TEXAS
Health and Human
Services Commission

House Appropriations Subcommittee on
Health and Human Services

Health and Human Services Commission General Update

June 29, 2004

TEXAS Health and Human Services Commission

Table of Contents

TEXAS
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Health and Human Services Budget Update

Executive Commissioner Albert Hawkins

Key HHS Budget Issues
Funding Needs

2004-2005 Biennium - General Revenue ($ in Millions)

	FY 2004	FY 2005	Biennial Total
Medicaid/CHIP Shortfall			
a. Medicaid Acute Care	**$112.6**	**$435.0**	**$547.6**
b. CHIP	**20.5**	**32.4**	**52.9**
• Various funding strategies identified to lower estimated shortfall			
• Supplemental appropriation by 79th Legislature, R.S., anticipated			
Community Care LTC Programs Projected Shortfall		**141.5**	**141.5**
• Various funding sources identified to maintain current service levels			
Substance Abuse Block Grant MOE Penalty	**9.8**	**6.7**	**16.5**
• Apply $1.6 M Enhanced FMAP in FY 04 to lessen the reduction			
• Carryback $5.0 M from FY2005 to level out state MOE requirement			
Waiting List for Children with Special Health Care Needs	**3.4**	**4.2**	**7.6**
• Projected surplus allows serving 997 children from the waiting list			
• Notification letter transmitted to the Governor and LBB			
Graduate Medical Education		**20.0**	**20.0**
• Funds expected to be available from unclaimed lottery proceeds			
Maintain FY05 Provider Reimbursement Rates at FY04 Levels		**53.2**	**53.2**
• Apply $53.2 M Enhanced FMAP to maintain provider rates			
• Excludes hospital reimbursement rates			

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Key HHS Budget Issues
Federal Funding Issues
2004-2005 Biennium

Federal Funding Issues

- Title XIX Targeted Case Management — $184.5 Million
  - Resolved for 2004-2005 biennium
- MH Block Grant MOE Penalty — $23.3 Million
  - Discussion with SAMHSA ongoing
- TANF Disallowance — $14.5 Million
  - Appeal filed, discussion ongoing
- SYNAR Enforcement — $5.0 Million
  - Resolved
- SHARS Disallowance (School Health & Related Services) — $30.0 Million
  - Pending further discussions

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Funding Sources Available FY 2004-2005

- **Enhanced Federal Medical Assistance Percentage (EFMAP) $269.0 Million**
  - The Federal Fiscal Relief provisions of the Jobs and Growth Tax Relief Reconciliation Action of 2003 (P.L. 108-27) increased the Federal Medical Assistance Percentage (FMAP) by 2.95 percentage points for five calendar quarters, the last two quarters of Federal Fiscal Year 2003 and first three quarters of Federal Fiscal Year 2004.
- **Disproportionate Share Hospital Gain for FY2004-2005* $120.0 Million**
  - Increasing the DSH payments to state owned acute care hospitals up to 160 percent of their uncompensated care.
- **UPL for State Operated Hospitals* $45.8 Million**
  - Supplemental Medicaid reimbursement for inpatient and outpatient services provided by state owned or operated acute care hospitals. (UTMB, MD Anderson, UT-Tyler, Texas Center for Infectious Disease)
- **Unappropriated Balance From MHMR Quality Assurance Fee Receipts (QAF)* $40.0 Million**
  - The Quality Assurance Fee is a daily fee per occupied bed applied to all ICF-MR providers, not to exceed 6 percent of each facility's gross cash revenues. An estimated QAF balance of $40 Million is available in FY2004-2005. Fee revenue from fees imposed on hospitals, nursing homes, home health care, and ICFs-MR can be used by the state for any purpose.

*Appropriation required

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Funding Sources Available FY 2004-2005

- **Unclaimed Lottery Proceeds** **$20.0 Million**
  - HHSC Rider 48 specifies that unclaimed lottery proceeds in excess of the Comptroller's Biennial Revenue Estimate be designated to fund Graduate Medical Education.
- **CSHCN Surplus** **$7.6 Million**
- **Article II Budget Transfers**** **$86.3 Million**
  - Various amounts within appropriations to Article II agencies have been identified to finance current operations. These amounts are available for transfer to address other funding needs and are itemized below. In addition to the amounts below, $6.7 Million from current appropriations has been set aside to maintain certain provider reimbursement rates at the FY2004 level.
    - LTC Lapse $47.6 Million
    - MHMR Refinance Savings $27.0 Million
    - Title XX (including TANF conversion of $8.6 Million) $11.7 Million

Total Available Amount **$588.7 Million**

** A temporary cash transfer from HHSC to TCADA will be required in FY2004 and then reversed in FY2005 to balance MOE funding at TCADA.

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Proposed Actions to Address Key Budget Issues

Reduce Medicaid/CHIP Shortfall	$300.5 Million
Maintain CCAD Services	$138.4 Million
Maintain Provider Reimbursement Rates***	$ 53.2 Million
Establish UPL for Urban, Non-public Hospitals	$ 25.0 Million
Restore Pregnant Women Coverage to 185 Percent	$ 20.3 Million
Restore GME Payments	$ 20.0 Million
Serve CSHCN Waiting List	$ 7.6 Million
Lessen TCADA MOE Penalty	$ 1.6 Million
Total, Proposed Actions	**$566.6 Million**

*** Excludes hospital reimbursement rates

Recap

Available Amount	$588.7 Million
Proposed Actions	($566.6 Million)
Amount Remaining	**$ 22.1 Million**

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Summary of Proposed Funding Sources & Uses to Address Issues

SOURCES:	EFMAP	DSH	UPL	QAF	Lottery	LTC Lapse	HCS	Title XX	CSHCN	Total
USES:										
Medicaid/CHIP Shortfall	140.0	74.7	45.8	40.0						300.5
CCAD Services	52.1					47.6	27.0	11.7		138.4
Provider Reimbursement Rates	53.2									53.2
UPL for Urban, Non-public Hospitals		25.0								25.0
Pregnant Women Coverage to 185%		20.3								20.3
GME					20.0					20.0
CSCHN Waiting List									7.6	7.6
TCADA MOE Penalty	1.6									1.6
Amount Remaining	22.1									22.1
Total	**269.0**	**120.0**	**45.8**	**40.0**	**20.0**	**47.6**	**27.0**	**11.7**	**7.6**	**588.7**

Note: The $140 million shown above for FMAP includes FY2003 FMAP in the amount of $75.2 million, which has not been approved.

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Consolidation Activities
Integrated Eligibility (IE)
TIERS

Gregg Phillips

Deputy Executive Commissioner

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Consolidation Activities

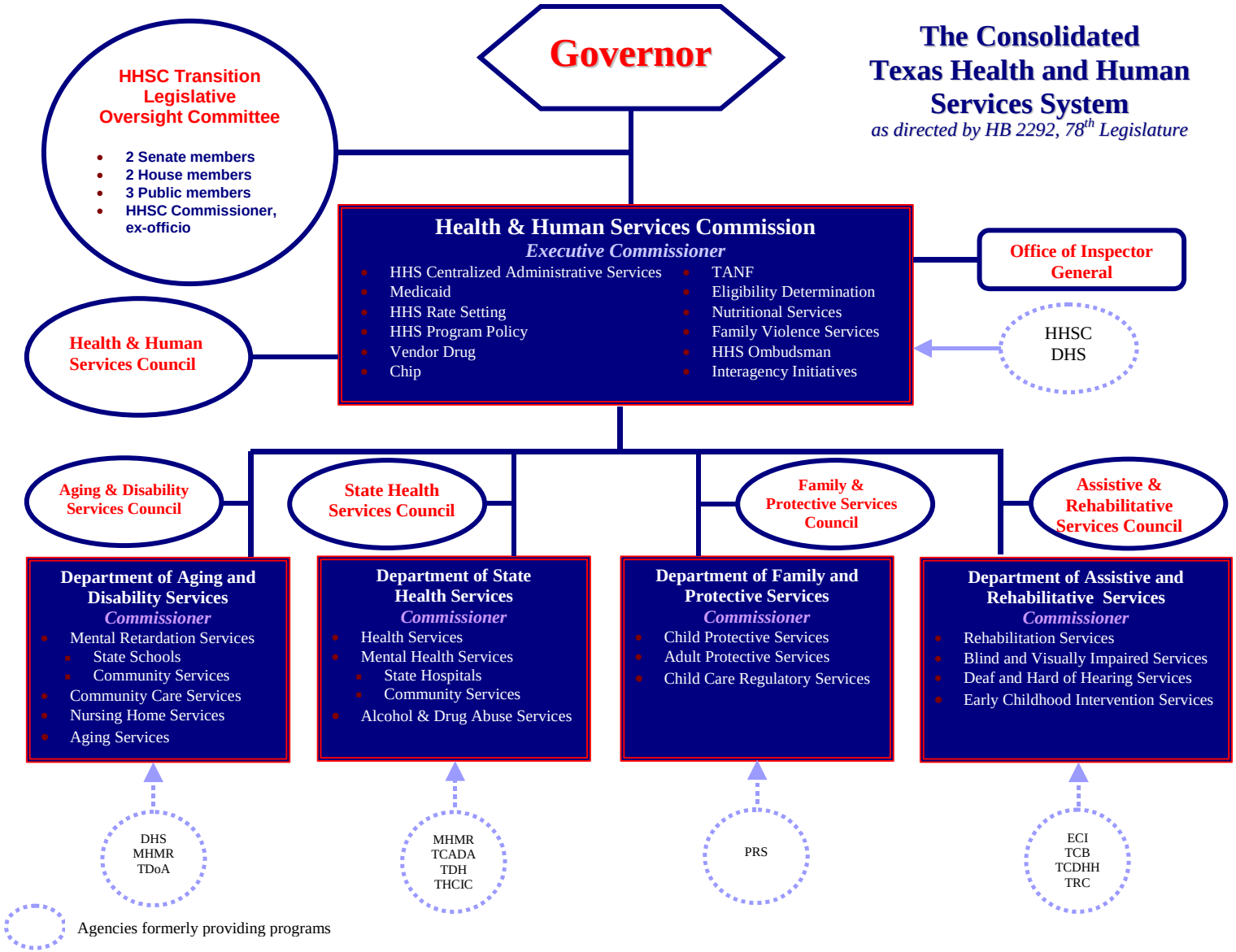
Transformation Timeline

- September 1, 2004 - Operational Dates DADS and DSHS
- June 2004 - Revised Transition Plan delivered to the Governor and the LBB

Activities

- Human Resources Management
  - June 2004 – Tentative award to Convergys to perform HR and Payroll functions.
    - $63 million in savings over the next five years.
- Office of Family Services Reorganization
- Request for Proposals (RFP) for Purchasing Services
- Optimization Projects for HHS Agencies

Consolidation Organizational Structure



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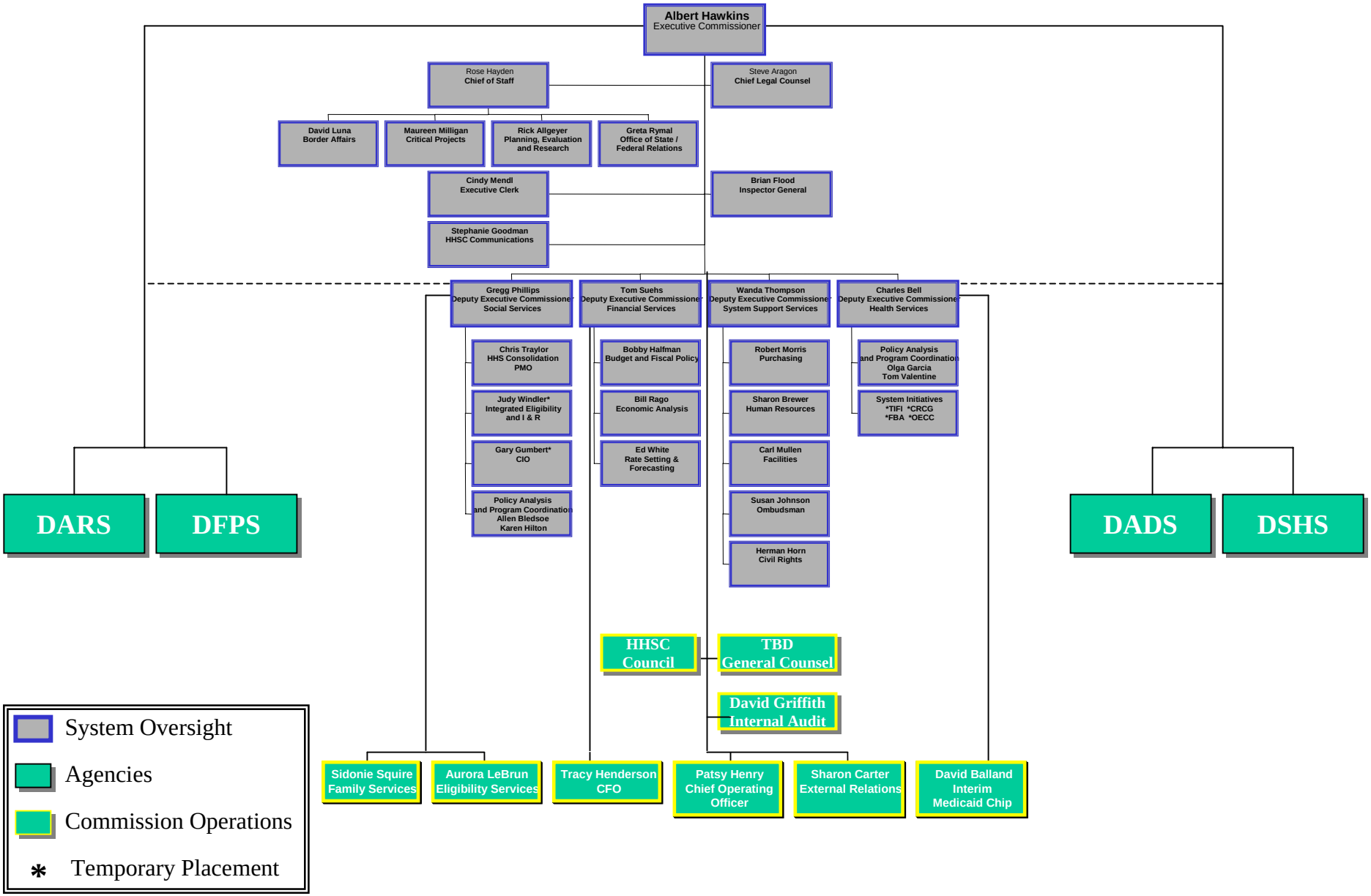

Consolidation Activities: HHSC Guiding Principles

Guiding Principles: Used for business decisions across the state's entire health and human services enterprise:

- Carefully compile decision criteria
- Require an open and competitive procurement process
- Establish strong contract management focused on performance and accountability
- Develop a transition strategy for affected state employees
- Provide open and active communications

Consolidation Activities: HHSC Guiding Principles

Decision Criteria: Develop and decide on the model that achieves the goal of providing the best value and services:

- **"As Is"** model – current function's mission, business operations and service level
- **"Optimized"** model – most effective way to perform those functions in-house
- **"Outsourced"** model – evaluate how the private sector would perform these functions and at what cost

Consolidation Activities: HHSC Outsourcing Model

- HHSC issues a Request for Proposals (RFP)
  - Defines scope of work;
  - Sets performance level expectations; and
  - Establishes criteria for evaluating proposals.
- Contractors are held accountable by performance and outcome standards built into the contract
- RFPs include a performance matrix establishing **clear** performance standards
- RFPs includes penalties for not meeting the performance standards

Consolidation Activities: HHSC Outsourcing Model

- Contracts also include provisions for performance bonds and liquidated damages if the contract terms are not met
- HHSC develops a transition strategy for affected state employees
  - Notifies employees early on about job changes;
  - Develops mitigation strategies for loss of productivity or high attrition; and
  - Utilizes the Texas Workforce Commission's (TWC) Rapid Response Services to provide immediate services to displayed employees.
- HHSC keeps all stakeholders informed of its business decisions and operations, and provides opportunities for two-way communication with the public

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Integrated Eligibility & Call Centers

Eligibility Simplification

Progress to date

February 2004

- Released Discovery Document indicating call center model would support process improvements and that cost effective operations are feasible

March 2004

- Released Business Case (cost-effectiveness study) indicating proposed model for call centers is cost effective and provides

April 2004

- Conducted public hearings on call centers and rules

May/June 2004

- Developed and published proposed rules
- Developed detailed Business Requirements for Call Centers
- Draft RFP released June 7
- Final RFP to be released by the end of June

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TIERS Pilot - Update

- TIERS Pilot continues in five offices in the Austin and San Marcos area:
  - Texas Works (TW) functionality was implemented in June 2003
    - Programs include Food Stamps, TANF, and Medicaid
- Successfully deployed the **combined** TIERS application in April 2004**;** incorporates **Long Term Care (LTC)** functionality along with existing TW functionality.
  - Added LTC Programs Community Care and Medicaid Eligibility
- In May 2004, **expanded pilot** scope to include **new LTC application** processing.
  - Applications processing accurately and timely

TIERS Pilot – Business Processes

Business Process Review continues to optimize.

- Incorporating lessons learned during pilot and identifying best practices.
  - Standardizing TW and LTCS processes where applicable
  - Implementing training needed to make TIERS knowledge base consistent across all areas.
    - Addressing regional staff issues with targeted training as appropriate
      - providing refresher training and on-hands review
      - staff indicate satisfaction with training
    - Increasing on-site support staff in local offices
      - validate effectiveness of training and provide assistance when needed
  - Implementing organizational management changes to facilitate greater focus, coordination and communication regarding TIERS

TIERS Budget

FY 04–FY 05

TIERS Project Budget for FY 2004 and 2005 is $123.2 M

- Current Expenditures through 3rd Quarter FY2004 include:
  - Cash & Federal Bond Match: $30.2 M
  - Bond Proceeds: $ 3.5 M
  - **Subtotal** $33.7 M
- Projected Encumbrances FY 2004 Q4 through FY2005 include:
  - Cash and Federal Bond Match $56.9 M
  - Bonds Proceeds $10.6 M
  - Debt Service & MLPP – (Bond Repayment FY 04 and FY 05) $22.1 M
  - **Subtotal** $89.5 M
- Total Expenditures and Projected Encumbrances for FY 2004 and FY 2005 is $123.2 M
- The TIERS total projected budget, for the life of the project, is estimated to be $296.6 M

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TIERS Next Steps

- Continue to stabilize application – address defects, incorporate changes based on architecture assessment.
- Make application ready to support Integrated Eligibility (IE) Model.
  - ➢Assess application for possible IE impact: policy, interfaces/trading partners, conversion process, testing, training needs.
  - ➢Ensures system flexibility to accommodate future agencies, programs, policies and processes.
  - ➢Leverage State's current investment while including additional capabilities and standardizing technology architecture across programs (TW, LTC, CHIP).
- The original TIERS strategy of geographic rollout by region will be modified.
  - ➢Developing rollout strategies to deploy IE business model.

Managed Care Expansion

Billy Millwee
Deputy Medicaid/CHIP Director
for Health Services

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Medicaid Managed Care Expansion - Activities

Recent Activities

- **February 2004** – Released expansion framework
- **March 2004** – Released draft RFP for public comment
- **March 8 – 19, 2004** – Held public hearings around the state to seek input on the proposed framework and the draft RFP
- **June 29, 2004** – Release final RFP

Medicaid Managed Care Expansion - Timeline

- **HMO Implementation Timeline:**
  - June 29, 2004 — Release Final RFP for HMO services
  - Aug 2004 — HMO proposals due to HHSC
  - Sep/Oct 2004 — Proposal evaluation
  - Nov 2004 — Contract negotiation
  - Dec 2004 — Contract award
  - June 2005 — Operational start date for existing Medicaid/CHIP HMO service areas
  - Sep 2005 — Operational start date for new Medicaid STAR and STAR+PLUS service areas
- **PCCM Implementation Timeline:**
  - June 2004 — Negotiate PCCM contract amendment
  - July 2004-March 2005 — System changes to support PCCM expansion
  - April 2005 — PCCM statewide enrollment begins
  - June 2005 — PCCM expansion complete

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Vendor Drug Program and Preferred Drug List (PDL)

Lisa Cotter Kirsch, Policy Analyst

Texas Medicaid/CHIP

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Vendor Drug Changes:
78th Legislature, Regular Session

- 34 day supply, if cost effective
- 4 brand name limit, if cost effective
- Medicaid/CHIP Preferred Drug List (PDL)

Vendor Drug Changes:
78th Legislature, Regular Session

4 Brand-Name and 34-Day Supply Limits

- HHSC is working with the University of Texas Center for Pharmacoeconomics to determine cost effectiveness.
- Will evaluate 4-brand and 34-day supply limits in context of current Vendor Drug initiatives and Texas' generic utilization rate.

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Medicaid/CHIP Preferred Drug List (PDL)

- H.B. 2292 directed HHSC to establish a preferred drug list for Medicaid/CHIP.
- Pharmaceutical companies are required to offer a supplemental rebate or a program benefit proposal to be considered for the PDL.
- The Governor-appointed Pharmacy and Therapeutics Committee (P&T) of doctors and pharmacists considers three factors when reviewing drugs: clinical efficacy, safety, and cost effectiveness.

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Medicaid/CHIP Preferred Drug List (PDL)

- HHSC decides which drugs to place on the PDL based on P&T Committee recommendations, net cost of competing drugs to the state, clinical considerations and other program benefits.
- Non-preferred drugs, which have been reviewed but not selected for the PDL, require prior authorization.
- Prior authorization must be determined within 24 hours, and a 72-hour emergency supply may be dispensed without a PA when needed.

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Pharmaceutical and Therapeutics (P&T) Committee

- Met 6 times since November and will meet quarterly beginning in August.
- Reviewed approximately 70% of the total drug spend in the Medicaid program.
- Plans to review certain drug classes for the CHIP PDL in August.
- Begins its annual re-review of initial drug classes in November.

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Medicaid/CHIP PDL: Prior Authorization

General

- For non-preferred drugs, prescribers request prior authorization via the Texas Prior Authorization Call Center: 1-877-PA-Texas.
- An automated prior authorization system, SmartPA, also will be used at the pharmacy point of sale to determine if a patient meets the state's prior authorization criteria.
- Prior authorization has been rolled out monthly for certain drug classes since February 2004.
- The initial prior authorization criteria for most drug classes include: therapeutic failure, allergy or contraindication with preferred product(s).
- An approved prior authorization is valid for one year.

Medicaid/CHIP PDL: Prior Authorization

Antidepressants & Atypical Antipsychotics:

- For antidepressants and atypical antipsychotics, the state has a continuity of care provision.
- Patients who have received a non-preferred drug through Texas Medicaid in the last six months will be allowed to continue taking that drug without the need for a prior authorization phone call.

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Medicaid/CHIP PDL: Prior Authorization

Statistics

- From February through May 2004, the call center fielded 147,000 prior authorization requests.
- Over 90% of requests were approved by the call center.
- In May 2004, the average call duration was under one minute and over 90% of calls were answered within 90 seconds.

Next Steps

- The state is in the process of refining PDL prior authorization criteria by drug class.
- Stakeholders have an opportunity to submit written comments on prior authorization criteria.
- The Drug Utilization Review Board will accept prior authorization public input on August 24th.

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Medicaid/CHIP PDL: Savings Status

- HHSC is on target for $150 million savings for the 2004-2005 biennium.
- Early data show that prescribing patterns are shifting toward preferred products.
- HHSC sent first quarter supplemental rebate bills to drug manufacturers in early June.

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Vendor Drug Rebates

Assumptions of Medicaid Rebates 2004-2005 Biennium (State Share in millions)					
	HB 1		Spring 2004		YTD Collected
	FY 2004	FY 2005	FY 2004	FY 2005	FY 2004
Rebates	$134.8	$146.5	$186.2	$223.2	$137.9
Supplemental Rebates	30.0	35.0	32.0	73.8	0.0
Total Rebates	$ 164.8	$ 181.5	$ 218.2	$ 297.0	$ 137.9

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Medicaid/CHIP Division Transformation

David Balland, Interim Associate Commissioner

Texas Medicaid/CHIP

Medicaid/CHIP Transformation

HHSC's Medicaid/CHIP Division, with the assistance of Deloitte Consulting, has recently completed a division-wide transformation effort aimed at:

- Improving **accountability** of the program and its staff
- Increasing **efficiency** of staff and program contractors
- **Reorganizing** the Division to promote improved management
- Reducing **risk** of future cost overruns and other problems
- Improving **financial management** of the program

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Medicaid/CHIP Transformation

The transformation effort has resulted in:

- A total headcount reduction of 20 FTEs (approximately 10% of total staff)
  - Accomplished via elimination of vacancies and some filled positions
- 27 key positions redesigned to require staff with new skill sets
  - New positions (which are currently being posted and filled) include two new directors to oversee the TMHP/ACS contract, certified contract managers, contract financial analysts, policy “project managers”, and others
- 36 new performance measures
  - Reduced from over 200 current “operating” measures used to manage the program
  - Designed to more effectively measure outcomes and hold managers and staff more accountable for program performance
- New “performance workplans” for each staff member
  - Individualized performance plans and measures by which each manager and staff member will be evaluated
  - All plans are directly tied to the 36 new program-level performance measures

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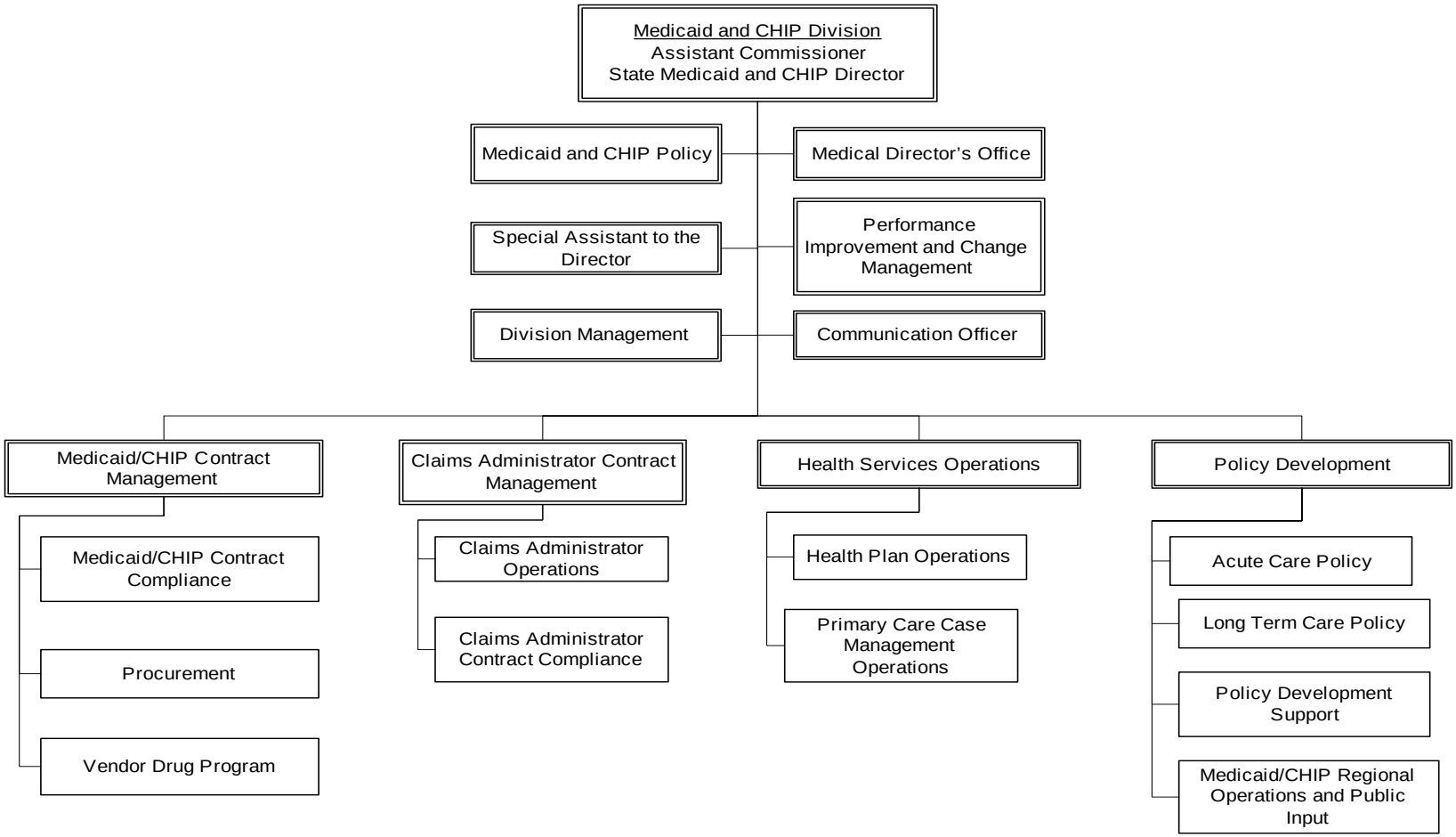
Medicaid/CHIP Transformation (continued)

- New "performance workplans" for each staff member
  - Individualized performance plans and measures by which each manager and staff member will be evaluated
  - All plans are directly tied to the 36 new program-level performance measures
- Over 3/4 of program functions reengineered
  - 31 of the most critical "business processes" have been streamlined to require less time to complete
  - Accountability has been clarified and decisions are designed to be made at the most appropriate point in the process
- A new financial management framework
  - Designed to provide managers with access to financial data required to more effectively manage the cost of the program
- A new, more efficient organization structure

Medicaid/CHIP Division Organizational Chart

New Medicaid/CHIP Division Organization (effective June 7)



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Medicaid/CHIP Transformation:
Contract Management Improvements

- Re-organization of the Medicaid/CHIP Division (MCD)
  - Centralized contract management within MCD
  - Improved performance standards and expectations of contract management staff
- Re-procurement of all managed care services.
  - Managed Care Organizations (MCO) must agree to new contract requirements
    - Identify clear performance requirements.
    - Define remedies and penalties for non-performance.
    - Improve financial reporting requirements.

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Appendix:
Spring 2004 Forecast
Vendor Drug Cost & Caseload

Medicaid Vendor Drug Caseload

FY2004 and FY2005 forecasts show number of prescriptions is increasing, but at a slower rate than FY2003

- Growth in number of prescriptions in FY 2003, FY 2004, and FY 2005 is largely due to increased caseloads (Recipient Months).
  - Prescription Growth Trends
    - FY 2002 8.1%
    - FY 2003 13.9%
    - FY 2004 8.4%
    - FY 2005 7.3%
- Some growth in the number of prescriptions is due to increased utilization (number of prescriptions per client) in the Aged, Disabled, and Blind groups.

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Medicaid Vendor Drug Prescriptions and Costs:

H.B. 1 and Spring 2004 Forecast

	H.B. 1		Spring 2004 Forecast		Difference	
	Total Prescriptions	$ per Rx	Total Prescriptions	$ per Rx	Total Prescriptions	$ per Rx
2004	35,271,239	$54.89	36,949,047	$60.05	1,677,808	$5.16
2005	35,961,050	$54.43	39,646,427	$64.21	3,685,377	$9.78

Medicaid Vendor Drug:
of Prescriptions, Prescriptions per RM, and Cost per Rx

	FY2001	FY2002	FY2003	FY2004	FY2005
Aged, Blind, & Disabled					
Nursing Home - UNLIMITED					
Rx	5,366,333	5,539,951	5,876,560	5,935,689	6,239,206
Cost/Rx	$ 46.2	$ 50.0	$ 54.3	$ 59.3	$ 64.6
Rx/RM	6.33	6.6	7.01	7.1	7.51
Own Home - UNLIMITED					
Rx	2,016,105	2,180,230	2,495,887	2,554,848	2,688,001
Cost/Rx	$ 53.6	$ 57.7	$ 63.1	$ 69.8	$ 77.0
Rx/RM	5.71	5.84	6.07	6.27	6.5
Own Home - LIMITED					
Rx	8,287,666	8,678,347	9,917,160	10,291,210	10,965,993
Cost/Rx	$ 74.1	$ 81.7	$ 90.4	$ 99.4	$ 111.0
Rx/RM	1.66	1.69	1.73	1.85	1.91
All Other					
Rx	11,814,927	13,362,525	16,307,239	17,912,332	19,468,326
Cost/Rx	$ 28.9	$ 31.9	$ 35.8	$ 39.6	$ 44.2
Rx/RM	0.74	0.71	0.7	0.7	0.7
Total*					
Rx	27,706,197	29,946,750	34,097,754	36,949,047	39,646,427
*Cost/Rx**	$ 47.7	$ 51.7	$ 55.8	$ 61.6	$ 68.2
Rx/RM	1.23	1.19	1.14	1.14	1.14

Average cost of prescriptions increases 43% from FY 2001 to FY 2005

- This increase does not include cost savings (PDL Market Shift)
- Average cost per Rx increases 30% (instead of 43%) when savings are considered

Average cost per Rx increased 20% from FY 2001 to FY 2003

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Medicaid Vendor Drug Caseload and Costs:
Historical and Current Trends

	Prescriptions	Trend	Cost per Prescription	Cost Trend
FY 2000	26,245,401	4.2%	$42.79	13.7%
FY 2001	27,706,197	5.6%	$47.68	11.4%
FY 2002	29,946,750	8.1%	$51.65	8.3%
FY 2003	34,097,754	13.9%	$55.77	8.0%
FY 2004	36,949,047	8.4%	$60.05	7.7%
FY 2005	39,646,427	7.3%	$64.21	6.9%
FY2004 and FY2005 Cost per Prescription and Trends, with State Supplemental Rebate Removed from Total Cost				
		FY2004	*$59.18*	*6.1%*
		FY2005	*$62.32*	*5.3%*

**Cost per prescription is adjusted for savings (PDL, Reimbursement change, 2.5% Fee Reduction) in FY 2004 and FY 2005. The last two rows show cost per prescription with the state supplemental rebate from the PDL removed from cost. Federal rebates have not been removed from cost.*

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Contract Administration

June 29, 2004

HHSC Contract Administration

Robert Hall

Services Development Director

HHSC Contract Administration

Contracting Process and Procedures Workgroup – October 2003

- Established a Contracting Cycle
- Identified the Roles and Responsibilities of HHSC Staff
- Established “Best-Practices”
- Created a Standard RFP Template
- Created a Standard RFP Evaluation Methodology
- Provided a framework for consistency using statutory references and forms

HHSC Contract Administration

Contract Process Improvements:

- Centralized Contract Administration Function
- Program/Division is Responsible for Contract Management
- Contracting Processes and Procedures – Approved April 2004
- Multiple training sessions for HHSC staff – June 2004
- Contracting Processes and Procedures – Effective July 2004
- Implement Web-based Contract Administration and Tracking System (HCATS) – Fall 2005.

HHSC Contract Administration

Who has a role in HHSC's Contract Processes?

- Administrative Services Development
- Programs/Divisions
- Procurement Team
- Evaluation Committee
- Legal Affairs
- Financial Services

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Medicare Prescription Drug Program

June 29, 2004

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Federal Medicare Prescription Drug Benefits

Trey Berndt
Special Assistant to the Director
Texas Medicaid/CHIP

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Medicare Prescription Drug Program: Phase I – Discount Cards

- Medicare Approved Drug Discount Card (Temporary Program - Starts June'04, ends December '05)
- Discounted drug prices
  - Approved cards issued by private sponsors (e.g. :pharmacy benefit managers)
  - 10-25% savings off retail price
- Medicare beneficiaries who do not receive Medicaid outpatient drugs are eligible.
- $600 credit for low-income beneficiaries who earn less than 135% of federal poverty level ($16,862 annual income for a couple)

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State's Role in Discount Card Program Administration

- Provide data to Medicare to identify dual eligible clients receiving Medicaid Rx coverage (300,000 + clients)
- Department of Aging Training for Medicare Benefits Counselors (e.g.: Area Agencies on Aging)
- Referral to discount card sponsors:
  - 1-800-MEDICARE
  - http://www.medicare.gov/

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Medicare Prescription Drug Program:
Phase II – "New Medicare Part D"

New Medicare drug benefit starts January 2006

- New "Part D" offers optional drug coverage to all Medicare eligibles
- Provided through a selected private drug plan (similar to an HMO for pharmacy only) or Medicare HMO
- Limited to private plan's formulary or list of covered drugs

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Medicare Prescription Drug Program: Dual Eligibility

- Dual Eligibility refers to individuals who are:
  - Medicare eligible (aged or disabled);
  - Low income; and
  - Also eligible for some level of Medicaid coverage

- There are different types of dual eligibility, but generally, they fall into two categories:
  - Full dual eligibles
  - Other dual eligibles

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Medicare Prescription Drug Program: Dual Eligibility

- Full Dual Eligibles:
  - Entitled to Medicaid benefits that Medicare does not cover, including Medicaid drug coverage
  - Include low-income aged and disabled individuals in community, waiver programs, nursing homes, and state schools
  - Not eligible for Phase I drug discount card, but will be eligible for Part D benefit in 2006
- Other Dual Eligibles:
  - Eligible only for Medicaid payments for Medicare premiums, deductibles, and coinsurance for Medicare services
  - Not entitled to Medicaid services
  - Include several categories of eligibility; incomes generally up to 135% of federal poverty level (if not in institution)
  - Will be eligible for both discount card program in 2004 and Part D benefit in 2006

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Medicare Prescription Drug Program: Part D Drug Coverage

Limited if not low income

- Beneficiaries pay monthly premiums (estimated at $35 in 2006)
- Based on annual amount of drug costs, beneficiaries may pay a significant portion:
  - Deductible (first $250 of drug costs)
  - 25% of drug costs between $250 and $2250
  - **100% of drug costs between $2250 and $5100 (no Medicare coverage = “gap”); premiums continue**
  - Copayments or 5% of drug costs after $5100;* Medicare pays 95%

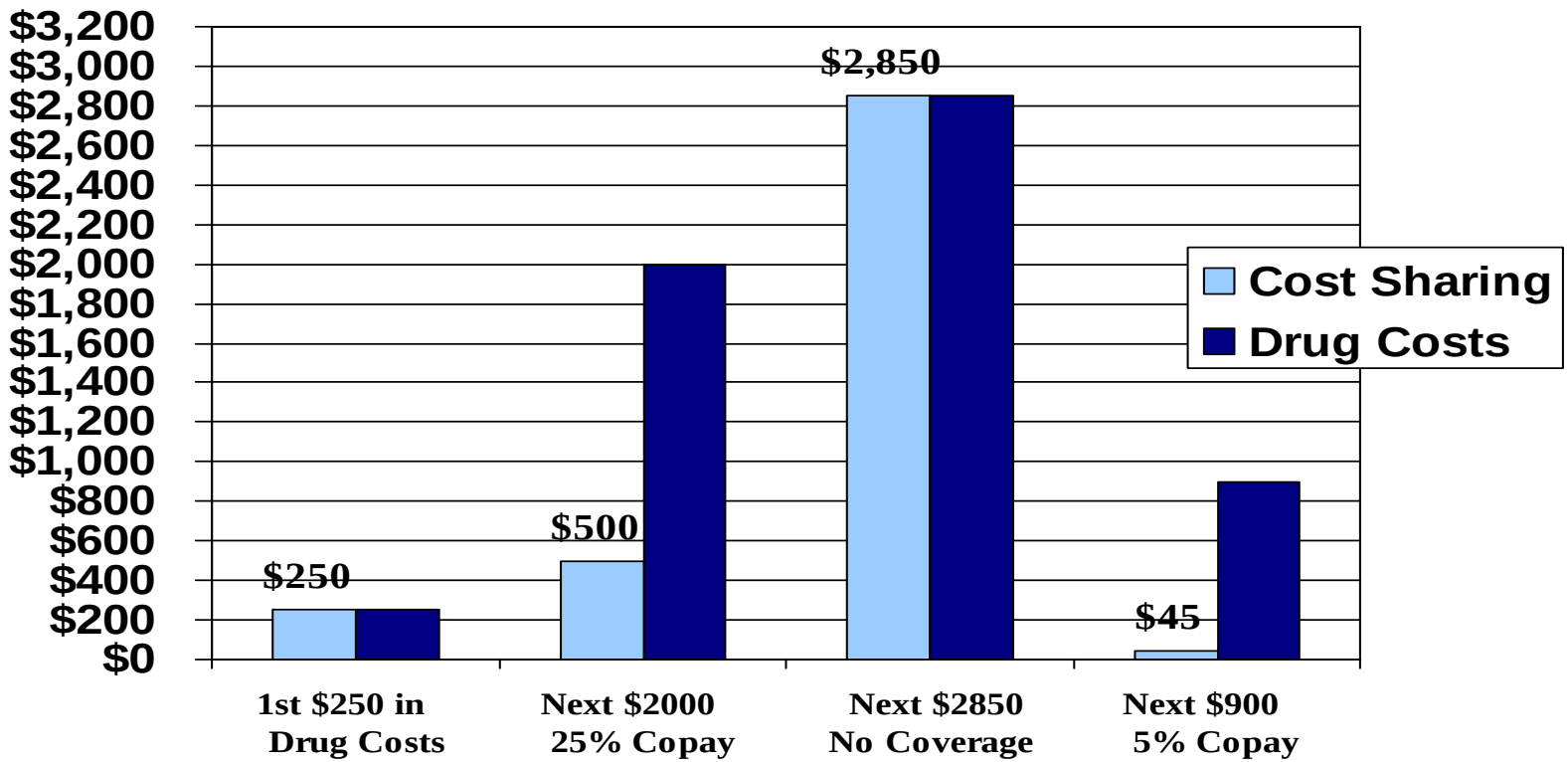
*At $5100 of drug costs, beneficiary has paid $3600 in out-of-pocket spending, not including premiums

Medicare Prescription Drug Program:

Part D - Cost Sharing Example A

(Income >150% FPL)

Standard Benefit - Individual with $6000 in Annual Drug Costs
Total Out of Pocket = $3645 (61%); Does Not Include Premiums

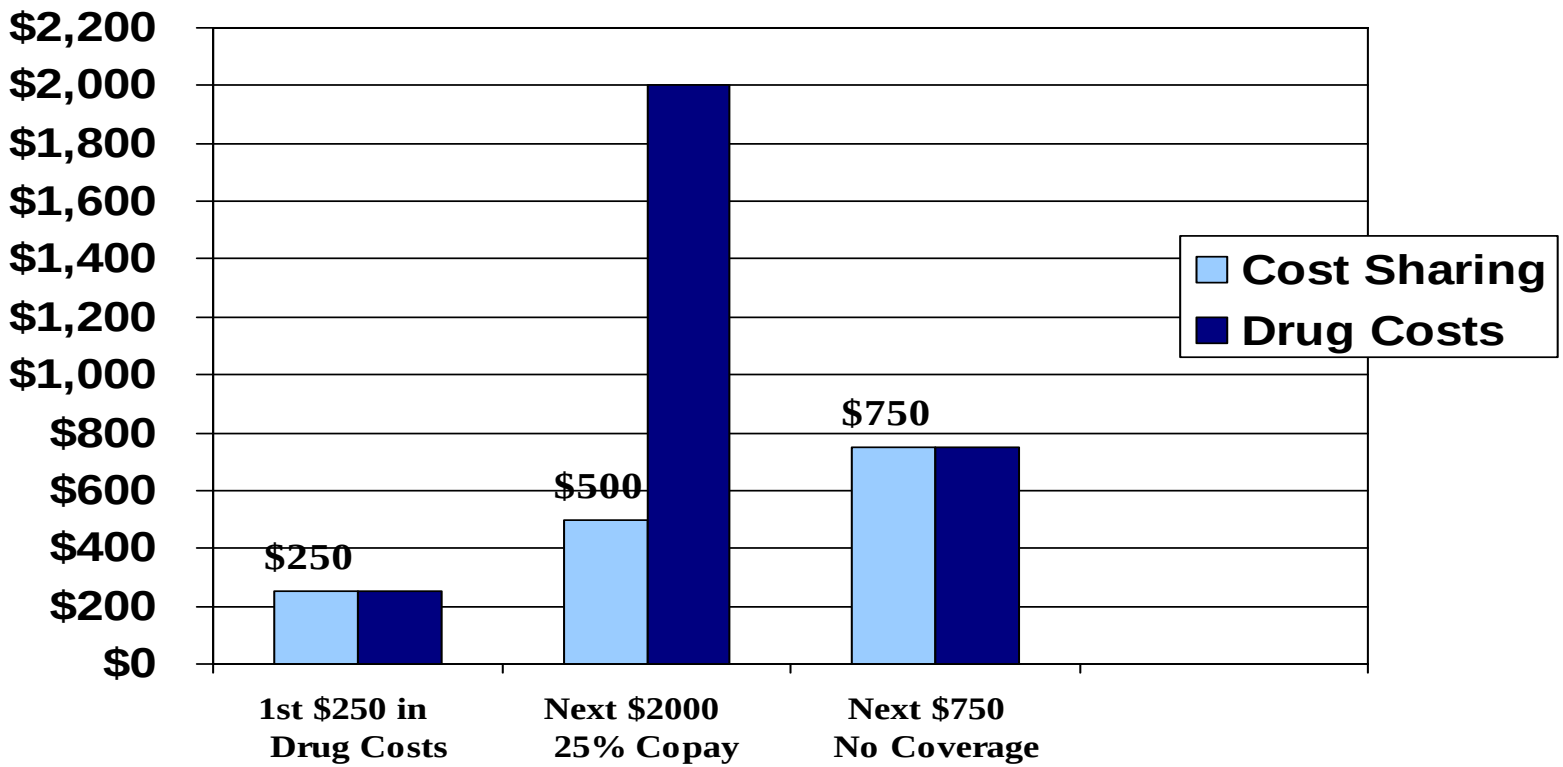


Medicare Prescription Drug Program:

Part D - Cost Sharing Example B

(Income >150% FPL)

Standard Benefit - Individual with $3000 in Annual Drug Costs
Total Out of Pocket = $1500 (50%): Does Not Include Premiums



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Medicare Prescription Drug Program: Part D Low-Income Subsidies

- Subsidies eliminate or lower premium, out of pocket cost sharing for low income beneficiaries
- Based on Income and Asset Test
- Premium subsidies–
  - **No premiums or deductibles for all dual eligible Medicaid clients** and some low income, Medicare beneficiaries
  - Sliding scale subsidies for other low income beneficiaries
- Cost sharing subsidies-
  - **No gap in coverage for all dual eligible Medicaid clients** and some low income Medicare-only individuals
  - Copays from $1 to $5 for all dual eligibles and some low income Medicare-only individuals

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Federal Responsibility for Medicaid "Dual Eligible" Drug Coverage

- Medicare assumes financial responsibility for Medicaid full dual eligible drug coverage in January 2006.
- State must discontinue Medicaid drug coverage for full dual eligibles at the end of December 2005.
- No federal Medicaid funding for Part D-covered drugs for full dual eligibles after that date.
- Medicare program must automatically enroll full dual eligibles who fail to select a Part D plan.

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State Medicaid Programs Monthly Payments to Medicare

- Maintenance of effort (MOE) payments – monthly payment to federal government based on an estimate of what the state would have paid for pharmacy benefits:
  - "Take back" factor (90% in 2006 and phased down to 75% by 2015) based on:
    - Number of Part D enrollees with full dual eligibility in that month; and
    - A per capita amount that approximates amount the state would have spent absent a Medicare drug benefit
      - Per capita amount is the state's average Medicaid spending on Part D-covered drugs for full dual eligibles in 2003, trended forward for drug cost inflation.

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State Maintenance of Effort Formula

Monthly payment by state to the Medicare program =

(Number of full dual eligibles enrolled in Part D)

X

(FY 2003 per capita dual eligible Rx costs x Inflation)

X

“Take back” factor (90% in ’06)

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State's Role in Medicare "Part D" Program Administration

- Convert dual eligible clients from Medicaid to Medicare drug coverage in 2006
- Make Monthly Maintenance of Effort Payments
- Administer Part D Low-Income Subsidy (2006)
  - States are responsible for determining eligibility for the low-income subsidy for Medicare drug benefit (50% federal match).
  - States must check low income subsidy applicants for Medicaid eligibility (will increase Medicaid aged/disabled caseloads).

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Texas Medicaid Budget Issues - Part D Drug Benefit

- Eligibility Determination:
  - Significant automation costs (given complex eligibility for subsidies) and staffing costs (determinations and appeals)
  - Application process for subsidy must work with state Medicaid eligibility system (TIERS)
- Caseload Cost Considerations:
  - Increase in Medicaid caseload due to requirement to screen low income subsidy applicants for Medicaid eligibility
- Uncertain Savings to the State:
  - Projected to save between $650 M to $1.2 B over 10 years
  - Estimates will be offset by new costs associated with eligibility determination and associated caseload growth
  - Savings likely to be in out years, when “take back” factor declines

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Conclusion

- ’06 -’07 Savings in Health and Human Services Costs?

Total Savings=
Savings in Medicaid and Other HHS Drug Costs
Minus
Monthly MOE Payments to Medicare +
New Costs for Dual Eligible Caseload Growth +
New Eligibility Determination Costs

- Cost/savings estimates under development; will be included in 2006-07 legislative appropriation request
- Proposed changes to federal Medicare drug legislation:
  - 100% federal match for Medicare eligibility activities
  - Changes to formula for state maintenance of effort

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Selected Texas Medicare/Medicaid Statistics

- Full Dual Eligibles (May ’04) – 311,562
- Non-full Dual Eligibles (May ’04) – 153,540
- Average Annual Medicaid Drug Cost, Aged and Disabled Individual in Nursing Facility – $3,634
- Average Annual Medicaid Drug Cost, Aged and Disabled Individual in Community – $1,492 (3 Rx limit)
- Projected Texas Medicare Eligibles (’06) – 2,478,000
- Projected Texas Medicare Potentially Eligible for Part D Low Income Subsidy (’06) – 680,000*

Sources: March 2003 Current Population Survey, Texas Health and Human Services Commission, Texas Department of Human Services

*Based on income only; assets testing will lower this estimate.