

# The 2nd National Medicare RX Drug Congress

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3.03 Medicaid & MMA Administrative Challenges:  
Priorities for State Legislators – November 1, 2005

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# Overview

- Challenges Stemming from Medicare Part D
  - Dual Eligibles
    - Effect of Hurricane Katrina
- Texas's Reaction due to increased cost sharing, budget shortfalls, etc.
  - Innovative strategies to address the needs of a growing Medicaid population.

# Challenges Stemming from Medicare Part D

- Dual Eligibles - the challenge for states is to make certain that all dual-eligibles are enrolled in a Medicare prescription drug plan by January 1, 2006 when their eligibility for Medicaid prescription drug coverage ends.
- The Centers for Medicare and Medicaid Services (CMS) has developed a procedure to “auto-assign and auto-enroll” full benefit dual eligibles in either a Medicare Advantage (MA) with a prescription drug benefit, if they were already enrolled in a Medicare Advantage Plan or a freestanding Prescription Drug Plan (PDP) if they were in Medicare fee-for-service.
- Under this plan, the states and beneficiaries will be notified of the assignment at the end of October 2005.

# Key Issues for Dual Eligibles

- Education and outreach to dual-eligibles to ensure that they understand their options:
  - They must enroll in a Medicare prescription drug plan to maintain prescription drug coverage.
  - If they are currently enrolled in a Medicare Advantage plan, they will be assigned to a Medicare Advantage plan that provides prescription drug coverage. If they separately enroll in a free-standing prescription drug plan, they will be disenrolled from the Medicare Advantage plan. *(The Medicare Advantage plans are supposed to notify all beneficiaries regarding this issue.)*
  - They are free to switch from the plan to which they have been assigned and to enroll in another plan.

# Key Issues for Dual Eligibles

- States and their partners (local governments, advocacy and service organizations) and/or family members will need to assist beneficiaries in selecting a plan that best meets their needs.
- CMS has put in place a “transition policy,” regarding maintenance medications. Under this policy, each plan must have in place a policy to continue existing prescriptions during a transition period to ensure continuity of care.

# Key Issues for Dual Eligibles

- Finally, the ongoing challenge will be coordination of care for dual eligibles between Medicare, Medicaid and the private prescription drug plans.
  - The hope is that the new Special Needs Plans (SNPs), Medicare Advantage plans designed to improve care coordination for Medicare beneficiaries with chronic illnesses and which can directly target dual-eligibles, will provide a successful model for care coordination. Ultimately, these SNPs should help identify existing barriers to care coordination that exist in current state and federal laws and regulations. This will hopefully lead to changes designed to better facilitate care coordination.

# Dual Eligibles and the Effect of Hurricane Katrina

- The protections for dual eligibles have been derailed for many Hurricane Katrina survivors and evacuees. Why????
  - Their home jurisdiction has changed.
  - Their support systems have changed.
  - They may be in a different jurisdiction by January 1, 2006.
  - In other words, they may be hard to find and harder to place in an appropriate plan.

# Dual Eligibles and the Effect of Hurricane Katrina

- Many states are providing assistance to Katrina survivors and evacuees, so this issue is not limited to the states directly impacted by Hurricane Katrina.
- Transition plans and beneficiary protections, specifically designed for Katrina survivors and evacuees, must be put in place.

# Texas's Reaction

- Disease Management
- Integrated Care Management
- Preferred Drug List
- Managed Care/Managed Care Expansion

# Disease Management (DM)

- Disease management is a systematic approach to health care delivery that identifies people with, or those at risk for developing, a specific chronic illness such as asthma, diabetes or congestive heart failure.
- Patients receive specific evidence-based information, medical equipment, and support to follow their physician's plan of care and practice healthy behaviors.

# Who is served by DM?

- **The initial implementation of DM for the fee-for-service population served people with congestive heart failure, cardiovascular arterial disease, diabetes, asthma and chronic obstructive pulmonary disease.**

# How are patients served by DM?

- The contracted DM vendor for this population performs the following activities to ensure a comprehensive approach to the management of chronic diseases:
  - identification and outreach to eligible beneficiaries;
  - health assessment and risk stratification;
  - enrollment and disenrollment of eligible/ineligible beneficiaries;
  - education of beneficiaries and providers;
  - quality assurance;
  - care management; and
  - outcomes measurement.

# Anticipated Savings of DM

- Current estimated savings in Year 1 of the contract is between \$15-18 million, net of vendor fees.
- The contract establishes a minimum of 5 percent guaranteed savings in total medical costs for the enrolled population.
  - 80 percent of the vendor's administrative fees are at risk for the cost savings guarantee
  - 20 percent of the vendor's administrative fees are at risk for attainment of clinical outcomes/quality variables

# Anticipated Outcomes of DM

- Decrease in utilization of inappropriate and unnecessary medical services.
- Appropriate utilization of and compliance with prescribed medications.
- Improvements in a wide range of disease specific and overall health quality indicators.

# Integrated Care Management (ICM)

- Pilot Program
- ICM is intended to:
  - improve patient health and social outcomes,
  - improve access to care,
  - constrain health care costs, and
  - integrate the spectrum of acute and long-term care services and supports.

# Characteristics of the ICM Model

- Rather than using an HMO as an intermediary, the ICM model will use an Administrative Services Organization (ASO), which is prohibited from reimbursing providers with capitated rates.
- Providers will continue to be reimbursed through the state's fee-for-service system.
- The noncapitated rates allow local public hospital districts to utilize federal funding by drawing down Medicaid Upper Payment Limits.

# Anticipated Savings of ICM

- Budget officials estimate that the roll-out of this model, along with the roll-out of other care management models across the state will save the state of Texas approximately \$109.5 million over the 2005-2006 biennium.

# Preferred Drug List (PDL)

- Texas state law has the following requirements for the PDL:
  - It may only contain drugs for which the state receives a supplemental rebate or program benefit from the manufacturer or labeler.
  - A Governor-appointed Pharmaceutical and Therapeutics (P&T) Committee of physicians and pharmacists makes recommendations about which drugs to place on the list based on clinical efficacy, safety and cost effectiveness.
  - All drugs with a federal Medicaid rebate agreement continue to be available to recipients, but the physician or other prescriber must obtain prior authorization for non-preferred drugs, which were reviewed by the committee but not selected to be on the preferred list.

# Managed Care/Managed Care Expansion

- Managed Care refers to a health system in which a network of health care providers agree to coordinate and provide health care to a population in exchange for a specific payment per person.
- Four major features distinguish managed care from traditional fee-for-service (FFS) health financing arrangements:
  - 1. Primary Care Providers (PCPs)
  - 2. Defined Network of Providers
  - 3. Utilization Review and Utilization Management (UR/UM)
  - 4. Capitation

# Managed Care Models in TX

- **Texas currently delivers services through two different managed care models:**
  - 1. Health Maintenance Organizations (HMO): Organizations licensed by the Texas Department of Insurance that deliver and manage health services under a risk-based arrangement. The HMO receives a monthly “capitation” payment for each person enrolled based on an average projection of medical expenses for the typical patient.
  - 2. Primary Care Case Management (PCCM): In this non-capitated model, each PCCM participant is assigned to a single PCP who must authorize most other services, such as specialty physician care, before Medicaid can reimburse them. The State sets up physician networks and contracts directly with providers. Providers receive fee-for-service reimbursement, plus PCPs receive a small monthly case management fee for each client.