Bill as Introduced

HB 735-FN – AS INTRODUCED

2003 SESSION

03-0032
01/09

HOUSE BILL ***735-FN***

AN ACT relative to prescription drugs and medicaid best practices.

SPONSORS: Rep. Wendelboe, Belk 29

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill requires the department of health and human services to establish certain programs to increase access to prescription drugs for seniors. The bill grants rulemaking authority to the commissioner of health and human services for the purposes of the bill.

This bill requires the department of health and human services to encourage health plans and health care systems participating in the medicaid program to use case management incorporating evidence-based practice guidelines.

The bill also establishes a 3-year task force to study increasing access to prescription drug medicines for needy seniors.

Explanation: Matter added to current law appears in ***bold italics.***
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03-0032
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Three

AN ACT relative to prescription drugs and medicaid best practices.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Chapter; Access to Prescription Drugs. Amend RSA by inserting after chapter 161-J the following new chapter:

CHAPTER 161-K

ACCESS TO PRESCRIPTION DRUGS

161-K:1 Definitions: In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Division" means the division of elderly and adult services, department of health and human services.

161-K:2 Medicaid Outreach and Enrollment Program Established. The department shall establish the medicaid outreach and enrollment program. Such program shall be administered by the division through the development of outreach initiatives to identify medicaid-eligible medicare beneficiaries who are not participating in the medicaid program and to promote and encourage enrollment of such eligible persons in the medicaid program. Initiatives may include, but are not limited to, mailings, advertisements, public service announcements, literature dissemination, and community outreach.

161-K:3 Report.

I. The department shall make an annual report to the general court beginning one year from the effective date of this chapter.

II. The department's report shall include but not be limited to the following:

(a) The baseline number of medicare beneficiaries who were medicaid eligible at the beginning of the previous year.

(b) The number of medicaid-eligible medicare beneficiaries who were targeted via the medicaid outreach and enrollment program.

(c) The number of medicaid-eligible medicare beneficiaries who enrolled in medicaid in a given year and any information of enrollment from the medicaid outreach and enrollment program.

(d) A description of the outreach initiatives utilized by the medicaid outreach and enrollment program.

(e) A detailed accounting of how funding was utilized.

161-K:4 Rulemaking. The commissioner shall adopt rules, pursuant to RSA 541-A, necessary for the implementation of this chapter.

Medicaid Rx Senior Eligibility
Expansion Program

161-K:5 Definitions: In this subdivision:

I. "Qualified medicare beneficiaries" means medicare beneficiaries with incomes equal to or below 100 percent of the federal poverty level who are eligible for medicaid assistance for the part A and part B medicare premiums and for medicare deductibles and co-insurance requirements as set forth in section 1905(p)(1) of Title XIX of the Social Security Act.

II. "Specified low-income medicare beneficiaries" means medicare beneficiaries who have incomes greater than 100 percent of the federal poverty level and less than and equal to 120 percent of the federal poverty level and meet the requirements set forth in section 1902(a)(10)(E)(iii) of Title 19 of the Social Security Act.

161-K:6 Medicaid Rx Senior Eligibility Expansion Program Established.

I. There is hereby established the medicaid Rx senior eligibility expansion program. To be eligible for the program, an individual shall:

(a) Be a U.S. citizen or a lawfully admitted alien;

(b) Be a state resident;

(c) Be at least 65 years of age or an individual between the ages of 19 and 64 who is otherwise eligible for benefits under Title II of the Social Security Act (Federal Old Age, Survivors, and Disability Insurance);

(d) Meet the definition of a qualified medicare beneficiary or a specified low-income medicare beneficiary as set forth in subparagraph (c); and

(e) Be ineligible for and/or not receiving a prescription drug benefit through a medicare supplemental policy or any other third party payer prescription benefit.

II. Individuals eligible for the medicaid Rx senior eligibility expansion program shall be entitled to the medicaid prescription drug coverage as provided to medicaid recipients as set forth in Title XIX of the Social Security Act.

161-K:7 Administration; Rulemaking.

I. The medicaid Rx senior eligibility expansion program shall be administered by the division. The department shall apply for a federal medicare 1115 demonstration waiver from the Secretary of Health and Human Services to expand medicaid eligibility for the purposes of prescription drug coverage to qualified medicare beneficiaries and specified low-income medicare beneficiaries under the medicaid Rx senior eligibility expansion program.

II. The commissioner shall make an annual report beginning one year after the effective date of this chapter to the general court relative to the effectiveness of the medicaid Rx senior disability eligibility program.

2 New Subdivision; Medicaid Best Practices. Amend RSA 167 by inserting after section 97 the following new subdivision:

Medicaid Best Practices

167:98 Medicaid Best Practices.

I. The department of health and human services shall identify medicaid patients who require ongoing and expensive care and develop interventions to improve their health, functional status and independence in an effort to promote adherence to best medical practices. The department shall encourage health plans and health care systems participating in the medicaid program to:

(a) Conduct patient needs assessments upon enrollment.

(b) Develop individual, patient-centered plans.

(c) Use case management incorporating evidence-based practice guidelines.

II. The department shall make an annual report beginning one year after the effective date of this section to the oversight committee established in RSA 126-A:13, relative to the effectiveness of this subdivision.

III. The commissioner of health and human services shall adopt rules, pursuant to RSA 541-A, necessary to implement this program.

3 Task Force Established. There is established a task force to study the feasibility of establishing a New Hampshire Rx senior patient assistance program. delete so that it would be more comprehensive

4 Membership and Compensation.

I. The members of the task force shall be as follows:

(a) Three members of the house of representatives, appointed by the speaker of the house.

(b) Three members of the senate, appointed by the president of the senate.

(c) The commissioner of the department of health and human services, or designee.

(d) Two pharmacists licensed in this state, appointed by the governor.

(e) A member of the public, appointed by the governor.

II. The members of the task force shall serve without compensation, however, legislative members of the task force shall receive mileage at the legislative rate when attending to the duties of the task force.

5 Duties. The task force shall study the feasibility of establishing a New Hampshire Rx senior patient assistance program. The committee shall consider eligibility guidelines and enrollment fees.

6 Chairperson; Quorum. The members of the task force shall elect a chairperson from among the members. The first meeting of the task force shall be called by the first-named house member. The first meeting of the task force shall be held within 45 days of the effective date of this section. Six members of the task force shall constitute a quorum.

7 Report. The task force shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the senate president, the house clerk, the senate clerk, the governor, and the state library on or before November 1, 2006.

8 Prospective Repeal. RSA 161-K:1 through RSA 161-K:7, relative to prescription drug access, is repealed.

9 Effective Date.

I. Sections 3-7 of this act shall take effect upon its passage.

II. Section 8 shall take effect at 11:59 p.m. on the day before a federal prescription drug plan takes effect.

III. The remainder of this act shall take effect 60 days after its passage.

LBAO
03-0032
1/27/03

HB 735-FN - FISCAL NOTE

AN ACT relative to prescription drugs and medicaid best practices.

FISCAL IMPACT:

Due to time constraints, the Office of Legislative Budget Assistant is unable to provide a fiscal note for this bill at this time. When completed, the fiscal note will be forwarded to the House Clerk's Office.

LBAO
03-0032
Revised 1/31/03

HB 735 FISCAL NOTE

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FISCAL IMPACT:

The Department of Health and Human Services stated this bill will increase state expenditures by $16,789,502 in FY 2004, $19,094,248 in FY 2005, $21,652,906 in FY 2006 and $32,100,108 in FY 2007. State restricted revenue will increase by $8,394,751 in FY 2004, $9,547,124, in FY 2005, $10,826,453 in FY 2006 and $16,050,054 in FY 2007. There will be no fiscal impact on county and local revenues or expenditures.

METHODOLOGY:

The Department indicated this bill requires the Commissioner to obtain a federal Medicaid waiver to expand prescription drug coverage to qualified Medicare beneficiaries and specified low-income Medicare beneficiaries under the Medicaid Rx Senior Eligibility Expansion Program. The Department stated this bill also requires the Department to establish a Chronic Disease Case Management Program. In estimating the fiscal impact, the Department made the following assumptions:

- This bill will be effective July 1, 2004 and outreach will begin 60 days later.
- Outreach efforts will require a Case Technician and a Program Specialist, funds for direct mail, public service announcements and other outreach activities.
- Chronic Disease Management Program savings will start after 20 months consistent with industry experience and will require additional personal, funds for operating costs and provider education.
- The Division of Family Assistance would be impacted by a greater number of applications for drug benefits.
- The analysis assumes the federal Centers for Medicare and Medicaid Services (CMS) will approve the waiver request. Additional expenditures are 50% state general funds and 50% federal Medicaid funds.
- Additional costs include Medicare Part B and Coinsurance/Deductible for QMB population and Medicare Part B for the SLMB population.
- Drug costs used are typical of the QMB/SLMB population and drug rebates are assumed to be 19%.
- 5,173 individuals would enroll in FY 2004 with an additional 20% in each of the following years.

Based on these assumptions, the Department estimated the following costs and savings:

Recipients:	FY 2004	FY 2005	FY 2006	FY 2007
Qualified Medicare Beneficiaries	2,356	2,945	3,681	4,601
Specified Low Income Medicare Beneficiaries	2,817	3,521	4,401	5,502
Total	5,173	6,466	8,082	10,103
Expenditures:				
Average Rx cost /month	$ 194	$ 213	$ 251	$ 297
Total Rx cost /year	12,018,433	16,524,706	24,372,433	35,951,118
Total net of 19% rebates	9,734,930	13,385,012	19,741,671	29,120,406
QMB $54 Co-insurance & $32 deductible	2,431,169	3,038,844	3,798,320	4,748,135
SLMB $54 Co-insurance	1,825,556	2,281,857	2,852,144	3,565,357
Outreach Employees w/ benefits	147,542	152,706	158,051	163,583
New Heights System Changes	250,000	-	-	-
Chronic Disease Management Cost (Savings)	2,153,360	(23,464)	(5,169,537)	(5,783,243)
Case Technicians in the Division	246,945	259,293	272,257	285,870
Total	$16,789,502	$19,094,248	$21,652,906	$32,100,108
State Funds	$ 8,394,751	$ 9,547,124	$10,826,453	$16,050,054
Federal Funds	$ 8,394,751	$ 9,547,124	$10,826,453	$16,050,054

HB 735-FN – AS AMENDED BY THE HOUSE

12mar03... 0492h

2003 SESSION

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01/09

HOUSE BILL ***735-FN***

AN ACT relative to prescription drugs and medicaid best practices.

SPONSORS: Rep. Wendelboe, Belk 29

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill requires the department of health and human services to establish certain programs to increase access to prescription drugs for seniors. The bill grants rulemaking authority to the commissioner of health and human services for the purposes of the bill.

This bill requires the department of health and human services to encourage health plans and health care systems participating in the medicaid program to use case management incorporating evidence-based practice guidelines.

The bill also establishes a 3-year task force to study increasing access to prescription drug medicines.

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CHAPTER 161-K

ACCESS TO PRESCRIPTION DRUGS

161-K:1 Definitions: In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

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161-K:2 Rulemaking. The commissioner shall adopt rules, pursuant to RSA 541-A, necessary for the implementation of this chapter.

Medicaid Rx Senior Eligibility

Expansion Program

161-K:3 Definitions: In this subdivision:

I. "Qualified medicare beneficiaries" means medicare beneficiaries with incomes equal to or below 100 percent of the federal poverty level who are eligible for medicaid assistance for the part A and part B medicare premiums and for medicare deductibles and co-insurance requirements as set forth in section 1905(p)(1) of Title XIX of the Social Security Act.

II. "Specified low-income medicare beneficiaries" means medicare beneficiaries who have incomes greater than 100 percent of the federal poverty level and less than and equal to 120 percent of the federal poverty level and meet the requirements set forth in section 1902(a)(10)(E)(iii) of Title 19 of the Social Security Act.

161-K:4 Medicaid Rx Senior Eligibility Expansion Program Established.

I. There is hereby established the medicaid Rx senior eligibility expansion program. To be eligible for the program, an individual shall:

(a) Be a U.S. citizen or a lawfully admitted alien;

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II. Individuals eligible for the medicaid Rx senior eligibility expansion program shall be entitled to the medicaid prescription drug coverage as provided to medicaid recipients as set forth in Title XIX of the Social Security Act.

III. Individuals eligible for the program established under this subdivision shall be provided a benefit of not more than $2,000 per year and shall be subject to a $5 copayment per prescription.

161-K:5 Administration.

I. The medicaid Rx senior eligibility expansion program shall be administered by the division. The department shall apply for a federal medicare 1115 demonstration waiver from the Secretary of Health and Human Services to expand medicaid eligibility for the purposes of prescription drug coverage to qualified medicare beneficiaries and specified low-income medicare beneficiaries under the medicaid Rx senior eligibility expansion program.

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New Heights System Changes	250,000	-	-	-
Chronic Disease Management Cost (Savings)	2,153,360	(23,464)	(5,169,537)	(5,783,243)
Case Technicians in the Division	246,945	259,293	272,257	285,870
Total	$16,789,502	$19,094,248	$21,652,906	$32,100,108
State Funds	$ 8,394,751	$ 9,547,124	$10,826,453	$16,050,054
Federal Funds	$ 8,394,751	$ 9,547,124	$10,826,453	$16,050,054

Amendments

Rep. Wendelboe, Belk. 29
March 4, 2003
2003-0492h
01/09

Amendment to HB 735-FN

Amend the bill by replacing section 1 with the following:

1 New Chapter; Access to Prescription Drugs. Amend RSA by inserting after chapter 161-J the following new chapter:

CHAPTER 161-K

ACCESS TO PRESCRIPTION DRUGS

161-K:1 Definitions: In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Division" means the division of elderly and adult services, department of health and human services.

161-K:2 Rulemaking. The commissioner shall adopt rules, pursuant to RSA 541-A, necessary for the implementation of this chapter.

Medicaid Rx Senior Eligibility

Expansion Program

161-K:3 Definitions: In this subdivision:

I. "Qualified medicare beneficiaries" means medicare beneficiaries with incomes equal to or below 100 percent of the federal poverty level who are eligible for medicaid assistance for the part A and part B medicare premiums and for medicare deductibles and co-insurance requirements as set forth in section 1905(p)(1) of Title XIX of the Social Security Act.

II. "Specified low-income medicare beneficiaries" means medicare beneficiaries who have incomes greater than 100 percent of the federal poverty level and less than and equal to 120 percent of the federal poverty level and meet the requirements set forth in section 1902(a)(10)(E)(iii) of Title 19 of the Social Security Act.

161-K:4 Medicaid Rx Senior Eligibility Expansion Program Established.

I. There is hereby established the medicaid Rx senior eligibility expansion program. To be eligible for the program, an individual shall:

(a) Be a U.S. citizen or a lawfully admitted alien;

(b) Be a state resident;

(c) Be at least 65 years of age or an individual between the ages of 19 and 64 who is otherwise eligible for benefits under Title II of the Social Security Act (Federal Old Age, Survivors, and Disability Insurance);

(d) Meet the definition of a qualified medicare beneficiary or a specified low-income medicare beneficiary as set forth in subparagraph (c); and

(e) Be ineligible for and/or not receiving a prescription drug benefit through a medicare supplemental policy or any other third party payer prescription benefit.

II. Individuals eligible for the medicaid Rx senior eligibility expansion program shall be entitled to the medicaid prescription drug coverage as provided to medicaid recipients as set forth in Title XIX of the Social Security Act.

III. Individuals eligible for the program established under this subdivision shall be provided a benefit of not more than $2,000 per year and shall be subject to a $5 copayment per prescription.

161-K:5 Administration.

I. The medicaid Rx senior eligibility expansion program shall be administered by the division. The department shall apply for a federal medicare 1115 demonstration waiver from the Secretary of Health and Human Services to expand medicaid eligibility for the purposes of prescription drug coverage to qualified medicare beneficiaries and specified low-income medicare beneficiaries under the medicaid Rx senior eligibility expansion program.

II. The commissioner shall make an annual report beginning one year after the effective date of this chapter to the general court relative to the effectiveness of the medicaid Rx senior disability eligibility program.

Amend the bill by replacing section 3 with the following:

3 Task Force Established. There is established a task force to study the feasibility of establishing a New Hampshire Rx patient assistance program.

Amend the bill by replacing section 5 with the following:

5 Duties. The task force shall study the feasibility of establishing a New Hampshire Rx patient assistance program. The committee shall consider eligibility guidelines and enrollment fees.

Amend the bill by replacing section 8 with the following:

8 Prospective Repeal. RSA 161-K:1 through RSA 161-K:5, relative to prescription drug access, is repealed.

2003-0492h

AMENDED ANALYSIS

This bill requires the department of health and human services to establish certain programs to increase access to prescription drugs for seniors. The bill grants rulemaking authority to the commissioner of health and human services for the purposes of the bill.

This bill requires the department of health and human services to encourage health plans and health care systems participating in the medicaid program to use case management incorporating evidence-based practice guidelines.

The bill also establishes a 3-year task force to study increasing access to prescription drug medicines.

Rep. Irwin, Hills. 44
March 18, 2003
2003-0815h
10/09

Amendment to HB 735-FN

Amend the bill by replacing sections 1 and 2 with the following:

1 New Chapter; Access to Prescription Drugs. Amend RSA by inserting after chapter 161-J the following new chapter:

CHAPTER 161-K

ACCESS TO PRESCRIPTION DRUGS

161-K:1 Definitions: In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Division" means the division of elderly and adult services, department of health and human services.

IV. "Qualified medicare beneficiaries" means medicare beneficiaries with incomes equal to or below 100 percent of the federal poverty level who are eligible for medicaid assistance for the part A and part B medicare premiums and for medicare deductibles and co-insurance requirements as set forth in section 1905(p)(1) of Title XIX of the Social Security Act.

V. "Specified low-income medicare beneficiaries" means medicare beneficiaries who have incomes greater than 100 percent of the federal poverty level and less than and equal to 120 percent of the federal poverty level and meet the requirements set forth in section 1902(a)(10)(E)(iii) of Title 19 of the Social Security Act.

161-K:2 Medicaid Rx Senior Eligibility Expansion Program Established.

I. There is hereby established the medicaid Rx senior eligibility expansion program. To be eligible for the program, an individual shall:

(a) Be a U.S. citizen or a lawfully admitted alien;

(b) Be a state resident;

(c) Be at least 65 years of age or an individual between the ages of 19 and 64 who is otherwise eligible for benefits under Title II of the Social Security Act (Federal Old Age, Survivors, and Disability Insurance);

(d) Meet the definition of a qualified medicare beneficiary or a specified low-income medicare beneficiary as set forth in subparagraph (c); and

(e) Be ineligible for and/or not receiving a prescription drug benefit through a medicare supplemental policy or any other third party payer prescription benefit.

II. Individuals eligible for the medicaid Rx senior eligibility expansion program shall be entitled to the medicaid prescription drug coverage as provided to medicaid recipients as set forth in Title XIX of the Social Security Act.

III. Individuals eligible for the program established under this subdivision shall be provided a benefit of not more than $2,000 per year and shall be subject to a $5 copayment per prescription.

161-K:3 Administration.

I. The medicaid Rx senior eligibility expansion program shall be administered by the division. The department shall apply for a federal medicare 1115 demonstration waiver from the Secretary of Health and Human Services to expand medicaid eligibility for the purposes of prescription drug coverage to qualified medicare beneficiaries and specified low-income medicare beneficiaries under the medicaid Rx senior eligibility expansion program.

II. The commissioner shall make an annual report beginning one year after the effective date of this chapter to the general court relative to the effectiveness of the medicaid Rx senior disability eligibility program.

2 New Subdivision; Medicaid Best Practices. Amend RSA 167 by inserting after section 97 the following new subdivision:

Medicaid Best Practices

167:98 Medicaid Best Practices.

I. The department of health and human services shall identify medicaid patients who require ongoing and expensive care and develop interventions to improve their health, functional status and independence in an effort to promote adherence to best medical practices. The department shall encourage health plans and health care systems participating in the medicaid program to:

(a) Conduct patient needs assessments upon enrollment.

(b) Develop individual, patient-centered plans.

(c) Use case management incorporating evidence-based practice guidelines.

II. The department shall make an annual report beginning one year after the effective date of this section to the oversight committee established in RSA 126-A:13, relative to the effectiveness of this subdivision.

2003-0815h

AMENDED ANALYSIS

This bill requires the department of health and human services to establish certain programs to increase access to prescription drugs for seniors.

This bill requires the department of health and human services to encourage health plans and health care systems participating in the medicaid program to use case management incorporating evidence-based practice guidelines.

The bill also establishes a 3-year task force to study increasing access to prescription drug medicines.

Rep. Wendelboe, Belk. 29
April 1, 2003
2003-1082h
01/09

FILE

Amendment to HB 735-FN

NOT ADOPTED

Amend the title of the bill by replacing it with the following:

AN ACT relative to prescription drugs and medicaid best practices and continually appropriating a special fund.

Amend the bill by replacing section 1 with the following:

1 New Chapter; Medicaid Rx Senior Eligibility Expansion Program. Amend RSA by inserting after chapter 161-J the following new chapter:

CHAPTER 161-K

MEDICAID Rx SENIOR ELIGIBILITY EXPANSION PROGRAM

161-K:1 Definitions: In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Division" means the division of elderly and adult services, department of health and human services.

IV. "Qualified medicare beneficiaries" means medicare beneficiaries with incomes equal to or below 100 percent of the federal poverty level who are eligible for medicaid assistance for the part A and part B medicare premiums and for medicare deductibles and co-insurance requirements as set forth in section 1905(p)(1) of Title XIX of the Social Security Act.

V. "Specified low-income medicare beneficiaries" means medicare beneficiaries who have incomes greater than 100 percent of the federal poverty level and less than and equal to 120 percent of the federal poverty level and meet the requirements set forth in section 1902(a)(10)(E)(iii) of Title 19 of the Social Security Act.

161-K:2 Medicaid Rx Senior Eligibility Expansion Program Established.

I. There is hereby established the medicaid Rx senior eligibility expansion program. To be eligible for the program, an individual shall:

(a) Be a U.S. citizen or a lawfully admitted alien;

(b) Be a state resident;

(c) Be at least 65 years of age or an individual between the ages of 19 and 64 who is otherwise eligible for benefits under Title II of the Social Security Act (Federal Old Age, Survivors, and Disability Insurance);

(d) Meet the definition of a qualified medicare beneficiary or a specified low-income medicare beneficiary as set forth in subparagraph (c); and

(e) Be ineligible for and/or not receiving a prescription drug benefit through a medicare supplemental policy or any other third party payer prescription benefit.

II. Individuals eligible for the medicaid Rx senior eligibility expansion program shall be entitled to the medicaid prescription drug coverage as provided to medicaid recipients as set forth in Title XIX of the Social Security Act.

III. Individuals eligible for the program established under this subdivision shall be provided a benefit of not more than $2,000 per year and shall be subject to a $5 copayment per prescription.

161-K:3 Administration.

I. The medicaid Rx senior eligibility expansion program shall be administered by the division. The department shall apply for a federal medicare 1115 demonstration waiver from the Secretary of Health and Human Services to expand medicaid eligibility for the purposes of prescription drug coverage to qualified medicare beneficiaries and specified low-income medicare beneficiaries under the medicaid Rx senior eligibility expansion program.

II. The commissioner shall make an annual report beginning one year after the effective date of this chapter to the general court relative to the effectiveness of the medicaid Rx senior disability eligibility program.

161-K:4 Pharmacy Benefit Management Program Assessment; Fund Established. Each pharmacy benefit management program shall be assessed 8 percent on its dispensing fees paid to pharmacies. Such assessment shall be assessed on the pharmacy payor. Such assessments shall be remitted on a quarterly basis to the department of health and human services, which funds shall be forwarded to the state treasurer for deposit in the Medicaid Rx senior eligibility expansion program fund. Such fund shall be continually appropriated to the department of health and human services and shall not lapse. The moneys in the account shall not be used for any purpose other than the program established in this chapter.

Amend the bill by replacing all after section 7 with the following:

8 New Subparagraph; State Treasurer; Medicaid Rx Senior Eligibility Expansion Program Fund. Amend RSA 6:12, I by inserting after subparagraph (lllllllll) the following new subparagraph:

(mmmmmmmmm) Moneys received under RSA 161-K:4, which shall be credited to the Medicaid Rx senior eligibility expansion program fund, established in RSA 161-K:4.

9 Prospective Repeal. The following are repealed:

I. RSA 161-K:1 through RSA 161-K:4, relative to the Medicaid Rx senior eligibility expansion program.

II. RSA 6:12, I(mmmmmmmmm), relative to the Medicaid Rx senior eligibility expansion

program fund.

10 Effective Date.

I. Sections 3-7 of this act shall take effect upon its passage.

II. Section 9 of this act shall take effect at 11:59 p.m. on the day before a federal prescription drug plan takes effect.

III. The remainder of this act shall take effect 60 days after its passage.

2003-1082h

AMENDED ANALYSIS

This bill requires the department of health and human services to establish the Medicaid Rx senior eligibility expansion program. The bill establishes an 8 percent assessment on pharmacy benefit management programs to fund the Medicaid Rx senior eligibility expansion program.

This bill requires the department of health and human services to encourage health plans and health care systems participating in the medicaid program to use case management incorporating evidence-based practice guidelines.

The bill also establishes a 3-year task force to study increasing access to prescription drug medicines.

Rep. Wendelboe, Belk. 29
April 1, 2003
2003-1083h
01/09

FILE

Amendment to HB 735-FN

NOT ADOPTED

Amend the title of the bill by replacing it with the following:

AN ACT relative to prescription drugs and medicaid best practices and making an appropriation therefor.

Amend the bill by replacing all after the enacting clause with the following:

1 New Subdivision; Medicaid Best Practices. Amend RSA 167 by inserting after section 97 the following new subdivision:

Medicaid Best Practices

167:98 Medicaid Best Practices.

I. The department of health and human services shall identify medicaid patients who require ongoing and expensive care and develop interventions to improve their health, functional status and independence in an effort to promote adherence to best medical practices. The department shall encourage health plans and health care systems participating in the medicaid program to:

(a) Conduct patient needs assessments upon enrollment.

(b) Develop individual, patient-centered plans.

(c) Use case management incorporating evidence-based practice guidelines.

II. The department shall make an annual report beginning one year after the effective date of this section to the oversight committee established in RSA 126-A:13, relative to the effectiveness of this subdivision.

2 Task Force Established. There is established a task force to study the feasibility of establishing a New Hampshire Rx patient assistance program.

3 Membership and Compensation.

I. The members of the task force shall be as follows:

(a) Three members of the house of representatives, appointed by the speaker of the house.

(b) Three members of the senate, appointed by the president of the senate.

(c) The commissioner of the department of health and human services, or designee.

(d) Two pharmacists licensed in this state, appointed by the governor.

(e) A member of the public, appointed by the governor.

II. The members of the task force shall serve without compensation, however, legislative members of the task force shall receive mileage at the legislative rate when attending to the duties of the task force.

4 Duties. The task force shall study the feasibility of establishing a New Hampshire Rx patient assistance program. The committee shall consider eligibility guidelines and enrollment fees.

5 Chairperson; Quorum. The members of the task force shall elect a chairperson from among the members. The first meeting of the task force shall be called by the first-named house member. The first meeting of the task force shall be held within 45 days of the effective date of this section. Six members of the task force shall constitute a quorum.

6 Report. The task force shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the senate president, the house clerk, the senate clerk, the governor, and the state library on or before November 1, 2006.

7 Appropriation.

I. There is hereby appropriated to the Foundation for Healthy Communities, the sum of $20,000 for the fiscal year ending June 30, 2004 and the sum of $5,000 for the fiscal year ending June 30, 2005, for the medication bridge program for purposes of sending enrollment packets to qualified medicare beneficiaries and specified low-income medicare beneficiaries. The governor is authorized to draw a warrant for said sums out of any money in the treasury not otherwise appropriated.

II. For the purposes of this section:

(a) "Qualified medicare beneficiaries" means medicare beneficiaries with incomes equal to or below 100 percent of the federal poverty level who are eligible for Medicaid assistance for the part A and part B medicare premiums and for medicare deductibles and co-insurance requirements as set forth in section 1905(p)(1) of Title XIX of the Social Security Act.

(b) "Specified low-income medicare beneficiaries" means medicare beneficiaries who have incomes greater than 100 percent of the federal poverty level and less than and equal to 120 percent of the federal poverty level and meet the requirements set forth in section 1902(a)(10)(E)(iii) of Title 19 of the Social Security Act.

8 Effective Date.

I. Sections 2-6 of this act shall take effect upon its passage.

II. The remainder of this act shall take effect July 1, 2003.

2003-1083h

AMENDED ANALYSIS

This bill requires the department of health and human services to encourage health plans and health care systems participating in the medicaid program to use case management incorporating evidence-based practice guidelines.

This bill makes an appropriation to the Foundation for Healthy Communities for the purposes of enrolling certain persons in the medication bridge program.

The bill also establishes a 3-year task force to study increasing access to prescription drug medicines.

Rep. Wendelboe, Belk. 29
April 2, 2003
2003-1091h
01/09

Amendment to HB 735-FN

FILE

Amend the bill by replacing section 1 with the following:

NOT ADOPTED

1 New Chapter; Medicaid Rx Senior Eligibility Expansion Program. Amend RSA by inserting after chapter 161-J the following new chapter:

CHAPTER 161-K

MEDICAID Rx SENIOR ELIGIBILITY EXPANSION PROGRAM

161-K:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Division" means the division of elderly and adult services, department of health and human services.

IV. "Qualified medicare beneficiaries" means medicare beneficiaries with incomes equal to or below 100 percent of the federal poverty level who are eligible for Medicaid assistance for the part A and part B medicare premiums and for medicare deductibles and co-insurance requirements as set forth in section 1905(p)(1) of Title XIX of the Social Security Act.

V. "Specified low-income medicare beneficiaries" means medicare beneficiaries who have incomes greater than 100 percent of the federal poverty level and less than and equal to 120 percent of the federal poverty level and meet the requirements set forth in section 1902(a)(10)(E)(iii) of Title 19 of the Social Security Act.

161-K:2 Medicaid Rx Senior Eligibility Expansion Program Established.

I. There is hereby established the Medicaid Rx senior eligibility expansion program. To be eligible for the program, an individual shall:

(a) Be a U.S. citizen or a lawfully admitted alien;

(b) Be a state resident;

(c) Be at least 65 years of age or an individual between the ages of 19 and 64 who is otherwise eligible for benefits under Title II of the Social Security Act (Federal Old Age, Survivors, and Disability Insurance);

(d) Meet the definition of a qualified medicare beneficiary or a specified low-income medicare beneficiary as set forth in subparagraph (c); and

(e) Be ineligible for and/or not receiving a prescription drug benefit through a medicare supplemental policy or any other third party payer prescription benefit.

II. Individuals eligible for the Medicaid Rx senior eligibility expansion program shall be entitled to the Medicaid prescription drug coverage as provided to Medicaid recipients as set forth in Title XIX of the Social Security Act.

III. Individuals eligible for the program established under this chapter shall be provided a benefit of not more than $2,000 per year and shall be subject to a $5 copayment per prescription.

161-K:3 Administration.

I. The Medicaid Rx senior eligibility expansion program shall be administered by the division. The department shall apply for a federal Medicare 1115 demonstration waiver from the Secretary of Health and Human Services to expand Medicaid eligibility for the purposes of prescription drug coverage to qualified medicare beneficiaries and specified low-income medicare beneficiaries under the Medicaid Rx senior eligibility expansion program.

II. The commissioner shall attempt to obtain and shall accept in the name of the state any and all donations, grants, or fees, both real and personal, from any governmental unit or public agency, or third-party payors, or from any institution, person, firm, or corporation given specifically for the purpose of funding this program.

III. The commissioner shall make an annual report beginning one year after the effective date of this chapter to the general court relative to the effectiveness of the Medicaid Rx senior disability eligibility program.

Amend the bill by replacing all after section 7 with the following:

7 Funding for Medicaid Rx Service Eligibility Expansion Program; New PAU. Amend HB 1-A of the 2003 legislative session by inserting after PAU 05-01-10-03-12 the following new PAU:

05 Health and Social Services
01 Dept of Health and Human Services
10 Div of Elderly & Adult Svcs
03 Grants to Locals
13 Rx Senior Eligibility Expansion Program

	FY 2004	FY 2005
090 Rx Senior Program	$3	$3
Estimated Source of Funds for Program		
00 Federal Funds	$1	$1
09 Gifts & Grants	$1	$1
General Fund	$1	$1

8 Prospective Repeal. The following are repealed:

I. RSA 161-K:1 – 161-K:3, relative to the Medicaid Rx senior eligibility expansion program.

II. Section 7 of this act.

9 Effective Date.

I. Sections 3-7 of this act shall take effect upon its passage.

II. Section 8 of this act shall take effect at 11:59 p.m. on the day before a federal prescription drug plan takes effect.

III. The remainder of this act shall take effect July 1, 2003.

2003-1091h

AMENDED ANALYSIS

This bill requires the department of health and human services to establish the Medicaid Rx senior eligibility expansion program. The bill establishes a new PAU in the 2003 operating budget for the purposes of funding such program.

This bill requires the department of health and human services to encourage health plans and health care systems participating in the medicaid program to use case management incorporating evidence-based practice guidelines.

The bill also establishes a 3-year task force to study increasing access to prescription drug medicines.

House Finance
April 2, 2003
2003-1106h
01/09

Amendment to HB 735-FN

Amend the bill by replacing section 1 with the following:

1 New Chapter; Medicaid Rx Senior Eligibility Expansion Program. Amend RSA by inserting after chapter 161-J the following new chapter:

CHAPTER 161-K

MEDICAID Rx SENIOR ELIGIBILITY EXPANSION PROGRAM

161-K:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Division" means the division of elderly and adult services, department of health and human services.

IV. "Qualified medicare beneficiaries" means medicare beneficiaries with incomes equal to or below 100 percent of the federal poverty level who are eligible for Medicaid assistance for the part A and part B medicare premiums and for medicare deductibles and co-insurance requirements as set forth in section 1905(p)(1) of Title XIX of the Social Security Act.

V. "Specified low-income medicare beneficiaries" means medicare beneficiaries who have incomes greater than 100 percent of the federal poverty level and less than and equal to 120 percent of the federal poverty level and meet the requirements set forth in section 1902(a)(10)(E)(iii) of Title 19 of the Social Security Act.

161-K:2 Medicaid Rx Senior Eligibility Expansion Program Established.

I. There is hereby established the Medicaid Rx senior eligibility expansion program. To be eligible for the program, an individual shall:

(a) Be a U.S. citizen or a lawfully admitted alien;

(b) Be a state resident;

(c) Be at least 65 years of age or an individual between the ages of 19 and 64 who is otherwise eligible for benefits under Title II of the Social Security Act (Federal Old Age, Survivors, and Disability Insurance);

(d) Meet the definition of a qualified medicare beneficiary or a specified low-income medicare beneficiary as set forth in subparagraph (c); and

(e) Be ineligible for and/or not receiving a prescription drug benefit through a medicare supplemental policy or any other third party payer prescription benefit.

II. Individuals eligible for the Medicaid Rx senior eligibility expansion program shall be entitled to the Medicaid prescription drug coverage as provided to Medicaid recipients as set forth in Title XIX of the Social Security Act.

III. Individuals eligible for the program established under this chapter shall be provided a benefit of not more than $2,000 per year and shall be subject to a $5 copayment per prescription.

161-K:3 Administration.

I. The Medicaid Rx senior eligibility expansion program shall be administered by the division. The department shall apply for a federal Medicare 1115 demonstration waiver from the Secretary of Health and Human Services to expand Medicaid eligibility for the purposes of prescription drug coverage to qualified medicare beneficiaries and specified low-income medicare beneficiaries under the Medicaid Rx senior eligibility expansion program.

II. The commissioner shall attempt to obtain and shall accept in the name of the state any and all donations, grants, or fees, both real and personal, from any governmental unit or public agency, or third-party payors, or from any institution, person, firm, or corporation given specifically for the purpose of funding this program.

III. The commissioner shall make an annual report beginning one year after the effective date of this chapter to the general court relative to the effectiveness of the Medicaid Rx senior disability eligibility program.

Amend the bill by replacing all after section 7 with the following:

7 Funding for Medicaid Rx Service Eligibility Expansion Program; New PAU. Amend HB 1-A of the 2003 legislative session by inserting after PAU 05-01-10-03-12 the following new PAU:

05 Health and Social Services
01 Dept of Health and Human Services
10 Div of Elderly & Adult Svcs
03 Grants to Locals
13 Rx Senior Eligibility Expansion Program

	FY 2004	FY 2005
090 Rx Senior Program	$3	$3
Estimated Source of Funds for Program		
00 Federal Funds	$1	$1
09 Gifts & Grants	$1	$1
General Fund	$1	$1

8 Prospective Repeal. The following are repealed:

I. RSA 161-K:1 – 161-K:3, relative to the Medicaid Rx senior eligibility expansion program.

II. Section 7 of this act.

9 Effective Date.

I. Sections 3-7 of this act shall take effect upon its passage.

II. Section 8 of this act shall take effect at 11:59 p.m. on the day before a federal prescription drug plan takes effect.

III. The remainder of this act shall take effect July 1, 2003.

2003-1106h

AMENDED ANALYSIS

This bill requires the department of health and human services to establish the Medicaid Rx senior eligibility expansion program. The bill establishes a new PAU in the 2003 operating budget for the purposes of funding such program.

This bill requires the department of health and human services to encourage health plans and health care systems participating in the medicaid program to use case management incorporating evidence-based practice guidelines.

The bill also establishes a 3-year task force to study increasing access to prescription drug medicines.

Committee Minutes

HB735
Copy

MINUTES
HOUSE COMMITTEE ON FINANCE
EXECUTIVE SESSION – April 2, 2003
Room 210-211, Legislative Office Building

Rep. Kurk, chairman, called the executive session to order at 1:30 p.m.

Members Present: Reps. Kurk, Weyler, Holbrook, Robert Johnson, Stone, Anderson, Wendelboe, Hager, Mercer, Emerton, Wheeler, Rodeschin, Rogers Johnson, Elliott, Dodge, King, Wallner, Smith, Blanchard, Coes, Mitchell, Densmore, Eaton

HB 25 FN-A, making appropriations for capital improvements.

Division II Chairman, **Rep. Weyler**, explained the capital budget and the changes his division made to HB25. In addition he responded to question regarding Instream Flow Pilot Program Study report, SRF matching funds, University System and Walker budget moving expenses. **Rep. Weyler** moved and **Rep. Dodge** seconded the motion to OTPA. Roll call vote of 21-2.

HB 135 FN-L, relative to charter schools.

Rep. Weyler explained the bill and the amendment 1066h specifically the IEP moving along in charter schools just as they would in a public school system. **Rep. Weyler** moved OTPA and **Rep. Mercer** seconded this motion. Passed, roll call vote 18-4.

HB 705, (New Title) establishing a committee to study the application of the communications services tax to the provision of Internet services and relative to the rate of the communications services tax and the property tax exemption for wooden poles and conduits.

Rep. Hager moved to OTP and **Rep. Eaton** seconded this motion. Passed roll call vote of 21-2

HB 785, requiring the commissioner of the department of education to establish a public school choice initiative.

Rep. Hager moved to retain this bill and **Rep. Eaton** seconded this motion. Passed, roll call vote 20-2.

HB 280 FN, relative to the poison information center.

Rep. Elliott moved to OTP and **Rep. Wallner** seconded this motion. Passed, roll call vote 21-2.

HB 735 FN, relative to prescription drugs and medicaid best practices.

Rep. Wendelboe moved and **Rep. Emerton** seconded this motion of OTPA. **Rep. Wendelboe** described the target as the poorest of the poor (income greater than 100% of poverty and less than 120% of federal poverty). However, the funding was stripped from the bill leaving the Senior RX program for 2004, $3 and for 2005, $3, the Federal funds for 2004, $1 and 2005, $1, Gifts and grants form 2004, $1 and 2005, $1, the general fund for 2004, $1 and 2005, $1. Passed, roll call vote of 21-2.

HB 608 FN, (New Title) reducing the education property tax rate and relative to the calculation of adequate education grants.

Rep. Kurk moved to OTPA and **Rep. Wendelboe** seconded this motion. **Rep. Kurk** described the Cost of an Adequate Education and the indexing formula also changes the transportation expenses, 100% of K-8th instead of 70% of k-12th, established the education property in 2004 of $4.92 and in 2005 of $.4.72 in 2006 of $4.52, in 2007 of $4.32, 2008 of $4.12 and 2009 of $3.92. $5.80 and $955,000 in total is raised by current tax without adjustment. **Rep. Kurk** responded to further question. Amendment 1053h – spreadsheets not yet available. The amendment 1053h, passed 13-9. OTPA, roll call vote 13-9.

HB 746 FN-A, revising the property tax relief program.

Rep. Wallner presented amendment 1070h and explained the reduction in rate and the demand to "keep our promise" to local districts. **Rep. Wendelboe** moved and **Rep. King** seconded the motion of OTPA. Passed, roll call vote of 22-0.

HB 717, relative to targeted aid to education.

Amendment 1035h deferring the effective date to July 1, 2005 to allow for consideration of a constitutional amendment. Passed, 16-7. Amendment 1092h passed 14-8. **Rep. King** moved and **Rep. Wendelboe** seconded this motion of OTPA and it passed by a roll call vote of 15-7.

Recessed at 5:20 p.m.

Respectfully submitted,

Rep. Robert Wheeler
For the Committee

OFFICE OF THE HOUSE CLERK

2003 SESSION

FINANCE

Bill #: ~~H~~ B 735 **Title:** _____

PH Date: ___/___/___ Exec Session Date: 04/02/03

Motion: OTP A Amendment #: ~~408~~ 1106

MEMBER	YEAS	NAYS
Kurk, Neal M. Chairman	20	
Wevler, Kenneth L. V Chairman	1	
Holbrook, Robert G	2	
Johnson, Robert A	3	
Stone, Joseph E	4	
Anderson, Eric	5	
Wendelboe, Fran	6	
Hager, Elizabeth S	7	
Mercer, Robert S	8	
Emerton, Larry A	9	
Wheeler, Robert L	10	
Rodeschin, Beverly T	11	
Johnson, Rogers J		1
Elliott, Larry G	12	
Dodge, Robert K		2
Hunter, Bruce F		
King, Frederick W	13	
Wallner, Mary Jane	14	
Smith, Mariorie K	15	
Blanchard, MarvAnn N	16	
Coes, Betsy A	17	
Mitchell, McKim W	18	
Densmore, Edward D	19	
Eaton, Daniel A	20	
TOTAL VOTE:	21	2

Printed: 1/6/2003

DIVISION III NOTES
4/2/03

HB 735-FN, relative to prescription drugs and Medicaid best practices. As amended by the House.

Rep. Wendelboe presented three amendments:

- 2003-1083h: The amendment calls for a 6% assessment fee on prescription drug manufacturers and explained that this legislation would help approximately 2,000 people. The eligibility level is 125% of the federal poverty level. It would cost approximately $1.6 million to fund.

- 2003-1082h: This amendment would appropriate $20,000 of General Fund in FY 04 and $5,000 in FY 05. The purpose would be to provide education to potential consumers about drug programs.

- 2003-1091h: This amendment would provide $3 of General Fund. The purpose would be to pass the bill and give an opportunity for more public input in the Senate to provide a more solid funding mechanism.

Rep. Emerton called for a vote on each amendment.

- 2003-1091h: Received a 5-2 show of hands vote
- 2003-1083h: Received no votes
- 2003-1082h: Received a 4-3 show of hands vote

After further discussion, the Committee adopted HB 735-FN, as amended by OLS #2003-1091h, on a 6-1 vote.

DIVISION III
2003 SESSION

Date: 04/02/03 Bill #: HB 735-FN

Bill Title: Relative to prescription drugs & Medicaid best practices.

Amendments

Sponsor: Rep. Wenbdelboe OLS Document #: 2003 - 1083h NO

Sponsor: Rep. Wendelboe OLS Document #: 2003 - 1082 NO

Sponsor: Rep. Wendelboe OLS Document #: 2003 - 1091 YES

Motions: OTP, OTPA, ITL, TABLE, RETAIN

Motion made by: Rep. Wendelboe Seconded by: Rep. Emerton

	YEAS	NAYS	ABSENT
EMERTON, LAWRENCE A. CHM	✓		
WENDELBOE, FRAN, V. CHM	✓		
ELLIOTT LARRY G., CLERK	✓		
RODESCHIN, BEVERLY T.	✓		
JOHNSON, ROGERS J.		✓	
KURK, NEAL M.			✓
WALLNER, MARY JANE	✓		
DENSMORE, EDWARD D.	✓		

6 - 1

Rep. Larry G. Elliott
Division III Clerk

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 735 Date 2,14,08

Committee

** Please Print All Information **

Name	Address	Phone	Representing	Pro (check one)	Con (check one)
Lori Real	Director		Dept of HHS	no	position

Hearing Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 735

BILL TITLE: relative to prescription drugs and medicaid best practices.

DATE: February 14, 2003

LOB ROOM: 205 **Time Public Hearing Called to Order:** 9:00 a.m.

Time Adjourned: 10:25 a.m.

(please circle if present)

Committee Members: Reps. Batula, Dalrymple, Chabot, Joseph, Manning, P. Katsakiores, Pilliod, Wendelboe, MacKay, S. Eaton, Barry, C. Brown, Daniels, McMahon, Price, Weldy, French, Seldin, Harris, Sokol, Shultis and Miller.

Bill Sponsors: Rep. Wendelboe

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

*Rep. Fran Wendelboe, sponsor. Introduced the bill and spoke in favor of its passage. She indicated that she would be suggesting some amendments and thought that the appointment of a subcommittee would be helpful in that regard. Submitted written testimony, in file. Rep. Weldy (Question): Do you know what the poverty level is? (Answer): I believe it is $12,000 annual income for a couple. Rep. Shultis (Question): Do you have a fiscal note? (Answer): It is $17 million. Rep. Dalrymple (Question): How does this relate to the existing PDM program? (Answer): It is likely that these people would be added to the First Health Program. Rep. Dalrymple (Question): Are savings possible? (Answer): I am not sure that savings will come from a disease management program. Rep. Dalrymple (Question): Will the task force on this bill do the same things as the PDM oversight committee? (Answer): If this bill is amended, this task force would be broadened. Some aspects of SB 96 (which, I believe, was defeated in the Senate) might be incorporated into this bill. Rep. Miller (Question): Is it your intent under 161-K:6 that people would qualify for Medicaid? (Answer): She said that she had previously answered that and repeated her answer. Rep. Miller (Question): Can you have both Medicare and Medicaid coverage? (Answer): Yes, with a waiver. Rep. Miller (Question): Is your bill specific if the waiver you have described has not been granted? (Answer): This is a short-term solution until the federal government begins coverage. Any cost savings will come from the waiver as it avoids the State share. Rep. Sokol (Question): What is 100% of federal poverty level? (Answer): It is a figure developed yearly by the federal government. Rep. Price (Question): What are the three criteria for participation? (Answer): (1) Age 65, (2) Disabled, and (3) Have no other prescription plans. Rep. Price (Question): How many individuals are in the QUIMBY and SLIMBY groups? (Answer): The fiscal note gives those numbers. Rep. Price (Question): Am I correct that there are three sections to the bill: Insurance, Task Force, and Disease Management Practice? (Answer): Yes. Rep. Shultis (Question): What is a PBM? (Answer): Pharmacy Benefit Management. Rep. Miller (Question): How do you save the money you quoted? (Answer): Please read the article I provided. The answer is in the article. Rep. Batula (Question): What will be the cost of the amendment? (Answer): Fiscal note needs to be revised; I believe it is flawed. Rep. Batula (Question):

Rep. Fran Wendelboe, sponsor (continued testimony): If the waiver fails, what are the consequences? (Answer): None. Rep. Batula (Question): There are bills asking to create study committees on prescriptions, along with existing studies. Should there be just one study committee? (Answer): The priority should be on the poorest of the poor. I will fight for this bill in Finance. Rep. Pilliod (Question): Can you compare federal poverty level and living wage? (Answer): I don't have those numbers. Rep. Pilliod (Question): You recommended evidence-based practice. Do they exist for all illnesses? (Answer): Some more obscure illnesses may not have such research. Rep. Pilliod (Question): You placed emphasis on the use of pharmacists to guide patients? (Answer): I am not suggesting that pharmacists should replace physicians. Rep. Chabot (Question): Are you aware that DHHS through SCOA has a prescription plan in place? (Answer): Senior prescription plan is a discount plan. What if you still cannot afford the medications after the discount? My plan, except for a low co-payment, pays for the medication. Rep. Miller (Question): Who are the case managers in the plan? (Answer): Case technicians do the processing of forms and other duties. The disease management part requires professional management.

*Lori Real, DHHS. Submitted written testimony, in file. With regard to the fiscal note, the budget is less than I anticipated, so any expansion of Medicaid is unlikely. The outreach costs are additional costs. Savings from disease management must be reinvested. Rep. Chabot (Question): Why are prescription costs escalating? (Answer): The costs of medicine are increasing. Rep. Price (Question): I assume you prepared the fiscal note? (Answer): The fiscal note was based on financial staff from three divisions of DHHS. The net cost for the first year would be $8 million, eventually increasing to $16 million. Rep. Weldy (Question): If a person doesn't qualify for Medicaid, is that forever? (Answer): No, you can apply again.

A subcommittee was formed: Reps. Dalrymple, Barry and Miller.

Pink Cards:

- Rep. Fran Wendelboe, sponsor. Supports the bill.
- Lori Real, DHHS. No indication of support or opposition.

Respectfully submitted,

Rep. James R. MacKay
Committee Clerk

JRM:co

HB 735-FN – AS INTRODUCED

2003 SESSION

03-0032
01/09

HOUSE BILL ***735-FN***

AN ACT relative to prescription drugs and medicaid best practices.

SPONSORS: Rep. Wendelboe, Belk 29

COMMITTEE: Health, Human Services and Elderly Affairs

2/14

$3.5 MM

1/2 pd by feds

ANALYSIS

This bill requires the department of health and human services to establish certain programs to increase access to prescription drugs for seniors. The bill grants rulemaking authority to the commissioner of health and human services for the purposes of the bill.

This bill requires the department of health and human services to encourage health plans and health care systems participating in the medicaid program to use case management incorporating evidence-based practice guidelines.

The bill also establishes a 3-year task force to study increasing access to prescription drug medicines for needy seniors.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

Wendelboe

~~Weldy~~
~~Shultis~~
~~Weldy~~
~~Dalrymple~~
~~Miller~~
~~Sokol~~
~~Fryer~~
~~Fitzgerald~~
~~Shurtleff~~
~~Miller~~
~~Batula~~
~~Fitzgerald~~
~~Dalrymple~~
~~Chabot~~

Real

~~Chabot~~
~~Fryer~~
~~Weldy~~

~~Dalrymple~~
Weldy
~~Katsakiores~~
~~French~~
~~French~~

EXEC. Session
~~Dalrymple~~
OTP en amend
2003 0492h
Vote 17-0

OTP/A
17-0

60 yr hyperplasia area
65 or older w/ no other Rx prgm.
~~Miller~~

applys only earned income 9000/combined 12,000 (neediest of the neediest)

Sub. Committee - ~~Rabuck~~ ~~Shultis~~ - ~~Dalrymple~~ Dalrymple - Shultis - Barry

03-0032
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Three

AN ACT relative to prescription drugs and medicaid best practices.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Chapter; Access to Prescription Drugs. Amend RSA by inserting after chapter 161-J the following new chapter:

CHAPTER 161-K

ACCESS TO PRESCRIPTION DRUGS

161-K:1 Definitions: In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Division" means the division of elderly and adult services, department of health and human services.

161-K:2 Medicaid Outreach and Enrollment Program Established. The department shall establish the medicaid outreach and enrollment program. Such program shall be administered by the division through the development of outreach initiatives to identify medicaid-eligible medicare beneficiaries who are not participating in the medicaid program and to promote and encourage enrollment of such eligible persons in the medicaid program. Initiatives may include, but are not limited to, mailings, advertisements, public service announcements, literature dissemination, and community outreach.

161-K:3 Report.

I. The department shall make an annual report to the general court beginning one year from the effective date of this chapter.

II. The department's report shall include but not be limited to the following:

(a) The baseline number of medicare beneficiaries who were medicaid eligible at the beginning of the previous year.

(b) The number of medicaid-eligible medicare beneficiaries who were targeted via the medicaid outreach and enrollment program.

(c) The number of medicaid-eligible medicare beneficiaries who enrolled in medicaid in a given year and any information of enrollment from the medicaid outreach and enrollment program.

(d) A description of the outreach initiatives utilized by the medicaid outreach and enrollment program.

(e) A detailed accounting of how funding was utilized.

161-K:4 Rulemaking. The commissioner shall adopt rules, pursuant to RSA 541-A, necessary for the implementation of this chapter.

Medicaid Rx Senior Eligibility
Expansion Program

161-K:5 Definitions: In this subdivision:

I. "Qualified medicare beneficiaries" means medicare beneficiaries with incomes equal to or below 100 percent of the federal poverty level who are eligible for medicaid assistance for the part A and part B medicare premiums and for medicare deductibles and co-insurance requirements as set forth in section 1905(p)(1) of Title XIX of the Social Security Act.

II. "Specified low-income medicare beneficiaries" means medicare beneficiaries who have incomes greater than 100 percent of the federal poverty level and less than and equal to 120 percent of the federal poverty level and meet the requirements set forth in section 1902(a)(10)(E)(iii) of Title 19 of the Social Security Act.

161-K:6 Medicaid Rx Senior Eligibility Expansion Program Established.

I. There is hereby established the medicaid Rx senior eligibility expansion program. To be eligible for the program, an individual shall:

(a) Be a U.S. citizen or a lawfully admitted alien;

(b) Be a state resident;

(c) Be at least 65 years of age or an individual between the ages of 19 and 64 who is otherwise eligible for benefits under Title II of the Social Security Act (Federal Old Age, Survivors, and Disability Insurance);

(d) Meet the definition of a qualified medicare beneficiary or a specified low-income medicare beneficiary as set forth in subparagraph (c); and

(e) Be ineligible for and/or not receiving a prescription drug benefit through a medicare supplemental policy or any other third party payer prescription benefit.

II. Individuals eligible for the medicaid Rx senior eligibility expansion program shall be entitled to the medicaid prescription drug coverage as provided to medicaid recipients as set forth in Title XIX of the Social Security Act.

161-K:7 Administration; Rulemaking.

I. The medicaid Rx senior eligibility expansion program shall be administered by the division. The department shall apply for a federal medicare 1115 demonstration waiver from the Secretary of Health and Human Services to expand medicaid eligibility for the purposes of prescription drug coverage to qualified medicare beneficiaries and specified low-income medicare beneficiaries under the medicaid Rx senior eligibility expansion program.

II. The commissioner shall make an annual report beginning one year after the effective date of this chapter to the general court relative to the effectiveness of the medicaid Rx senior disability eligibility program.

2 New Subdivision; Medicaid Best Practices. Amend RSA 167 by inserting after section 97 the following new subdivision:

Medicaid Best Practices

167:98 Medicaid Best Practices.

I. The department of health and human services shall identify medicaid patients who require ongoing and expensive care and develop interventions to improve their health, functional status and independence in an effort to promote adherence to best medical practices. The department shall encourage health plans and health care systems participating in the medicaid program to:

(a) Conduct patient needs assessments upon enrollment.

(b) Develop individual, patient-centered plans.

(c) Use case management incorporating evidence-based practice guidelines.

II. The department shall make an annual report beginning one year after the effective date of this section to the oversight committee established in RSA 126-A:13, relative to the effectiveness of this subdivision.

III. The commissioner of health and human services shall adopt rules, pursuant to RSA 541-A, necessary to implement this program.

3 Task Force Established. There is established a task force to study the feasibility of establishing a New Hampshire Rx ~~senior patien~~t assistance program.

4 Membership and Compensation.

I. The members of the task force shall be as follows:

(a) Three members of the house of representatives, appointed by the speaker of the house.

(b) Three members of the senate, appointed by the president of the senate.

(c) The commissioner of the department of health and human services, or designee.

(d) Two pharmacists licensed in this state, appointed by the governor.

(e) A member of the public, appointed by the governor.

II. The members of the task force shall serve without compensation, however, legislative members of the task force shall receive mileage at the legislative rate when attending to the duties of the task force.

5 Duties. The task force shall study the feasibility of establishing a New Hampshire Rx senior patient assistance program. The committee shall consider eligibility guidelines and enrollment fees.

6 Chairperson; Quorum. The members of the task force shall elect a chairperson from among the members. The first meeting of the task force shall be called by the first-named house member. The first meeting of the task force shall be held within 45 days of the effective date of this section. Six members of the task force shall constitute a quorum.

7 Report. The task force shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the senate president, the house clerk, the senate clerk, the governor, and the state library on or before November 1, 2006.

8 Prospective Repeal. RSA 161-K:1 through RSA 161-K:7, relative to prescription drug access, is repealed.

9 Effective Date.

I. Sections 3-7 of this act shall take effect upon its passage.

II. Section 8 shall take effect at 11:59 p.m. on the day before a federal prescription drug plan takes effect.

III. The remainder of this act shall take effect 60 days after its passage.

LBAO
03-0032
1/27/03

HB 735-FN - FISCAL NOTE

AN ACT relative to prescription drugs and medicaid best practices.

FISCAL IMPACT:

Due to time constraints, the Office of Legislative Budget Assistant is unable to provide a fiscal note for this bill at this time. When completed, the fiscal note will be forwarded to the House Clerk's Office. $17 MM

~~Savings?~~ Waived

~~Combine 3 Rx bills into one?~~

Lori Real

Savings would not cover the cost of the program.
Current budget is less than allocation.
New people who would qualify w/this program
fiscal note = ~~State funds 8 MM~~ — $16 MM 4th year
(cost and Savings)

+ drug cost per month

Testimony

735

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF HEALTH PLANNING & MEDICAID

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-5254 1-800-852-3345 Ext. 5254
Fax: 603-271-8431 TDD Access: 1-800-735-2964

Nicholas J. Vailas
Commissioner

Lori H. Real
Director

Testimony on HB 735 Relative to Prescription Drugs and Medicaid Best Practices
House Health, Human Services & Elderly Committee
by
Lori H. Real, M.H.A.
Director, Office of Health Planning and Medicaid
February 14, 2003

For the record, my name is Lori Real and I serve as Director of the Office of Health Planning and Medicaid at the New Hampshire Department of Health and Human Services.

My purpose today is to provide information on the Medicaid Best Practices section of House Bill 735. This section of the bill calls on the Department to implement "chronic disease management" for the Medicaid program in order to generate cost savings to finance a prescription drug benefit expansion.

The Department believes disease management is an important concept that has potential to improve quality of care and *perhaps* also to produce health care cost savings. However, this field is still quite young, especially when applied to state Medicaid populations. The Department has two critical concerns with HB 735's premise that savings from chronic disease management will finance a pharmacy program expansion:

1. The research has not shown that disease management programs reliably produce significant savings.

2. A disease management program would require the State to invest unbudgeted start-up dollars.

POINT 1: The research has not shown that disease management programs can be counted on to produce significant cost savings.

a. Disease Management: Findings from Leading State Programs

The results of leading state initiatives in Medicaid disease management was recently summarized in an "issue brief" produced in December 2002 for *State Coverage Initiatives*, a national grant program funded by the Robert Wood Johnson Foundation. Under the heading "DM Program Outcomes," the issue brief states:

> States began implementing Medicaid disease management programs fairly recently and, to date, there has been limited quantitative research conducted to assess their impact. Only a handful of states have completed formal program evaluations, while several others have provided qualitative information on their experience. These early reports

indicate that disease management has contributed to quality improvements in Medicaid, but it has not produced overwhelming savings (at least not in the short term). Nevertheless, one indication of program success is that virtually all of the early DM states have elected to continue and even expand their DM programs.

Disease Management: Findings from Leading State Programs (AcademyHealth December 2002)

b. Other Relevant Literature

1. In May 2001, Dr. Dawn Galbreath, Director of the University of Texas Disease Management Center, completed the first systematic review of the medical literature including all clinical trials on disease management programs from 1996-2001. The articles covered a variety of conditions – asthma, diabetes, congestive heart failure, and coronary artery disease. Dr. Galbreath concluded:

- First, the clinical effectiveness of disease management has not been definitively proven at present. The number of studies has been relatively small, and many have suffered from methodological flaws.

- Second, there were very few studies that have demonstrated economic benefits resulting from disease management.

Disease Management Trials 1996-2001, compiled by Autumn Dawn Galbreath, M.D. and presented at "Health Care Costs: Why are They Increasing? What Can We Do?" (May 22, 2001)

2. Ten months earlier, the Veterans Administration conducted a literature review of case management for serious mental health disorders such as chronic mental illness, depression, and alcoholism and drug abuse. Medicaid recipients also suffer disproportionately from these mental health conditions. The authors found "few examples of successful programs." The authors also found that improved health outcomes mostly came "at unknown cost," and they cautioned that case management could actually prove "more expensive for uncertain benefit." *Impacts of Case Management Programs*, VA Technology Assessment Program (July 2000).

Consequently, the literature taken as a whole does not offer any clear endorsement of disease management, nor does it tell us "how to do it right," especially for the Medicaid population. Most important, the jury is still out on whether disease management can generate significant cost savings.

c. Florida's Experience

The experience of Florida shows that disease management requires states to "spend money in order to save money." The front-end investment may be substantial and any resulting savings may not be realized for some period of time. According to industry experts, it may take 20 months after a disease management program is started before a believable first-year financial assessment can occur. *How Time and Circumstance Changed Disease Management*, Managed Care (December 2001). Moreover, Medicaid officials have found that accurately projecting budget savings from disease management can be very difficult, as illustrated by Florida's experience.

Florida has the most developed and documented disease management initiative for the Medicaid population. However, its experience illustrates potential problems with anticipated cost savings.

In 1997, the Florida legislature directed its Medicaid agency to implement a disease management initiative for Medicaid clients. Beginning in 1998, the state implemented contracts with private disease management vendors in asthma, diabetes, congestive heart failure, and other chronic illnesses. Projected state savings were $4 million in 1998, $40 million in 1999, and $20 million in 2000. Based on the anticipated savings, the legislature immediately reduced the state Medicaid agency's budget by the projected amounts.

Three years after those budget cuts, state officials have still not determined if the new disease management strategy works. In a 2001 audit, the legislature's watchdog agency found that the program had not saved the state money because it was difficult to implement and had reached only a small percentage of Medicaid recipients. Meanwhile, the state had advanced over $24 million to six different disease management vendors. The failure to achieve savings contributed to the Medicaid budget deficit of $1.5 billion projected for fiscal year 2001-2002.
Medicaid Disease Management Initiative, Office of Program Policy Analysis and Governmental Accountability (OPPAGA), Report No. 01-27 (May 2001).

d. Unstable Medicaid enrollment can impede program cost effectiveness.

Research studies show improved patient outcomes only when patients actively participate in disease management over a sustained period of time. Even in private sector health plans, fluctuating membership make it a "formidable challenge" to measure cost savings. *Methods to Measure Disease Management Cost Savings*, Accordant Health Services (June 2000). The savings that are generated as a result of disease management may never be realized or will be transferred to another health plan.

Medicaid's enrollment and eligibility is considerably more transient than experienced by commercial health plans. Medicaid recipients may be eligible for Medicaid this month, lose eligibility the next month, and regain it the following month. In New Hampshire, the average enrollment of individuals in Medicaid is *only eight months*. Thus, it is likely that disease management programs would have limited effectiveness if participation remained voluntary for Medicaid enrollees. New Hampshire could institute guaranteed enrollment for 12 months, but the State has not previously adopted this requirement because of the increased costs involved. Even a one-year lock-in is a relatively short time period to expect significant behavior change and cost savings.

e. Medicaid client outreach and education is difficult to do well and costly.

Outreach to the Medicaid population has long been a challenge for state agencies and safety net providers, and the same problem hampers effective disease management. Unlike members of commercial health plans, Medicaid recipients often do not have telephones, and they may not stay long at the same mailing address. Even when individuals can be reached, the "take up rate" or "compliance" with the disease management program may be disappointing. In Florida, the disease management organizations that contracted with Florida lacked experience serving the Medicaid population. As a result, implementation was far more costly and time-consuming than expected, and enrollment fell way short of projections. Florida's Medicaid Disease Management Initiative (May 2001).

POINT 2: A disease management program would require the State to invest unbudgeted start-up dollars.

Based on a preliminary analysis, the Department identified four conditions as potential candidates for disease management: Asthma, Congestive Heart Failure, Diabetes, and Hypertension.

- The Department estimates the cost of contracting with a vendor to conduct disease management would be approximately $2 million in Year 1 increasing to $2.5 million in Year 4.

- It is not possible to assess cost savings until 20 months after implementation, according to the industry standard. The State would need to invest $2 million in each of the first two years of this initiative before we could assess whether disease management is producing savings.

- In no year are the projected disease management savings substantial enough to cover the pharmacy expansion program. The net negative cost to the state in general fund dollars begins at $8M in year one and increases to $15M in year 4.

Conclusion: Savings from Medicaid Disease Management will not cover the Pharmacy Program Expansion Costs.

The most important message for you today is simply that savings from Medicaid disease management would not be sufficient to support the pharmacy program expansion that is contemplated in HB 735.

Thank you for offering me this opportunity to testify. At this point, I would be happy to answer any questions from the Committee.

Sub. Comm. Dalrymple - ~~Hastert~~ - Barrey - Miller

VALLEY NEWS

Published 2/7/03



Ji Chen, pharmacy manager at Gifford Medical Center, supervises a pharmacy clinic that saved $171,000 in unnecessary health-care costs last year.
(Valley News -- Jim Korpi)

Out From Behind the Counter

By Steve Gordon

Valley News Staff Writer

Every Thursday, one of the pharmacists at Gifford Medical Center in Randolph spends the day meeting with patients at the hospital's outpatient internal medicine clinic. She talks with, on average, five people for an hour or more each about their medical histories, current condition and the drugs they are taking. She reviews the patients' charts, looking over test results and prescriptions.

This once-a-week "pharmaceutical care clinic" began last March, and in the next nine months resulted in nearly 200 "interventions," in which the pharmacist made adjustments or corrections in prescribed drug therapies, sometimes saving patients unnecessary medication, sometimes saving them from potentially serious prescription errors. According to a report just completed by Ji Chen, Gifford's pharmacy manager, the interventions saved $171,000 in unnecessary health care spending.

The Gifford clinic, funded by a state grant, is a symbol of how the job of pharmacist has evolved into something far different from the druggist of a few decades ago. The evolution is still taking place, but one thing is clear:

Hospital pharmacists have largely moved out from behind closed doors, away from the stereotype of simply dispensing drugs on order, to become major players in an increasingly team-oriented approach to medical care, a transition one local pharmacist referred to as "from basement to bedside."

Chen herself is another symbol of that evolution. She graduated from Massachusetts College of Pharmacy in 1993 with what was then the standard degree in the field: a five-year bachelor of science. It was around that time, though, that the nation's pharmacy schools began raising that standard to a six-year doctorate, known as a PharmD. Chen worked for several years at hospitals in Massachusetts, then in 1997 began a four-year, part-time program to add the advanced degree to her credentials. She moved to the Upper Valley in 1997 when she took a job in Dartmouth-Hitchcock Medical Center's pharmacy department. In 1999, she was hired as Gifford's pharmacy manager, and in 2001 she got her doctorate.

Her department does the same tasks that hospital pharmacies have been doing for decades -- transcribing physicians' prescriptions, dispensing drugs and reviewing drug regimens for appropriateness. But it also has become a more active part of the patient-care teams in the hospital, in its on-site nursing home and in the several on- and off-site clinics associated with the medical center.

"It's a collaboration," Chen said of health care today, one that is particularly important at a time when the number of drug therapies continues to grow at a rate with which physicians, who she said often get only a couple of semesters on pharmacology in medical school, can find it difficult to stay current.

The most frequently noted fact about the world of pharmacy today is the shortage of pharmacists. A group called the Pharmacy Manpower Project Inc. issued a report in 2001 that stated: "Employers of pharmacists in all practice settings report higher than usual pharmacist vacancy rates, escalating salaries and difficulty coping with service demands from increased medication use."

But the matter of the shortage cannot be separated from the transition to more "clinical pharmacy" work; they are two sides of the same coin. If dispensing drugs were still the primary focus of hospital pharmacy, there might not be a shortage, because automation is taking over much of that task. What's new, in part, is that the number and complexity of drug therapies today call for a higher level of monitoring how and when they are administered and the potential for drug-drug and drug-food interactions.

And with the cost of today's drugs so high -- they are among the fastest-growing expenses in today's health-care market -- the pharmacist's role in eliminating unnecessary medications, substituting less expensive ones when possible and making sure drugs are administered correctly can, as Gifford found out last year, save a lot of money.

The Pharmacy Manpower Project predicts that the need for pharmacists doing "order fulfillment" actually will drop -- from 136,400 in 2001 to 100,000 by

2020. More than offsetting that, though, will be the increased need for pharmacists involved more directly in patient care in community settings and in hospitals, nursing homes, etc. That need is expected to grow from 48,000 to nearly 300,000.

Many will be doing the type of work that Ji Chen and her staff do at Gifford. She said 30 to 40 percent of her department's time is spent on clinical pharmacy, referring to such jobs as making adjustments in drug-therapy regimens, substituting more effective and/or lower-cost drugs for the ones prescribed, evaluating the effectiveness of drugs in the hospital's formulary (the list of drugs available), carrying out chart reviews of patients in the hospital and the nursing home, and reviewing patient admission information in order to recommend treatments. Frequently, they answer requests from doctors or nurses for pharmacy consultations.

And they catch errors. The issue of physician error came to the fore in 1999 with the release of the national Institute of Medicine's report called *To Err Is Human*, which detailed a frighteningly high number of people who die or are made ill by iatrogenic errors, or those made by health-care practitioners. "Approximately 20 percent of medical injuries or deaths among hospitalized patients may be the result of an adverse drug reaction," according to a November 2002 article in the *American Journal of Health-Systems Pharmacists*. "In addition, the mean length of stay, cost and mortality are nearly double for patients suffering an adverse drug reaction."

Chen said while it's all but impossible for physicians to stay current with the fast-changing number and types of drug therapies, it's the pharmacist's job and training to do just that. When pharmacists look over prescriptions written by Gifford doctors, they look for, among other things, instances when the wrong drug was chosen, or the right drug in the wrong dose, or with the wrong directions for administering it. Every three months, Chen sends reports on the more serious errors to the doctors. They appreciate the feedback, she said.

"It's their license, too. They're pretty smart. They know."

For much of the 1990s, while a pharmacist at DHMC, Brian Fontaine watched and participated in the transition to clinical pharmacy. He remembers a day, about two years into his 10-year stint there, when he was taking part in patient rounds and noticed that he was getting curious looks from a social worker accompanying the group. (Rounds are when doctors and sometimes others meet with patients and then with each other to discuss care planning.) Later, the social worker caught up with Fontaine to say she'd been wondering why they needed a pharmacist on rounds. "By the end of the first 20 minutes," she told him, "it was crystal clear to me why we needed a clinical pharmacist."

That kind of reaction makes the job rewarding, said Fontaine, who eventually moved to Valley Regional Hospital in Claremont, and now works at Alice Peck Day Memorial Hospital in Lebanon. As clinical pharmacy took hold at the medical center, doctors, nurses and others began not just listening to

pharmacists' offerings, but seeking out their advice, he said. "They come to rely upon you to make sure they have the most optimal drug therapy for that patient."

"It's not a reactive job," Fontaine said, contrasting his job with the traditional behind-the-scenes work. "It is a participation in the thinking process that leads up to the care plan."

Pharmacist Ann Birner started at DHMC 10 years ago (she, too, had worked at Valley Regional), and now is the medical center's clinical specialist in hematology/oncology. She got her initial pharmacy degree in 1978, worked for years in retail and hospital settings, and then decided in 1999 to add the PharmD because she thought the additional education would help in her oncology work. "I was working with physicians and nurses who were so knowledgeable ... and I just wanted to expand my knowledge base."

She said her career has reflected the shift in the nature of hospital pharmacy work. Unlike during her tenure in Claremont, she has frequently accompanied Hitchcock doctors on their rounds with patients, giving her the opportunity to be part of discussions about which drug will be best, and sometimes to suggest alternatives and explain why. Even when the suggestion is not accepted, she said, the discussion is helpful. "The thing I like about the (doctors) I work with is, they don't just say no."

Birner noted that she reviewed patient charts and medication regimens early in her career, too, but from the remoteness of the pharmacy office. "What you don't get," she said, "is that more direct knowledge of a patient that you get when you're out on the floor."

She is one of several pharmacists at DHMC who are stationed outside the central pharmacy. They are on the hematology-oncology, general medicine, intensive care and cardiac-care units, according to Bob Theriault Jr., pharmacy director. "And the units that don't have a pharmacist say, 'When am I getting (one)?' " he said. Hitchcock has 10 pharmacists in the central pharmacy, plus four "resource" pharmacists and three specialists on patient units. Theriault hopes to add a specialist in infectious disease soon.

The medical center's pharmacy used to have the equivalent of a full-time employee calling physicians to clarify orders for such problems as vagueness in the order or illegible handwriting. Having pharmacists on the floors, working with physicians at the time the prescription is written, has helped to eliminate the need for that task, Theriault said. Also simplifying the filling of orders is the medical center's "robot," which reads orders and, using bar codes, dispenses packaged drugs that go into carts sent to units throughout the hospital. (The robot has a zero error rate in its 18 months at DHMC, according to an ongoing checking procedure, Theriault said.)

The potential benefit to patients from the shift to clinical pharmacy was detailed in November's *American Journal of Health-Systems Pharmacists*. It reported results of a study on including a pharmacist in some of the daily

rounds in a 600-bed academic medical center. "When a pharmacist participated ... medication errors were reduced by 51 percent. The number of patients without a medication error during their hospitalization increased." In addition, the length of time that an error persisted before being caught was less than a day in the intervention group, more than two days in the control group. The study found that medication errors were found in nearly 80 percent of patients in the control group.

"These data lend more evidence to the compelling body of literature supporting the active participation of pharmacists in medical rounds as a means of reducing the frequency and duration of medication errors," the article stated.

Pharmacists' more direct involvement with patients can have other effects, too, however. More than at any time earlier in her career, Birner now comes face-to-face with patients who are among the sickest people in the hospital. Some of them die there, or shortly after leaving. "I think my whole outlook on life has changed since I started working with cancer patients," she said.

Fontaine, who does not have a PharmD, and Birner, who does, agree on this about the advanced degree: It's not necessary to have one to be a good clinical pharmacist because the key to the job is the knowledge that comes from working closely with patients and other practitioners. "People who say that you can't practice in the clinical pharmacy realm ... unless you have a PharmD, I would have to vehemently disagree with," he said. (Chen has a somewhat different view. She said on-the-job experience can make up 60 or 70 percent of a good clinical pharmacist's training, but the rest is from academic experience, which can help the confidence level of pharmacists and the people they work with.)

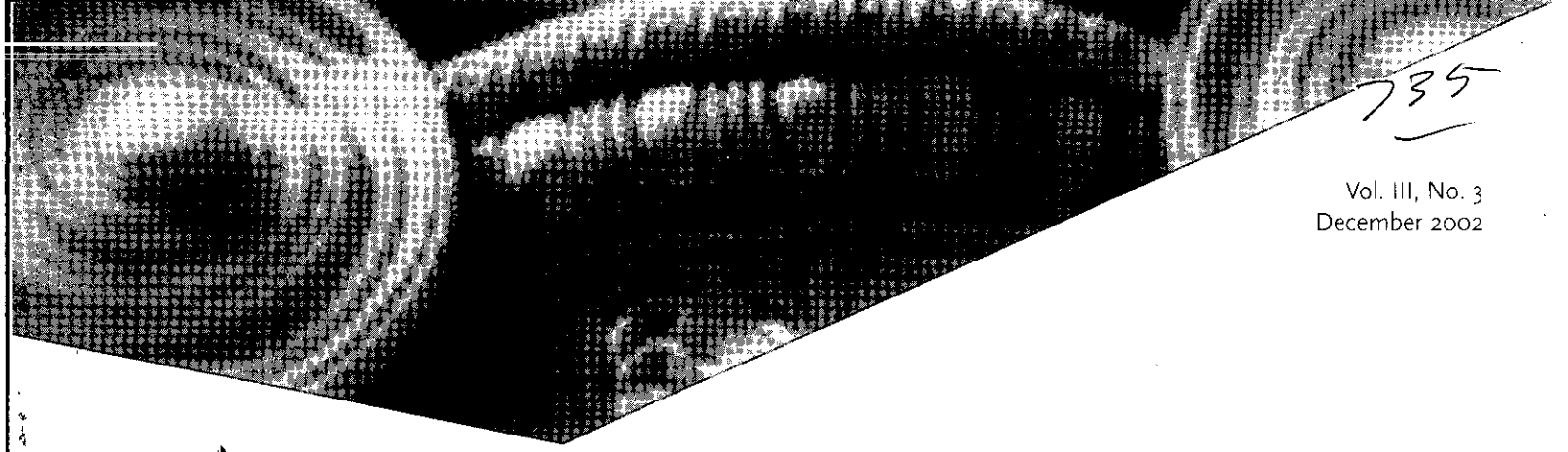
Another key is acceptance by the other practitioners: If doctors, nurses, therapists and others aren't willing to make room for an additional member of the team, the pharmacist's impact will be minimized. Chen and Birner said their co-workers at Gifford and DHMC have been accepting and helpful. Fontaine said one of the reasons he was hired by APD several months ago was to help that hospital move more toward a clinical-pharmacy model. He said he's noticing changes already: Some doctors and nurses have started soliciting pharmacists' input in ways they wouldn't have in the past. "When they start seeking you out, you know, in terms of value and acceptance, you're finally getting there."

Chen said the future holds even more change. She expects that by early next year, Gifford will move completely to "physician order entry," a system in which prescriptions are entered by the doctor into a computer, freeing the pharmacist from the task of entering, and often just trying to read, handwritten orders. Congress is considering legislation to give pharmacists provider status, meaning they or their employers could be reimbursed directly for services they provide. If that happens, she said, she'll plan to have a full-time pharmacist working in the outpatient clinics at Gifford, doing every day what the pharmacist in the once-a-week clinic is doing now.

"I think that's the future, to be in a clinic, to be on the floor -- not in the basement. It's exciting."

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Vol. III, No. 3
December 2002

STATE COVERAGE INITIATIVES

issue brief

Disease Management: Findings from Leading State Programs

by Ben Wheatley

Disease management programs are designed to contain costs by improving health among the chronically ill. More than 20 states are now engaged in developing and implementing Medicaid disease management programs for their primary care case management and fee-for-service populations.

Amid rising health care expenditures and declining tax revenues, state efforts to expand access to health insurance coverage have been put on hold in many parts of the country. Recently, states have had to take a number of difficult steps to reduce program expenditures, including restricting eligibility, reducing benefits, and cutting provider payments. These measures generate cost savings but also restrict access to care. Another option, which is now being more widely adopted by states, is to develop disease management (DM) programs that are designed to contain costs by improving health among the chronically ill.

More than 20 states are now engaged in developing and implementing Medicaid DM programs for their primary care case management (PCCM) and fee-for-service populations.[1] While most of these programs are in an early stage of development, a small number of states began implementing these programs in the 1990s and have already gained several years of experience.

This issue brief, which follows an earlier SCI report on state DM programs,[2] describes the experience of eight states—Florida, Maryland, Mississippi, North Carolina, Texas, Utah, Virginia, and West Virginia—that were early adopters of Medicaid DM and highlights some of the key challenges they have encountered.

Medicaid Disease Management Models

The DM programs developed by states in recent years vary in several respects. In addition to the specific diseases that states have elected to target, these programs have differed in terms of how they are administered and which medical services and medical professionals they include.

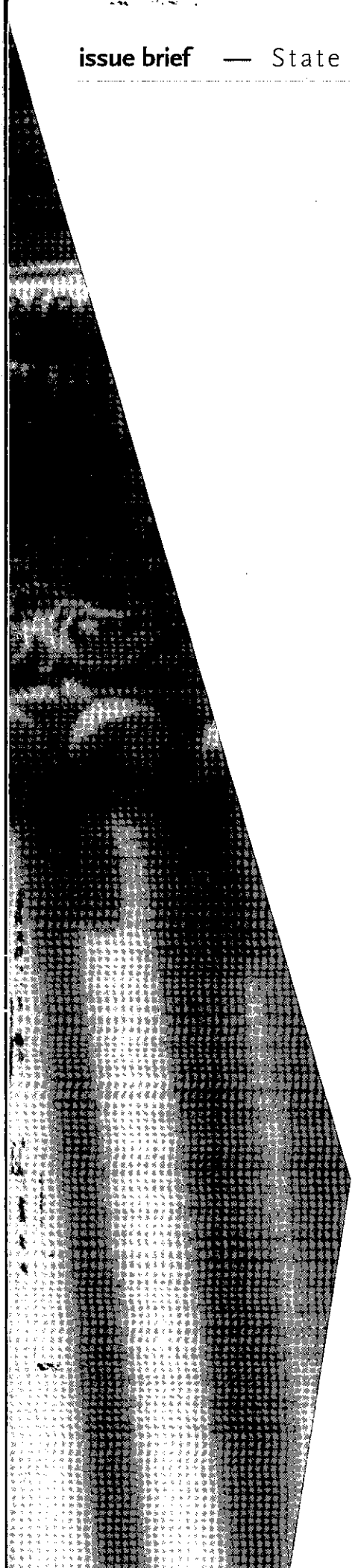
Program Administration

A number of states have elected to work with disease management organizations (DMOs) in administering DM programs for Medicaid enrollees. Washington recently completed contracts with two DM vendors to provide services to members with asthma, diabetes, congestive heart failure, and renal disease. Florida is currently contracting with six DM vendors to manage care services for Medicaid enrollees with nine different medical conditions.[3]

Several states have also designed DM programs that have been administered in-house. For example, in the 1990s, Maryland created the Diabetes Care Program as an adjunct to their existing PCCM program. Physicians and nurses who completed a five-hour continuing education course could qualify to receive a $20 monthly care management fee per member served.[4] Virginia and West Virginia created pilot programs for asthma and diabetes (respectively) and received financial support from the National

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Pharmaceutical Council to assist with program costs, including physician training in state-of-the-art treatment protocols and patient communication strategies.[5]

Medical Services

The DM programs in Florida, North Carolina, Texas, and West Virginia have focused broadly on patient care management, which includes all medical services and relevant lifestyle counseling for patients with specific diseases. Others, such as the current programs in Virginia and Mississippi, focus primarily on managing pharmaceutical services.[6] In Mississippi, pharmacists are reimbursed by Medicaid for performing patient assessments, drug therapy reviews, and patient education. The goal is to establish care coordination, reduce duplicate and contraindicated drug prescriptions, and increase adherence to clinical guidelines.[7] Pharmaceutical DM programs are less labor intensive (and less costly) than comprehensive DM programs, but may also offer less potential for care improvements and savings unless they take a broader perspective.

Medical Professionals

DM programs provide a care management function that is performed by various professionals in different states. Virginia and Mississippi have pharmacists serving in that role. West Virginia qualifies physicians, nurse midwives, certified registered nurse anesthetists, and family and pediatric nurse practitioners to become managing providers.[8] Private DM vendors typically hire RNs to serve as care managers and may add others to the care team, such as dieticians to ensure that diabetics and heart patients are following appropriate dietary restrictions.

In addition, DM care teams must work in conjunction with patients' existing physicians. DMOs collaborate with physicians to develop and implement patient care plans, and they often provide feedback reports on patients' health status or health care utilization patterns (e.g., number of emergency room visits by asthma patients). Vendors often produce "exception reports" to direct the attention of physicians to patients with flagging clinical indicators (e.g., rising hemoglobin A1c [HbA1c] levels). In addition, DM programs seek to inform physicians about state-of-the-art treatment protocols through continuing education classes or dissemination of current guidelines.

DM Program Outcomes

States began implementing Medicaid DM programs fairly recently and, to date, there has been limited quantitative research conducted to assess their impact. Only a handful of early adaptors have completed formal program evaluations, while several others have provided qualitative information on their experience. These early reports indicate that disease management has contributed to quality improvements in Medicaid, but it has not produced overwhelming savings (at least not in the short term). Nevertheless, one indication of program success is that virtually all of the early DM states have elected to continue and even expand their DM programs.

Performance Indicators

The types of measures that states can use to assess the effectiveness of their DM programs include:

- Overall cost savings (usually based on the amount spent per member per month as compared to some baseline);
- Component cost savings (e.g., reductions in emergency room visits or hospital admissions, as compared to the baseline);
- Return on investment (which accounts for DM program costs as well as medical savings);
- Secondary prevention activities (e.g., weight monitoring, exercise, or reductions in salt intake);
- Clinical measures (e.g., changes in weight or HbA1c levels);
- Adherence to clinical guidelines (e.g., percentage of heart failure patients receiving ACE inhibitors); and
- Education of providers and patients (e.g., treatment protocol education classes, health fairs, counseling for smoking cessation).

The emphasis on particular measures varies by state. For example, Florida's evaluations focused primarily on cost savings, while North Carolina's focused heavily on health and clinical indicators.

Evaluation Challenges

Measuring the fiscal impact of Medicaid disease management is extremely difficult.[9] To calculate program savings, states must compare actual expenditures for DM enrollees against the amount that would have been spent if the program had not been in operation. To estimate this baseline

figure, states can calculate last year's spending (e.g., for enrollees with asthma) and then make an inflation adjustment to predict spending in the current year. Alternatively, states can compare expenditures for DM program participants in the present year against expenditures for non-participants who have the same condition. Florida used both of these baselines to evaluate its DM programs.

These baselines can be misleading, however. Medicaid case mix changes frequently as enrollees cycle on and off the program. Spending levels in any given year (or for any given comparison group) may be more reflective of which patients are enrolled in the program during that time than of the care management provided by the DMO. In addition, savings to the program that result from public policy changes (e.g., Florida Medicaid's implementation of a supplemental drug rebate and prior authorization for hospital services) may be inappropriately credited to the DMO. On the other hand, efforts that DMOs make to educate providers on state-of-the-art treatment guidelines or to help patients make healthy lifestyle changes may produce longer term budget savings that are not captured during the 12-month evaluation period.

In assessing the impact of its case management program for hemophilia, Utah found that a number of confounding variables influenced the results. While the case management program was working to reduce utilization of (and expenditures for) blood factor, developments in the private market were pushing in the opposite direction. Treatment patterns were changing as more doctors began using blood factor prophylactically; the costs of blood factor were increasing overall; and a product shortage resulted in greater utilization of a particularly expensive blood product.[10] This example shows that there are any number of variables that make measuring the impact of DM difficult.

Preliminary Outcomes

States that have conducted DM program evaluations to date include Florida, Maryland, North Carolina, and Virginia. Other states, including Mississippi and West Virginia, are working on their evaluations and should have them completed in the next several months.

The Florida Experience

Florida, which operates one of the oldest—and by far the largest—Medicaid disease management program in the country, has now completed evaluations for four diseases: asthma, diabetes, hemophilia, and HIV/AIDS.[11] In general, Florida officials believe that the programs have been successful in generating improvements in care quality and expenditure reductions (e.g., unnecessary emergency room visits), but that DM program costs have generally offset these savings.

An evaluation of Florida's small initial asthma program indicated that DM led to a net savings in Medicaid costs. Although prescription drug costs increased by an average of $125 per person per year, inpatient and outpatients costs decreased by $200 per person per year. However, these savings estimates do not factor in the costs of conducting the DM program (which included six health fairs that instructed asthma patients on how to manage their condition).[12]

Florida's DM programs for diabetes, hemophilia, and HIV/AIDS (which remain in operation) provide more direct support to enrollees, assigning care nurses to patients and coordinating their care. State officials believe that these programs have been successful in reducing preventable health problems and service costs, but independent evaluations have shown mixed results in terms of overall cost savings (see Table 1).

Both the hemophilia and HIV/AIDS programs showed overall savings of approximately 40 percent against the previous year's baseline. However, spending reductions for DM participants relative to non-participants were not statistically significant for either program.[13] These results illustrate the importance of baseline selection in assessing program outcomes.

The evaluations showed conclusive savings in some categories of spending. The hemophilia program produced substantial savings for medical services against both baselines, and the HIV/AIDS program demonstrated significant inpatient savings. However, while medical and pharmacy costs in the HIV/AIDS program both showed savings against the prior year baseline, they showed losses when compared to non-participants in the program.

In May 2001, a Florida legislative audit was released criticizing the DM program for having gotten off to a sluggish start.[14] The legislature had projected to save $113 million over four years (1998 to 2001) but the program was not close to producing that level of savings at the time the audit was conducted.[15]

Table 1: Savings Estimates from Three Florida DM Programs[16]

	Diabetes		Hemophilia		HIV/AIDS	
	Baseline[a]	*Non-participants*[b]	*Baseline*	*Non-participants*	*Baseline*	*Non-participants*
Overall	NS	NS	-38%*	NS	-40%***	NS
Medical	NS	NS	-151%***	-102%***	-21%***	+8%*
Inpatient	-17%**	NS	+26%***	NS	-94%***	-28%***
Outpatient	+11%**	+13%***	-100%***	NS	+11%***	+11%*
Pharmacy	+31%**	+21%***	-41%*	NS	-12%***	+13%***

[a] Spending per DM enrollee as compared to prior year's baseline (adjusted for inflation).
[b] Spending per DM enrollee as compared to (eligible) non-participants in the DM program (same year).
NS = Not statistically significant.
*** P ≤ .0001
** P < .001
* P < .05

The audit also charged that, by establishing separate DM programs for so many different diseases, the state had created a siloed system that was inefficiently serving patients with comorbidities.

In June 2001, Florida reached an agreement with Pfizer Health Solutions to operate a new DM program for Medicaid patients with asthma, diabetes, hypertension, and congestive heart failure. In exchange for allowing all Pfizer drugs to be placed on the Medicaid preferred drug list without supplemental price rebates, Pfizer agreed to provide DM services and to guarantee at least $33 million in Medicaid savings over two years. The state later reached a similar agreement with Bristol-Myers Squibb, with guaranteed savings of $16 million.[17] For Florida, these DM savings have to be measured against the budget savings not generated through the Medicaid drug list. However, by serving patients with multiple conditions, these new programs addressed some of the concerns relating to program silos.

In-House Models

States that designed in-house DM programs (including Maryland, North Carolina, Virginia, and West Virginia) were able to record some successes in improving care quality and reducing expenditures (see Table 2). Virginia's pilot program, the Virginia Health Outcomes Partnership (VHOP), reported significant gains in an article published in *Inquiry* in 2000. However, this pilot program was expensive to administer and the state later moved to an outsourced DM model focusing on pharmaceutical care management that was much less costly to operate.

Table 2: Findings from Early Medicaid Disease Management Programs[18]

State	Disease(s)[19]	Dates	Findings
Florida	Asthma, HIV/AIDS, CHF, Hemophilia, ESRD, Diabetes, Hypertension, Pre-Diabetes, Depression	1998–present	• Programs generally reduced inpatient hospital costs but often increased other costs, especially pharmacy spending. • Net reductions in spending were generally offset by DM program costs. • Results vary considerably depending on which baseline measure is used. • Programs produced improvements in care quality.
Maryland	Diabetes	1991–1997	• Average annual spending decreased by $1,738 for AFDC (Aid to Families with Dependent Children) recipients but increased by $1,147 for those eligible for Supplemental Security Income. • Emergency room (ER) visits declined; physician visits increased (for both). • Program privatized to Medicaid managed care organizations in 1997.
Mississippi	Asthma, Diabetes, Hyperlipidemia, Coagulation Disorders	1998–present	• Preliminary findings (very small asthma sample) indicate a 96 percent reduction in hospital costs and a 58 percent reduction in ER costs. • Pharmaceutical and medical costs were not measured. • Diabetic HbA1c levels decreased significantly. • Immediate savings were harder to obtain for other two diseases.
North Carolina	Asthma, Diabetes	1998–present	• 67 percent of pediatric asthma patients received asthma control medication in Access II/III programs, versus 53 percent in HMOs. • HbA1c testing increased (83 percent vs. 66 percent in baseline); the percentage with poor glycemic control improved (33 percent vs. 54 percent).
Texas	Diabetes	1999–2001	• Cost-effectiveness was not determined due to low participation. • Surveys showed measurable improvements in enrollee self-management skills and lifestyle.
Utah	Hemophilia	1998–present	• Blood factor utilization decreased by 134,000 units (first year). • Expenditures increased by $140,000 during that time. • With case management, ER visits now "minimal."
Virginia (1)	Asthma	1995–1997	• There was a 41 percent reduction in ER visits for patients with DM-trained physicians (vs. an 18 percent reduction for other physicians). • Dispensing of recommended drugs increased by as much as 25 percent. • There was an estimated $3 in savings per $1 spent (net $659 in savings per physician trained vs. $235 in training costs).
Virginia (2)	Diabetes, CHF/Hypertension, Asthma/COPD Depression, GERD	1997–2002	• Vendor estimated $700,000 in hospital savings and a sizable reduction in "hits" (indicating problems in patient care). • Overall savings were limited, according to the state. • State will expand the program by adding new diseases. • Request-for-proposal released in Summer 2002.
West Virginia	Diabetes	2000–2001	• Participation in pilot was very limited. • Program is now in evaluation phase (due end of 2002). • The state is seeking to extend statewide program with additional diseases in 2003, but the budget is limited.

Pharmaceutical Models

As described above, Mississippi's program has given pharmacists a central role in coordinating patient care, verifying treatment regimens, and educating chronically ill patients about their conditions. Preliminary results show some hospital and emergency room savings for a limited number of asthmatics and diabetics receiving these services, although final evaluation results are not yet completed. Mississippi is now developing a more comprehensive DM program for patients with asthma, diabetes, and hypertension. The program is expected to begin in January 2003 and will place DMOs at risk for achieving program savings.

Virginia began implementing its statewide DM program in 1997. State officials indicate that the program has produced some savings, but not as much as had been hoped. The state is now expanding the program to serve patients with more diseases and is also instituting contracts that will require guaranteed savings from contractors. The expanded program will maintain a focus on pharmaceutical care management.

Key Challenges and Responses by States

States that have been operating disease management programs for a number of years have gained considerable experience in how to run these programs more effectively. The following lessons may be helpful to other states that are developing DM programs.

- **Automatic enrollment**
  Some states (including Texas and West Virginia) have struggled with low program enrollment. In order to ensure higher participation, Florida instituted automatic enrollment with a 30-day opt-out period for enrollees identified through claims data as having a particular disease.

- **Outreach**
  Locating program eligibles is challenging for DMOs because Medicaid enrollees are mobile and contact information provided by the state is often inaccurate or incomplete.[20] Having to track down potential enrollees increases DMO administrative costs and reduces program savings. In response, some DMOs have hired staff to locate particular Medicaid enrollees (rather than having call nurses perform that function). Alternatively, under the new Pfizer model, care managers work in collaboration with 10 local hospitals to help identify program eligibles. While hospitalization is a good enrollment opportunity for DM companies and a "teachable moment" for Medicaid patients, enrollment comes after major costs to the Medicaid program have already been incurred.

- **Predictive modeling**
  Identifying enrollees that have the potential to become high-cost cases is a key challenge for state DM programs, and for the DM industry generally. Accurate risk-assessments are needed in order to target DM resources most effectively. Currently, some DM programs identify high-risk groups based on charges incurred in the prior year, which can lead to inaccurate predictions. However, the industry is working to refine its predictive modeling techniques to help to ensure greater accuracy and more effective risk stratification.

- **Guaranteed savings**
  While some of the early Medicaid DM programs did not place DMOs at-risk for savings, more recent outsourced state programs typically include some type of savings guarantee, often between 5 and 6.5 percent (e.g., Florida, Mississippi, and Washington). These savings figures are based on expenditures for all Medicaid enrollees with a particular disease, giving DM companies responsibility for a broad group of patients.

- **Baseline estimates**
  Establishing adequate spending baselines is challenging for a number of reasons. Given the potential for changes in medical practice, public policy, and other relevant factors, using a comparison group from the same year (rather than a prior year) may be the more accurate way to measure baseline spending.

- **Comprehensive services**
  States have generally found that the more work that they put into provider education and patient case management, the more savings they generate. However, more intensive DM programs are also expensive to operate, reducing their overall budget impact. Given the current budget climate, states such as West Virginia are seeking more cost-effective ways to administer these programs.

- **Multiple vendors**
  States have found that contracting with multiple vendors that each manage only one disease can result in silos of care and added administrative complexity, as patients who develop comorbid conditions are frequently required to switch DM programs. The trend now is for states to give vendors responsibility for several disease conditions and to reduce these types of transitions.

- **Working with Medicaid enrollees**
  Although the Medicaid population presents a number of administrative challenges, DM vendors have observed that Medicaid patients can be remarkably easy to work with once engaged in the program. Several DMOs have reported that these patients are appreciative of the care they receive and are conscientious about monitoring their conditions.

Conclusion

Disease management is one of the few policy options available to states that offers at least the potential to improve care quality while also containing costs. While the early adopters of Medicaid DM have not found it to be an immediate panacea, they do believe that DM provides a longer-term direction for state Medicaid programs and a potentially significant cost-saving strategy. A key challenge for states, and for the DM industry as a whole, will be to develop common standards for measuring cost and clinical outcomes, which will enable states to evaluate the true impact of these programs.

About the Author

Ben Wheatley is a senior associate on the State Coverage Initiatives (SCI) program, which helps states improve the availability and affordability of health insurance coverage through providing grants, technical assistance, workshops, and information on best practices. AcademyHealth (www.academyhealth.org), a nonprofit health services research and policy organization, serves as the national program office for SCI.

Endnotes

1 The number of states with disease management/case management programs increased from 11 in Fiscal Year (FY) 02 to 21 in FY03. See Smith, V. and V. Wachino, "Medicaid Spending Growth: Results from a 2002 Survey," Kaiser Commission on Medicaid and the Uninsured, September 2002, Appendices D and E.

2 Wheatley, B., "Medicaid Disease Management: Seeking to Reduce Spending by Promoting Health," State Coverage Initiatives Issue Brief, AcademyHealth, August 2001. See www.statecoverage.net/pdf/issuebrief0801.pdf.

3 Since 1998, Florida has contracted with a number of other DM contractors. However, several of these programs have concluded (e.g., a hemophilia program administered by Accordant Health Services Inc., and Florida's initial asthma program, administered by Integrated Therapeutic Group, the disease management subsidiary of Schering-Plough Corp.).

4 This fee was paid monthly regardless of whether the patient was seen by the care manager in that month. Patients enrolled in the program received preventive services (e.g., nutrition counseling and therapeutic footwear) that were not covered in Maryland's other managed care programs. See Stuart, M. "Redefining Boundaries in the Financing and Care of Diabetes: The Maryland Experience," *The Milbank Quarterly* Vol. 72, No. 4, 1994, pp. 679-93.

5 Like Virginia, West Virginia originally designed its program as a pilot that would be available only in certain areas of the state (see www.statecoverage.net/statereports/wv1.pdf and www.statecoverage.net/statereports/wv5.pdf). However, the Health Care Financing Administration subsequently ruled that the program had to be extended statewide in order to meet federal law. This limited the state's ability to measure the success of the program against a control group (i.e., Medicaid enrollees in areas of the state without the DM program). Nevertheless, much of the pilot had been completed before the statewide program was implemented, which will allow for some comparisons. Evaluation results are expected by the end of 2002.

6 The DM programs in Virginia and Mississippi have both undergone changes over time (see Table 2).

7 Carlson, B. "Others Await Promise of Mississippi's Experiment With Pharmaceutical Care," *Managed Care Magazine*, March 1999. Also see www.managedcaremag.com/archives/9903/9903.states.shtml.

8 Midwives were included because of the high incidence of gestational diabetes.

9 The Disease Management Association of America and National Committee for Quality Assurance are now developing standardized measures to assess DM program outcomes.

10 Note that Utah's evaluation simply tracked blood factor utilization and expenditures for hemophilia patients over time. There was no control group. See "Case Management for Utah Medicaid Hemophilia Population Proves Cost-Effective," Utah Department of Health Internal Report, February 2000. Also see www.statecoverage.net/statereports/ut1.pdf.

11 The state is not planning to conduct formal evaluations of the other diseases included in the initial DM program (end-stage renal disease, congestive heart failure, and hypertension). However, the state will conduct budget reconciliations with the vendors to determine whether there were net budget savings. The state will evaluate the Pfizer and Bristol Myers Squibb programs, but no date has been set on their release.

12 The asthma DM program, which was provided free of charge to the state by Integrated Therapeutic Group, had limited participation. The program ended in February 2001.

13 Although the results were statistically insignificant, the results showed overall savings vs. non-participants (-1.1 percent for hemophilia and -2.4 percent for HIV/AIDS).

14 "Medicaid Disease Management Initiative Sluggish, Cost Savings Not Determined, Design Changes Needed," Office of Program Policy Analysis and Government Accountability, an office of the Florida Legislature, May 2001 (see www.statecoverage.net/statereports/fl20.pdf).

15 In particular, the diabetes program, which was the largest in the state in terms of number of enrollees, struggled to produce savings. The DMO serving this population had entered an at-risk contract and was directed to forfeit an advance payment of $7.6 million made by the state at the beginning of the year.

16 Evaluation results were released in June 2001. See www.nashp.org/Files/Rogers.PDF for a summary. Note: these results do not incorporate program costs; however, state officials report that the hemophilia and HIV/AIDS programs did produce budget savings (against the prior-year baseline) even with program costs factored in.

17 For more information on the Pfizer program, see www.statecoverage.net/statereports/fl14.pdf. For more information on the BMS program, see www.nga.org/common/issueBriefDetailPrint/1,1434,2640,00.html.

18 Sources: **Florida**: Parker, S. et al. "Evaluation of Disease Management in the Florida Medicaid Program," June 2001 (see also footnote 13); **Maryland**: See footnote 4; **Mississippi**: Personal communication regarding preliminary evaluation results (final results due out by the end of 2002); **North Carolina**: Division of Medical Assistance internal report: "Using HEDIS Measures to Evaluate Medicaid Managed Care Organizational Performance: The Treatment of Persistent Asthma in the Pediatric Medicaid Population," November 2000 (see www.statecoverage.net/statereports/nc7.pdf); and "Managed Care Diabetes Project: Evaluation Report, June 2002 (see www.dhhs.state.nc.us/dma/ca/mcdiabetpro.pdf;) **Texas**: Texas Medicaid Managed Care Diabetes Pilot – Final Report, December 31, 2001 (see www.statecoverage.net/statereports/tx15.pdf); **Utah**: See footnote 10, and personal communication with state official (Sept. 2002); **Virginia (1)**: Rossiter, L. et al. "The Impact of Disease Management on Outcomes and Cost of Care: A Study of Low-Income Asthma Patients," *Inquiry*, Summer 2000, pp. 188-202; **Virginia (2)**: The Virginia Department of Medical Assistance Services Disease Management Program, Six-Month Annual Outcomes Evaluation, June 2002. Heritage Information Systems, Inc.; **West Virginia**: Personal communication with state officials (September 2002).

19 CHF = congestive heart failure; ESRD = end-stage renal disease; COPD = chronic obstructive pulmonary disease; GERD = gastroesophageal reflux disease.

20 See Connors, S. et al. "Contracting for Chronic Disease Management: The Florida Experience," Center for Health Care Strategies Informed Purchasing Series, March 2001 (www.chcs.org/publications/pdf/ips/cdm-report.pdf). See also, Agency for Health Care Administration, "The Florida Medicaid Disease Management Initiative," February 2000. Also see www.statecoverage.net/statereports/fl2.pdf.



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Voting Sheets

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 735-FN

BILL TITLE: **relative to prescription drugs and medicaid best practices.**

DATE: March 4.2003

LOB ROOM: 205

Amendments:

Sponsor: Rep. Wendelboe	OLS Document #:	2003	0492h
Sponsor: Rep.	OLS Document #:		
Sponsor: Rep.	OLS Document #:		

Motions: (OTP), OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. McMahon

Seconded by Rep. Miller

Vote: 17-0 (Please attach record of roll call vote.)

Motions: OTP (OTP/A), ITL, Interim Study (Please circle one.)

Moved by Rep. Dalrymple

Seconded by Rep. Katsakiores

Vote: 17-0 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. James R. MacKay, Clerk

OFFICE OF THE HOUSE CLERK 2003 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: HB 375 Title: Relative to Prescription Drugs.

PH Date: 2/14/03 Exec Session Date: 3/4/03

Motion: OTP Amendment #: 2003-04926

MEMBER	YEAS	NAYS
Batula, Peter L. Chairman	✓	
Dalrymple, Janeen A. V Chairman	✓	
Chabot, Robert F	absent	
Manning, Joseph P	✓	
Katsakiores, Phyllis M	✓	
Pilliod, James P	✓	
Wendelboe, Fran	✓	
MacKay, James R	✓	
Eaton, Stephanie	absent	
Barry, J Gail	✓	
Brown, Carolyn A	✓	
Daniels, Eric M	absent	
McMahon, Charles E	✓	
Price, Pamela G	✓	
Weldy, Norman E	✓	
French, Barbara C	✓	
Seldin, Gloria	✓	
Harris, Sandra C	absent	
Sokol, Hilda W	✓	
Shultis, Elizabeth C	✓	
Miller, Joseph M	✓	
	17	0

TOTAL VOTE:

OFFICE OF THE HOUSE CLERK 2003 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: HB375 Title: Relative & Prescription Drugs

PH Date: 2/14/03 Exec Session Date: 3/4/03

Motion: OTP/A Amendment #: 2003-0492h

MEMBER	YEAS	NAYS
Batula, Peter L. Chairman	✓	
Dalrymple, Janeen A. V Chairman	✓	
Chabot, Robert F	absent	
Manning, Joseph P	✓	
Katsakiores, Phyllis M	✓	
Pilliod, James P	✓	
Wendelboe, Fran	✓	
MacKay, James R	✓	
Eaton, Stephanie	absent	
Barry, J Gail	✓	
Brown, Carolyn A	✓	
Daniels, Eric M	absent	
McMahon, Charles E	✓	
Price, Pamela G	✓	
Weldy, Norman E	✓	
French, Barbara C	✓	
Seldin, Gloria	✓	
Harris, Sandra C	absent	
Sokol, Hilda W	✓	
Shultis, Elizabeth C	✓	
Miller, Joseph M	✓	
	17	0

No Consent

TOTAL VOTE:

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

EXECUTIVE SESSION on HB 735-FN

BILL TITLE: **relative to prescription drugs and medicaid best practices.**

DATE: March 18, 2003

LOB ROOM: 100 SH

Amendments:

Sponsor: Rep. Irwin	OLS Document #:	2003	0815h
Sponsor: Rep.	OLS Document #:		
Sponsor: Rep.	OLS Document #:		

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Irwin

Seconded by Rep. Goulet

Vote: 15-0 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: 15-0

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Ray F. Langer, Clerk

OFFICE OF THE HOUSE CLERK 2003 SESSION

EXECUTIVE DEPARTMENTS AND ADMINISTRATION

Bill #: HB735 **Title:** _____

PH Date: ____/____/____ **Exec Session Date:** ____/____/____

Motion: OTP/A **Amendment #:** _____

MEMBER	YEAS	NAYS
O'Neil. Michael. Chairman	15	
Hamel. Albert W. V Chairman	1	
Langer. Rav F	2	
Goulet. Maurice E	3	
Zolla. William R	4	
Allan. Nelson S	abs	
Dexter. Judson K	5	
Hall. Charles Q	6	
Robertson. Carl G	14	
Bergin. Peter F	abs	
LaFlamme. Paul G	7	
Milligan. Robert H	abs	
Field. William D	8	
Fitzgerald. James M	9	
Mavbeck. Margie	10	
Clavton. William K	abs	
Schulze. Joan H	11	
DeJoie. John	abs	
Irwin. Anne-Marie	12	
Pilotte. Maurice L	13	
Sullivan. Francis B	abs	
	15 D	

TOTAL VOTE:
Printed: 1/6/2003

OFFICE OF THE HOUSE CLERK 2003 SESSION

EXECUTIVE DEPARTMENTS AND ADMINISTRATION

Bill #: HB 735 **Title:** _____

PH Date: ____/____/____ **Exec Session Date:** ____/____/____

Motion: OTP/A **Amendment #:** 0815h

MEMBER	YEAS	NAYS
O'Neil. Michael. Chairman	15	
Hamel. Albert W. V Chairman	1	
Langer. Rav F	2	
Goulet. Maurice E	3	
Zolla. William R	4	
Allan. Nelson S	abs	
Dexter. Judson K	5	
Hall. Charles Q	6	
Robertson. Carl G	7	
Bergin. Peter F	abs	
LaFlamme. Paul G	8	
Milligan. Robert H	abs	
Field. William D	9	
Fitzgerald. James M	10	
Mavbeck. Margie	11	
Clavton. William K	abs	
Schulze. Joan H	12	
DeJoie. John	abs	
Irwin. Anne-Marie	13	
Pilotte. Maurice L	14	
Sullivan. Francis B	abs	
	15 -0	

TOTAL VOTE:
Printed: 1/6/2003

Committee Report

COMMITTEE REPORT

COMMITTEE: **Health, Human Services and Elderly Affairs**

BILL NUMBER: **HB 735-FN**

TITLE: relative to prescription drugs and medicaid best practices.

DATE: March 4, 2003 CONSENT CALENDAR YES ☐ NO ☒

☐ OUGHT TO PASS

☒ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

This bill requires the Department of Health Services to establish certain programs to increase access to prescription drugs for seniors and disabled persons. The bill grants rule-making authority to the Commissioner of Health and Human Services for the purposes of the bill. The committee heard compelling testimony that supports a prescription program targeted for the most needy seniors and medically disabled individuals that often fall through the cracks. Even though this population is small in numbers, it represents a group who are not only very low income, but have assets of less than $2, 500.00. In addition, this bill would establish a Prescription Drug Task Force that would explore cost and access of prescriptions for citizens of this state. The fiscal note is 3.5 million dollars in the first year, half of which will be funded by the federal government. The bill as proposed establishes disease management, which will finance the cost of the program, averaged over three years. The department of Health and Human Services expressed they would like to use those funds for existing programs and not adding a new coverage. While the committee is concerned about the fiscal impact the committee voted unanimously to support the policy of the bill and allow finance to consider other revenue streams.

Vote 17-0.

Rep. Janeen Dalrymple
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Health, Human Services and Elderly Affairs

HB 735, relative to prescription drugs and medicaid best practices. **OUGHT TO PASS WITH AMENDMENT**

Rep. Janeen Dalrymple for Health, Human Services and Elderly Affairs: This bill requires the Department of Health Services to establish certain programs to increase access to prescription drugs for seniors and disabled persons. The bill grants rule-making authority to the Commissioner of Health and Human Services for the purposes of the bill. The committee heard compelling testimony that supports a prescription program targeted for the most needy seniors and medically disabled individuals that often fall through the cracks. Even though this population is small in numbers, it represents a group who are not only very low income, but have assets of less than $2, 500.00. In addition, this bill would establish a Prescription Drug Task Force that would explore cost and access of prescriptions for citizens of this state. The fiscal note is 3.5 million dollars in the first year, half of which will be funded by the federal government. The bill as proposed establishes disease management, which will finance the cost of the program, averaged over three years. The department of Health and Human Services expressed they would like to use those funds for existing programs and not adding a new coverage. While the committee is concerned about the fiscal impact the committee voted unanimously to support the policy of the bill and allow finance to consider other revenue streams. **Vote 17-0.**

HB 735-FN

This Bill requires the department of health services to establish certain programs to increase access to prescription drugs for seniors and disabled persons. The bill grants rule making authority to the commissioner of health and human services for the purpose of the Bill.

The Committee heard compelling testimony that supports a prescription program directed targeted for the most needy seniors and medically disabled ~~Public~~ individuals who often fall through the cracks.

~~It supports a small~~ Even though this population is small in number ~~who normally fall through the cracks for when it comes to prescription~~

It represents a group ~~who~~ who have ~~no significant~~ are not only very low income but have assets of less than $2,500 or assets. In addition this bill would include establishing a prescription drug task force ~~that would address issues and concerns related to cost,~~ that would evaluate cost and access of prescriptions for citizens of this State

~~There was extensive discussion about the fiscal note and testimony. Corrections to 1st year cost of approx~~ The fiscal note is 3.5 million dollars in the first year. Half of which will be funded by the federal government. The bill is proposed as an insurance assessment management which will finance the cost of the program over the next 3 years. The department of HHS expressed they would like to have more funds for existing programs and not adding a new coverage while the committee is concerned about the fiscal impact the committee voted unanimously to support the policy of the bill and also finance & consider other revenue streams.

Rep Jones & Dellwyche

PLB

COMMITTEE REPORT

COMMITTEE: **Executive Departments and Administration**

BILL NUMBER: **HB 735-FN**

TITLE: relative to prescription drugs and medicaid best practices.

DATE: March 18, 2003 CONSENT CALENDAR YES ☒ NO ☐

☐ OUGHT TO PASS

☒ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

This bill was sent to the Executive Departments and Administration Committee as the second committee. The committee found the commissioner did not need rules to implement the medicaid Rx Senior Eligibility Expansion Program or the Medicaid Best Practices or the Chronic Disease Case Management Program. Therefore, the committee amended the bill to remove the administrative rules section of the bill.

Vote 15-0.

Rep. Anne Marie Irwin
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

CONSENT CALENDAR

Executive Departments and Administration

HB 735-FN, relative to prescription drugs and medicaid best practices. **OUGHT TO PASS WITH AMENDMENT**

Rep. Anne Marie Irwin for Executive Departments and Administration: This bill was sent to the Executive Departments and Administration Committee as the second committee. The committee found the commissioner did not need rules to implement the medicaid Rx Senior Eligibility Expansion Program or the Medicaid Best Practices or the Chronic Disease Case Management Program. Therefore, the committee amended the bill to remove the administrative rules section of the bill. **Vote 15-0.**

HB 736-FN

This bill was sent to EDuA as the second committee. The committee found the commissioner did not need rules to implement the Medicaid Rx Senior Eligibility Expansion Program or the Medicaid Best Practices or the Chronic Disease Case Management Program.

OTP ō amendment
March 18, 03

Anne-Marie Irwin

COMMITTEE REPORT

COMMITTEE: Finance

BILL NUMBER: **HB 735-FN**

TITLE: relative to prescription drugs and medicaid best practices.

DATE: April 2, 2003 CONSENT CALENDAR YES ☐ NO ☒

☐ OUGHT TO PASS

☒ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

The policy intent of HB 735 was to provide prescription drug coverage to a segment of the disabled and senior citizens who are under 120% of poverty and have assets under $2,500. This category (of approximately 2,000 people) currently gets some assistance on their Medicare premiums (part A and part B). The corrected fiscal note was $3.2 million, half of which would come from general funds. While the Committee believes it important to assist these very needy individuals, it was felt that under the current economic climate, it is not possible to fund the program. The committee did put $1 in each line and allowed for acceptance of gifts or grants. There is also a section directing the Department of Health and Human Services to effect cost saving through disease management, and another section establishing a task force to study prescription drug access for all segments of our population.

Vote 21-2.

Rep. Fran Wendelboe
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Finance

HB 735-FN, relative to prescription drugs and medicaid best practices. **OUGHT TO PASS WITH AMENDMENT**

Rep. Fran Wendelboe for Finance: The policy intent of HB 735 was to provide prescription drug coverage to a segment of the disabled and senior citizens who are under 120% of poverty and have assets under $2,500. This category (of approximately 2,000 people) currently gets some assistance on their Medicare premiums (part A and part B). The corrected fiscal note was $3.2 million, half of which would come from general funds. While the Committee believes it important to assist these very needy individuals, it was felt that under the current economic climate, it is not possible to fund the program. The committee did put $1 in each line and allowed for acceptance of gifts or grants. There is also a section directing the Department of Health and Human Services to effect cost saving through disease management, and another section establishing a task force to study prescription drug access for all segments of our population. Vote **21-2.**

COMMITTEE REPORT

COMMITTEE: Finance

BILL NUMBER: **HB 735-FN**

TITLE: relative to prescription drugs and medicaid best practices.

DATE: April 2, 2003 CONSENT CALENDAR YES ☐ NO ☒

☐ OUGHT TO PASS

☒ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

The policy intent of HB 735 was to provide prescription drug coverage to a segment of the disabled and senior citizens who are under 120% of poverty and have assets under $2,500. This category (of approximately 2,000 people) currently get some assistance on ~~their~~ Medicare premiums (part A and part B). The corrected fiscal note was $3.2 million ~~dollars~~, half of which would come from general funds. While the committee believes it important to assist these very needy individuals, it was felt that under the current economic climate, it is not possible to fund the program ~~at this time.~~ The committee did put $1 in each line and allowed for acceptance of gifts or grants. There is also a section directing the Department of Health and Human Services to effect cost saving through disease management, and a task force to study prescription drug access for all segments of our population.

another section establishing

Vote 21-2.

Rep. Fran Wendelboe
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Committee on Finance
New Hampshire House of Representatives
Legislative Office Building
Concord, New Hampshire 03301

603-271-3165

The policy intent of HB 735 was to provide prescription drug coverage to a ~~~~ defined segment of ~~the~~ the disabled and senior citizens who are under 120% of poverty and have assets under 2,500. This category (of approximately 2,000 people) currently get some assistance on their medicare premiums, part A and part B

The ~~original~~ corrected fiscal note was ~~~~ 3.2 million dollars, half of which would come from general funds. ~~The~~ While ~~the committee~~ believes it ~~felt it was~~ important to assist these very needy individuals, it was felt that, under the current economic climate, it ~~was~~ is not possible to fund ~~an expansion~~ at this time. The Committee, ~~in lieu~~ did ~~put $2 in each year, (1/ federal, 1/ state, and 1/ private)~~ fund $2 in each year, and allowed for acceptance of gifts or grants.

There ~~was~~ is also a section directing the Department ~~of Human Services~~ to effect cost saving through disease management ~~and~~ ~~~~

Committee on Finance
New Hampshire House of Representatives
Legislative Office Building
Concord, New Hampshire 03301

603-271-3165

~~Section on~~ a ~~Boston~~ task force to ~~Con~~ study prescription drug access for all segments of our population.