Legislative Research Council
SouthDakota

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CLAWBACK PROVISION OF THE MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003

The passage of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 will offer, for the first time, prescription drug coverage for people with Medicare. Coverage for prescription drugs under the Medicare Part D package begins on January 1, 2006. This paper addresses a funding portion of the MMA - the phased-down state contribution, referred to as the "clawback." As the federal government begins the implementation of this major new program, many questions remain to be answered about the program's operation and effects.

Background

Who are "dual eligibles"?

Dual eligibles are persons who qualify, in some way, for *both* Medicare and Medicaid coverage. Medicare is a federal health insurance program for people age 65 and older and for individuals with disabilities. Medicaid is a state administered program that provides medical assistance for certain individuals with low incomes and limited financial resources. Medicaid covers various services, most notably long-term care services and until 2006, prescription drugs. Dual eligibles as a whole are a particularly vulnerable subgroup of medicare beneficiaries. Mere eligibility for Medicaid coverage means they tend to be poor and report lower health status than other beneficiaries. Coverage and payment policies, which affect how beneficiaries receive their care, are complicated by the intersection of Medicare and 50 separate state Medicaid plans.

Although drugs are an optional Medicaid service, all states have provided prescription drug benefits to eligible Medicaid beneficiaries for many years. Therefore, Medicaid has, until 2006, filled the gap in Medicare prescription drug coverage for dual eligibles. Beginning in January 2006, the MMA requires that all individuals who are eligible for both Medicare and Medicaid – dual eligibles – begin receiving their prescription drugs through the Medicare Part D program. This change will result in a significant shift in benefits for elderly and disabled dual eligible beneficiaries as they will receive their drugs through a prescription drug plan rather than through the state. States have primary responsibility for determining eligibility and enrolling individuals in their Medicaid

programs, and the MMA requires that states continue that responsibility in implementing the new Part D.

What is the clawback?

Although the new law shifts drug coverage for dual eligibles from Medicaid to Medicare, it does not provide full fiscal relief to states or guarantee equivalent coverage to dual eligibles. As of January 1, 2006, states can no longer secure federal Medicaid matching funds for the cost of providing prescription drug benefits to dual eligibles who are eligible to enroll in Part D. As a result, states no longer will have to expend state Medicaid matching funds on providing prescription drug coverage to dual eligibles. However, states are required to continue financing much of the cost of providing the new Medicare Part D benefit to dual eligibles on an ongoing basis. The mechanism through which states will help finance the new federal Medicare drug benefit is the monthly phased-down state contribution commonly referred to as a "clawback" payment. The payments are designed to return to the federal government a significant share of the amount states would have spent on dual eligibles' prescription drug coverage under Medicaid if the new law had not been enacted. The amount of each state's payment roughly reflects the expenditures of its own [general funds] that the state would make if it continued to pay for outpatient prescription drugs through Medicaid.

Neither the U.S. Senate nor U.S. House-passed version of the legislation contained the clawback provision. It was inserted by House and Senate conferees in order to stay within a budget constraint. The cost of the MMA is limited to no more than $400 billion over ten years.

Clawback payments are scheduled to begin in February 2006. To ensure that states make the monthly payments, the statute requires that states pay interest on any unpaid amount. Any unpaid amount, plus interest, is to be offset "immediately" against the federal Medicaid matching funds the state would otherwise receive in the quarter in which the payment is due. The monthly payment is to be deposited into the Medicare Prescription Drug Account in the Medicare Part B Trust Fund, from which Part D and the low-income subsidy programs are funded.

The Formula. The Federal statute explicitly establishes the state contribution formula. In theory, the formula generates an estimate of the amount a state's Medicaid program would have spent on dual eligibles' drug coverage had the MMA not been enacted. In 2006, states are required to pay the federal government 90% of what states would have paid for Mediciad drug costs; over the next 9 years, that portion is reduced to 75%. In 2015 and thereafter the proportion remains at 75%.

Monthly State Payment	=	1/12	x	Per Capita Expenditures	x	Dual Eligibles	x	Phased-Down Percentage

The three components of the formula:

1. Per Capita Expenditures: State share of per capita Medicaid expenditures on prescription drugs covered under Part D for dual eligibles during 2003, trended forward.
2. Dual Eligibles: Number of dual eligibles enrolled in a Medicare Part D plan in the month for which payment is made.
3. Phased-down Percentage: Phased-down percentage for the year as specified in the Act (see chart).

Annual Phased-Down Percentage

Year	State Percentage
2006	90
2007	88 1/3
2008	86 2/3
2009	85
2010	83 1/3
2011	81 2/3
2012	80
2013	78 1/3
2014	76 2/3
2015 and thereafter	75

Concerns

Constitutional?

There is an important distinction in the new clawback provision compared to the more traditional strings tied to federal funding. It is common for the federal government to use its spending power to encourage a certain set of state behaviors by conditioning state entitlement to federal grants based on a state's compliance with federal program standards. In the clawback provision, by contrast, the federal government has unilaterally declared that the states owe it a certain amount in perpetuity to help defray the cost of a federal program. Short of a law change, the only way states can remove this burden is to withdraw from the Medicaid program entirely.

The Tenth Amendment of the Bill of Rights, ratified in 1791, clarifies state's powers: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." Over the years, in response to national crisis, many of the government's powers – particularly those over social programs – were centralized at the federal level.

Some question if the clawback provision is constitutional under the judicial doctrine of federalism. Recent decisions by the U.S. Supreme Court and appeals courts have placed new restrictions on the ability of Congress to use its spending power to encourage state action. The clawback provision – and the consequences of late payment – would appear to cross the line. When Congress attaches conditions to federal funding, the Supreme Court has previously stated "the financial inducement

offered by Congress might be so coercive as to pass the point at which pressure turns into compulsion."

There appears to be little doubt that some states will go to court to challenge the clawback. It may be hard for the feds to argue in court that states, by signing up for the federal-state Medicaid partnership, somehow waived their sovereignty and agreed to remit state funds to pay for a federal program. As Kevin B. Piper, MA, CHE put it …"As a matter of law, states cannot let the clawback go unchallenged. Regardless of the many positive aspects of the new Medicare drug benefit, the clawback simply raises too many fundamental issues to be left unexamined by the Supreme Court".

Troubling Precedent?

The philosophy of requiring state governments to help pay for costs of federal beneficiaries in a federally created and operated entitlement could establish a troubling precedent. There is much concern that the very notion of requiring states to send money to the federal government to help finance a federal Medicare benefit is highly problematic.

Congress gave the responsibility of program oversight to the federal government, so states no longer have control over program benefits or expenses. In the future, if Medicare Part D expenditures are higher than projected and Congress wishes to address the overrun, one option would be to increase state clawback payments. So, the federal government has designed the program, decided on the benefits leading to its expenses, *and*, designed the formula that computes state payment amounts. Also, because the clawback payments are now part of the federal budget baseline, if states want Congress to change the law, this change would be treated as reducing revenues to the federal government and increasing the costs.

Flawed Formula?

Because the payment methodology is based on a formula rather than actual expenditures, there is much uncertainty concerning its actual impact to states. One factor in this formula for determining the size of each state's clawback payments is the per capita state Medicaid expenditures on prescription drugs for dual eligibles in 2003. This figure varies widely across states as some states offer more comprehensive prescription drug benefits and/or are currently more aggressive about adopting cost-control measures than others. As a result, the formulated growth rate may be higher than the actual rate of growth they are experiencing in Medicaid prescription drug spending.

States were looking for fiscal relief with the passage of the MMA but are left concerned that they may actually be spending more under the new Act.

South Dakota Specific

South Dakota's dual eligible population of 11,900/month will be automatically enrolled in a Part D plan effective January 1, 2006 [if they have not already chosen a plan]. In

October 2005 South Dakota received a letter from the CMS which reflects the monthly phased-down State contribution payment process (clawback). **(See Appendix A – CMS letter)** The first clawback payment is due February 1, 2006, for the month of January. Eleven payments will be made in 2006, of which five payments will be made in state FY06. The South Dakota Department of Social Services (DSS) is estimating the total clawback payments for calendar year 2006 to be $13,874,989. **(See Appendix B – Preliminary Estimate)** The DSS estimates the overall fiscal impact to the general fund for the clawback will be neutral. Because the plan has not gone into effect yet, the figures are largely based on estimates at this point. However, at this juncture, the DSS has requested no additional general funding nor does the agency anticipate a savings in either SFY06 or SFY07.

At this point it appears the main concerns for South Dakota revolve around issues with the calculation:

- Some of the manufacturer rebates collected in 2003 are for 2002 drug expenditures.
- The formula inflates the base year by a national factor that is significantly larger than actual growth in drug expenditures in South Dakota.
- Currently there is no allowance to "rebase" the 2003 base year.
- Clawback does not take into account cost saving measures implemented by South Dakota [or any states] since 2003.

Closing

The idea of making states pay for a federal program has certainly generated much controversy. From the perspective of state-federal relations, the enactment of the clawback payment requirement represents a truly revolutionary change. There is no doubt the 700 page MMA legislation is sparking many questions and concerns and leaving states in a difficult position. At this juncture, it appears this issue may likely be decided in the court system. As Justice Sandra Day O'Connor stated: "The task of ascertaining the constitutional line between federal and state power has given rise to many of the Court's most difficult and celebrated cases."

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

Mr. Larry Iversen, Division Director
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OCT 3 1 2005 REC'D

Dear Mr. Iversen:

The purpose of this letter is to notify you of your Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) phased-down State contribution full dual-eligible per-capita Medicaid drug payment amount for 2006. The Federal statute explicitly establishes the phased-down State contribution formula. The information in this letter, which reflects our dialogue with you about your Medicaid drug costs, will be the basis for your monthly phased-down State contribution payments. These State contributions are one component of a package of MMA provisions that are expected to provide a significant new savings to States, as well as comprehensive Medicare drug coverage for your dual-eligible beneficiaries.

As you know, the phased-down contribution for 2006 reflects 90 percent of the expected state costs of Medicaid drug coverage for your dual-eligible beneficiaries, as determined by the MMA. Please note that the percentage in the phase-down contribution formula declines for all of the States from 90 percent in 2006 to 75 percent over the next 10 years. This decline significantly reduces the State contribution payment each year. In particular, in 2006, the expected cost is determined by multiplying a measure of your 2003 per-capita Medicaid drug costs by an update factor, specified in the statute to be the 2003-2006 National Health Expenditure (NHE) inflation factor for prescription drug expenditures.

The MMA requires that CMS notify each State no later than October 15 before each calendar year, beginning October 15, 2005, of its annual per capita drug payment expenditure amount for the next year. Throughout this implementation phase we have made every effort to involve the States. We have conducted numerous all-State calls to share a dialogue regarding the implementation methodology, and have worked individually with each State to ensure that the baseline data submitted are accurate and consistent with the statutory requirements.

Payments for the phased-down State contribution begin in January 2006, and are made on a monthly basis for each subsequent month. These payments are defined by MMA to be the product of the annual per-capita full dual-eligible drug payments and the monthly State enrollment of full dual-eligibles. The phased-down State contribution data for your State is included in the enclosure to this letter.

We very much appreciate the State's cooperation in implementing this process and the other provisions in the MMA. We believe that the package of MMA provisions will serve the dual-eligible population well, and will result in overall benefits to our State partners who have worked

so hard to help us put this program in place. States will have additional savings in 2006, derived from new subsidies from Medicare to help pay for drug coverage for State retirees. States with prescription assistance programs (SPAP) will see additional savings from Medicare coverage for beneficiaries who previously received coverage through the SPAP. In addition, because the phased-down contribution does not begin until February and the Medicare coverage begins in January, your State will make only 11 monthly phased-down contribution payments in 2006, further enhancing state savings next year.

Please contact Roger Buchanan (410-786-0780 or roger.buchanan@cms.hhs.gov) if you have any questions or need further clarification regarding the data or calculations.

Sincerely,

Dennis G. Smith
Director

Enclosure

cc: Regional Administrator
Associate Regional Administrator, Medicaid

The phased-down State contribution payments are defined by MMA to be the product of the annual per-capita full dual eligible drug payments and the monthly state enrollment of full dual eligibles. The methodology for this calculation is described in more detail in this attachment. The calculation involves establishing a fee-for service per-capita drug cost, adjusting that cost by the Medicaid rebate percentage, and weighting in any full-dual eligible managed care drug costs. The State share of this result is then projected forward for 2006 using the National Health Expenditures drug cost, and reduced by 10 percent for the phase-down factor.

The baseline fee-for-service per-capita costs are established using information reported by the State in calendar year 2003 through the Medicaid Statistical Information System (MSIS.) For States which cover full dual eligibles in comprehensive HMO or PACE programs, the per-capita dual eligible drug payment is defined by MMA to be the weighted combination of the fee-for-service (FFS) drug payments and comprehensive capitated drug payments. The capitated per-capita dual eligible drug cost was provided by your State in response to a template developed by CMS. The weights used to combine the FFS and capitated per-capita drug costs were derived from the MSIS-reported enrollment numbers.

We recently shared with States the full-dual-eligible enrollment for the 2003 calendar year. This is the denominator of the baseline per-capita dual eligible drug cost. Based on follow up discussions with States regarding those enrollment numbers, we have adopted a revised methodology to establish monthly dual eligibility status from the quarterly MSIS dual eligibility coding. The final methodology assigns full dual status to each month of eligibility in a quarter for eligible MSIS enrollees having a full dual eligible code for that quarter. This methodology is applied consistently to determinations of monthly dual status for both payments and enrollment. In addition, we have worked extensively with each State over the last year to ensure that the baseline MSIS data accurately reflect the State Medicaid program.

The fee-for-service per-capita payment amounts are developed using the State-submitted MSIS drug claim files reported the months of January-December 2003 (MSIS fiscal year 2003 quarters 2-4 and fiscal year 2004 quarter 1). The final payment amount includes the amount paid on all drug claims with the following exclusions:

1. claims associated with individuals who were not a full dual eligible in the prescription fill month,
2. claims for Part D excluded drugs,
3. claims for individuals in pharmacy-plus or other 1115 drug-only demonstrations,
4. claims for Indian Health Service or Family Planning services,
5. claims with an invalid National Drug Code (NDC) including an alpha character, and
6. claims with an invalid prescription fill date.

This coding for the fields used to determine these exclusions is defined in the MSIS data dictionary available at:

http://www.cms.hhs.gov/medicaid/msis/default.asp

The table below contains the final 2003 enrollment month numbers, the 2003 baseline payment amounts and the per-dual-eligible drug payments for your State, as well as the factors used to determine the final 2006 per-capita drug payment amount. Note that some values in this table are rounded for presentation purposes, but that all calculations up to the final per-capita drug expenditure baseline are made using full decimal precision.

	Fee-for-service	Capitated	Weighted Overall
Final Enrollment Months	135,886	0	
Total FFS Drug Payments	$36,736,362		
Drug Rebate Factor	21.09%		
Baseline Per-capita Drug Cost	$213.33	$0	$213.33
2003-2006 NHE Inflation Factor			35.54 % ($605 to $820)
2006 Total Per-capita Drug Cost			$289.14
2006 State Share Percentage			34.93%
2006 State Per-capita Drug Cost			$101.00
2006 Phased-Down Percentage			90%
Final 2006 State Per-capita Phasedown Payment (January-September/October-December)*			$90.90/$96.49

*October-December per-capita number reflects FY 2007 Federal Medical Assistance Percentage (FMAP)

The final per-capita baseline number provided above will be multiplied by your monthly full-dual eligible enrollment, as reported in your monthly MMA dual enrollment file and matched to Part D enrollment, to establish each month's phased down State contribution bill. This billing will begin using the November, 2005 enrollment to establish the January, 2006 payment. This payment will be due February 1 with a grace period to February 25th.

Preliminary Estimate of Clawback – CY2006

Multiply:

Adjusted CY03 per-capita drug expenditures for dual eligibles = $2,681

X

State FY06 Match Rate = 34.93%

X

Applicable growth factor = 1.3834

X

Number of dual eligibles for the month = 11,900

X

2006 Monthly Factor Adjustment = 90%

$13,874,989
General Funds

Gross per-capita dual eligible CY03 drug expenditures of $3,400 adjusted for manufacturer rebates

Rebate factor 21.14%

National Health Expenditures Inflator 2003 $639; 2006 $884
Growth of 38.34%

Year	Factor
2006	90%
2007	88.33%
2008	86.67%
2009	85%
2010	83.33%
2011	81.67%
2012	80%
2013	78.33%
2014	76.67%
2015 & After	75%

June 6, 2005