Presentation to the House Committee on Public Health

Health and Human Services Commission

June 16, 2004

Presentation Overview

- Vendor Drug Program and Preferred Drug List
- Medicaid Vendor Drug Current Trends
- Medicare Prescription Drug Program

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Vendor Drug Program and Preferred Drug List (PDL)

Olga Garcia, Senior Policy Advisor

Texas Medicaid/CHIP

Vendor Drug Program

In Medicaid, pharmacy services are provided through the "Vendor Drug" program

- The state contracts with pharmacies to provide Medicaid clients with pharmacy benefits.
- Over 3,700 or approximately 70% of all licensed Texas pharmacies under contract.
- Pharmacies submit bills called "claims" to the state, and are reimbursed for providing appropriate prescriptions to Medicaid enrollees.
- HHSC Vendor Drug Program performs most administrative functions.

Vendor Drug Program

Vendor Drug Background

- Medicaid Vendor Drug Program was implemented September 1971.
- Outpatient drug coverage is an optional Medicaid service, except for children and nursing home residents.
- Open formulary
- Three prescription limit for aged, blind, and disabled FFS adults in community other than LTC waiver participants
- Unlimited prescriptions for children, Medicaid managed care enrollees, residents of nursing homes, and long term care waiver clients.

Vendor Drug Program

Vendor Drug Program

- Provides statewide access to prescription medications as prescribed by the treating physician or other health care provider to:
  - Medicaid eligible recipients
  - Children with Special Health Care Needs (CSHCN)
  - Children's Health Insurance Program (CHIP)
  - Kidney Health Care Recipients

Medicaid Rebate Program

Medicaid National Manufacturer Rebate Program

- Federal Centers for Medicare and Medicaid Services (CMS) determines the rebate amounts
  - Federal requirement for open formulary (with exceptions) in exchange for Medicaid rebates
- Medicaid state programs apply the national rebate amounts to state usage rates and perform the rebate billing and collection function
  - Rebates are not available if outpatient drugs are included in a capitation rate paid to HMOs
  - Texas does not include outpatient drugs in the HMO capitation rates.

Vendor Drug Utilization

Texas Medicaid Drug Use Review (DUR)

- Educational program established in response to federal requirement
  - Promotes appropriate use of pharmaceuticals
- Requires states to implement retrospective and prospective reviews
- DUR Board determines therapeutic criteria and standards used in the reviews

Vendor Drug Changes: 78th Legislature, R.S.

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

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) considered three factors when reviewing drugs: clinical efficacy, safety, and cost effectiveness.

Medicaid/CHIP PDL: Status

- P&T Committee has met 6 times since November and will meet quarterly beginning in August.
- The P&T Committee will review certain drug classes for the CHIP PDL in August 2004.
- HHSC has reviewed approximately 70% of the total drug spend in the Medicaid program.
- HHSC is on target for $150 millions savings for the 2003-2004 biennium.

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Medicaid Vendor Drug Current Trends

Lisa Carruth, Director

System Forecasting

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.

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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Federal Medicare Prescription Drug Benefits

Trey Berndt
Special Assistant to the Director
Texas Medicaid/CHIP

Medicare Prescription Drug Program:
Drug Phase I – Temporary Program

Medicare Approved Drug Discount Card (Starts June '04, ends December '05)

- Discounted drug prices
  - ➢ administered by 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 family of two)

Medicare Prescription Drug Program: Drug Phase II

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

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

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

Medicare Prescription Drug Program:
Dual Eligibility

- 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
  - Will be eligible for both discount card program in 2004 and Part D benefit in 2006

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%

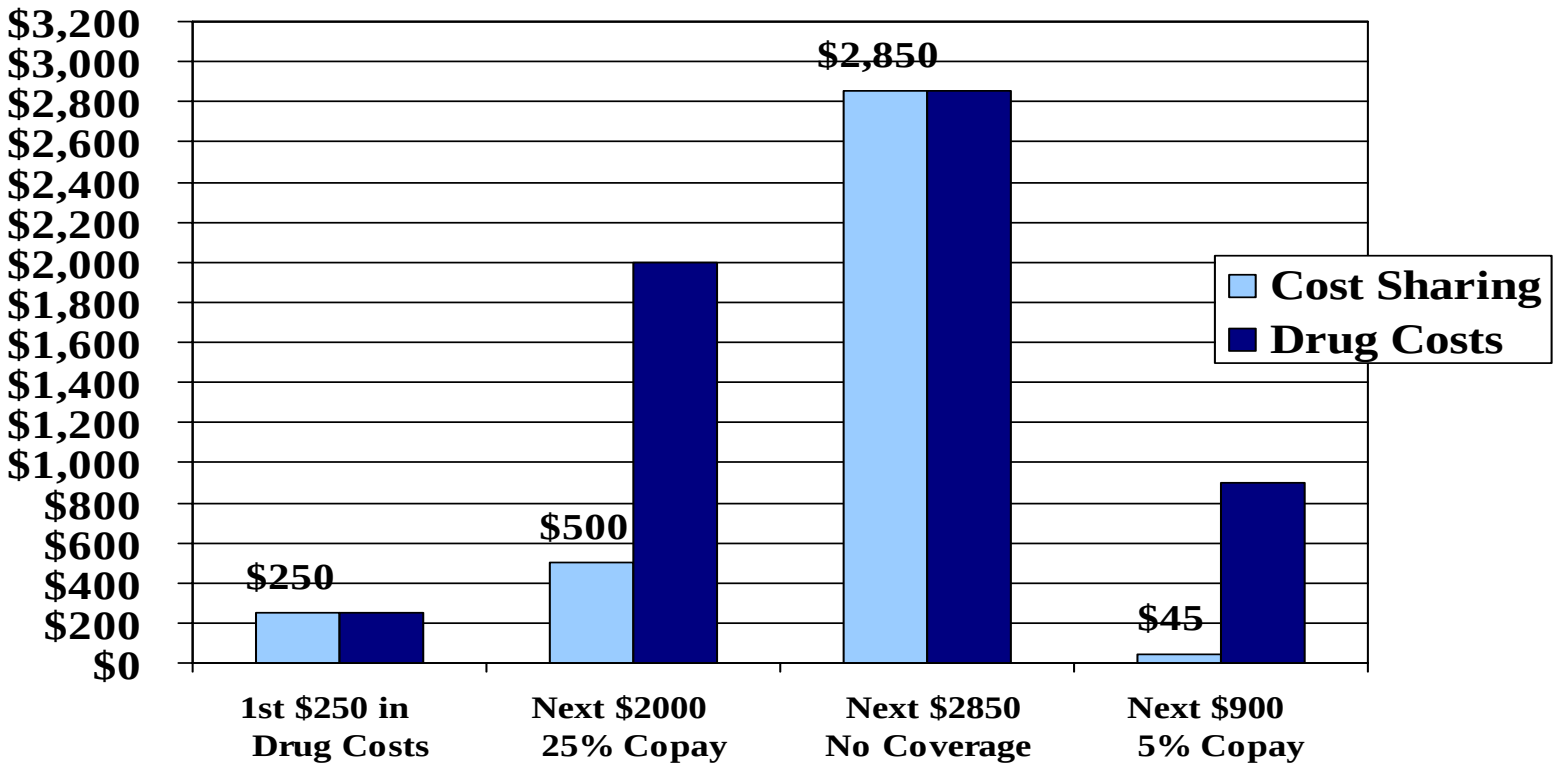
*At $5100 of drug costs, beneficiary has paid $3600 in out-of-pocket spending, not including premiums

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

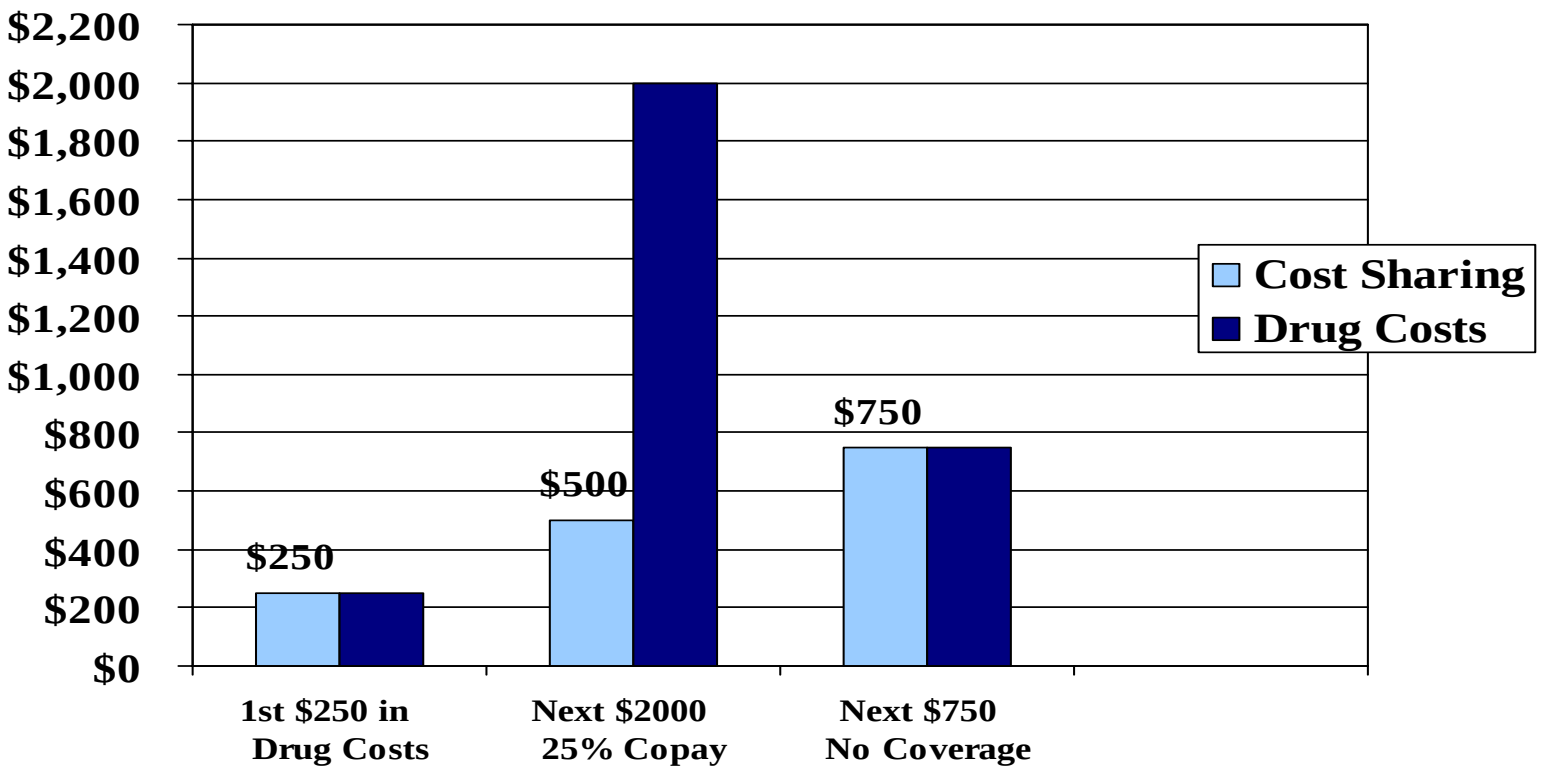


Medicare Prescription Drug Program:

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



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

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.

State Medicaid Programs
Monthly Payments to Medicare

- Maintenance of effort 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.

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)

State's Role in Medicare Drug Program Administration

- Discount Card (June 2004)
  - Provide data to Medicare to identify dual eligible clients receiving Medicaid Rx coverage (300,000 + clients)
  - Caseworkers will provide information and referral to discount card sponsors (enrollment begins May 2004)
- Conversion of dual eligible clients from Medicaid to Medicare Drug Coverage in 2006
- 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).

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

- State HHS agencies will assist with the coordination of information on temporary drug discount card program
- Cost/savings estimates for Part D Medicaid impacts 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 payments that better reflect state Medicaid drugs savings initiatives

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.

Federal Poverty Level (FPL) Guidelines Annual Income, 2004

Family Size	74% FPL (SSI)*	100% FPL	135% FPL	150% FPL
Individual	$6,889	$9,310	$12,569	$13,965
Couple	$9,243	$12,490	$16,862	$18,735

*Supplemental Security Income

Source – U.S. Department of Health and Human Services