What "savings" can be imputed or implied?
 - Can we influence the definition and delivery of primary and chronic care to better serve these populations?

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ED Utilization in Rite Care

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ED Rate Differential for Rite Care

- Premise: As many as 25% of the emergency department visits in Rite Care are for conditions that could have been treated in a physician's office or primary care clinic
- The new health plan contracts reflect assumptions around increased PCP reimbursement, and create an incentive payment for plans that implement strategies that demonstrate reduced ED utilization
- Contracts will be amended to state that DHS payments to the plans must reflect treatment in the most appropriate setting, and that rates will be adjusted to reflect that directive

SAVINGS: \$898,896 gen. rev./\$2,019,128 All Funds

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