Bill as Introduced

HB 735-FN – AS AMENDED BY THE HOUSE

12mar03... 0492h
25mar03... 0815h
10apr03... 1106h

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

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.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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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; 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.

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.

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

9 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.

10 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.

LBAO
03-0032
Revised 1/31/03

HB 735 FISCAL NOTE

AN ACT relative to prescription drugs and medicaid best practices.

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

PI HHS

LBAO
03-0032
Amended 4/21/03

HB 735 FISCAL NOTE

AN ACT relative to prescription drugs and medicaid best practices.

FISCAL IMPACT:

The Department of Health and Human Services stated this bill, as amended by the House (House Amendment #2003-1106h), will increase state expenditures and revenue by an indeterminable amount in FY 2004 and in each year thereafter. There will be no fiscal impact on county and local revenue or expenditures.

This bill appropriates $1 in general funds, $1 in federal funds and $1 in gifts and grants in each year of the biennium ending June 30, 2005 for the purpose of funding the Medicaid Rx Service Expansion Program.

METHODOLOGY:

The Department indicated this bill requires the Department to apply for a federal Medicaid demonstration waiver to include qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs) as individuals eligible for Medicaid prescription drug benefits. This bill also requires the Department to implement Medicaid best practices. The Department stated a federal waiver is not likely without adequate and sustainable state funding, and assumed donations, grants or fees will not satisfy this requirement. In order to provide an estimate of the fiscal impact of this bill, the Department made the following assumptions:

- State funding would be obtained to support the program.
- Approval of a waiver will be received in early FY 2004.
- Approximately 2,101 individuals would be eligible and participate based on data from December 2002. (1,063 QMBs and 1,038 SLMBs)
- Enrollment in the program would be limited to the current number of QMB and SLMB participants, and a waiting list would be established in order to limit expansion of the program or additional Medicare cost-sharing costs to the Medicaid program from new applicants attracted by the pharmacy benefit.
- The prescription drug cost per person was estimated based on experience with similar populations inflated by 19.8% for FY 2003, 22.6% for FY 2004, and 22.5% for FY 2005 through FY 2007.
- 100% of the enrollees would incur costs greater than the $2,000 annual benefit limit.

- The $5 co-payment would be paid at the point of sale and would not impact program costs since all enrollees are assumed to require the full $2,000 benefit.
- Manufacturer rebates are expected to be 22%.
- Medicaid best practices refers to chronic disease management. Savings from disease management of asthma and diabetes are included in the operating budget in the amount of $400,000 in FY 2004 and FY 2005, and assumed to offset provider payment costs. Additional savings may be possible through outsourcing to a disease management contractor, but these savings will continue to be dedicated to provider payments.

Based on these assumptions the program revenues and expenditures would be as follows:

	FY 2004	FY 2005	FY 2006	FY 2007
QMB & SLMB Enrollees	2,101	2,101	2,101	2,101
Rx costs per enrollee per year	$ 3,552	$ 4,356	$ 5,328	$ 6,528
Impact of $2,000 annual benefit limit	2,000	2,000	2,000	2,000
Enrollee Co-payments	0	0	0	0
Annual Rx Costs (enrollees x 2,000)	4,202,000	4,202,000	4,202,000	4,202,000
Total cost after manufacturer rebates @ 22%	$,3,327,560	$3,277,560	$3,277,560	$3,277,560
State Cost - 50%	$1,638,780	$1,638,780	$1,638,780	$1,638,780
Federal Cost – 50%	$1,638,780	$1,638,780	$1,638,780	$1,638,780

Committee Minutes

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Date: May 6, 2003
Time: 4:10 pm
Room: LOB 101

The Senate Committee on Public Institutions/Health and Human Services held a hearing on the following:

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

Members of Committee present:

Senator Martel
Senator Boyce
Senator Estabrook
Senator Kenney
Senator O'Hearn

The Chair, Senator Andre Martel, opened the hearing.

Senator Andre Martel, D. 18: I'm opening the hearing now on HB 735-FN, relative to prescription drugs and Medicaid best practices. Representative Wendelboe is here who is the prince sponsor and I have four other speakers in all. Representative Wendelboe.

Representative Fran Wendelboe: Thank you Senator Martel, for the record my name is Representative Fran Wendelboe, I represent District 29 in Belknap County. I am here before you on House Bill 735, which deal with prescription drugs and Medicaid best practices.

I would like to start off and make one comment, I was the sponsor of the piece of legislation that the prior bill talked about, the –inaudible—tax that's being expanded to –inaudible--- the reason that that was enacted was not because of the insurance companies inability to pay for it. It was because the insurance companies were getting a service that their insured were paying a premium for and then were not having to pay it because the State of New Hampshire and the federal government were paying for all children's immunization.

It was a voluntary thing and some volunteered to do it, and some didin't and the ones that paid it were upset at the ones that didn't pay it so we came up with the next thing to keep everybody honest. It's worked very well, and my –inaudible—just told me today that we received a 2 million dollar check from that source of revenue, just as an aside.

House Bill 735 does three things: It requires the Department of Health & Human Services to establish certain programs to increase access to prescription drugs for seniors. The original fiscal note on this bill was about $17 million dollars a year. It was very much in error for a lot of different reasons and there is an amended fiscal note that you have that shows that the cost now is approximately 3.2 million dollars in 2004, half of which would be federal funds. The expansion of prescription drug coverage would go to people that are referred to as QMBs and SLMBs. QMBs are people that make up to 100% of poverty. SLMBs make up to 120% of poverty, both categories have total assets of $2,500 or less. The poorest of the poor – right now we cut off people at 58% of poverty for Medicaid.

Medicaid covers your prescription drug, Medicare doesn't. So these are people that are eligible for Medicare, but they also don't have more than $2,500 in assets. Right now the state or federal government pays their Part A and Part B premiums for Medicare coverage, recognizing how low income that they are. However they don't have prescription drug access. So this bill proposes expending prescription drug access just to that population of approximately 2,00 people.

Obviously we don't have 1.6 million dollars a year in the budget so the Finance Committee amended it to $3.00. One dollar in each line for general other and federal which would allow if circumstances changed and we had some funds either come in from the federal source to pay this. Or a foundation grant or so on that we would have a program in place that we could immediately start serving the poorest of the poor for prescription drug access.

Another possibility opens up is that people that are on Medicaid, is what's called a duel eligible for Medicare, they are 65 or if they are disabled. We cover at 58% of poverty for Medicaid. I'm looking at numbers if we changed that 58% to a lower number perhaps to go to 50% or 45%. What that would be to a financial impact to the state. People on Medicare have 100% of your costs for physicians and hospitalization paid for by the federal government. Once they become Medicaid we have to pay 50%. So if we could move more of

the Medicaid people back on to Medicare that would free up state dollars. That would pay this and then on the other hand we could not only give the people that had the Medicaid reduced from 58% to something lower; but we would have additional dollars that we could expand prescription drug coverage with that additional money for people that are QMBs or SLMBs up to 120% of poverty.

I'm still working on rough numbers, I don't know if that is something that would work; but that would be one of the possibilities by having this legislation in place. If that were something available to be done we would have legislation in place to expand prescription drug coverage to the former Medicaid people and for the QMBs and SLMBs.

The second part of this bill requires the Department of Health & Human Services to participate and to encourage private health insurance and disease management. I do have a handout for you from the Valley News talking about a diseased management program that they have done on a local level with the Pharmacy Disease Management Program. In the fiscal note the Department of Health & Human Services does say that they project that the original fiscal note of my bill by the third year would have paid for itself. However, they said whatever savings that they would get for disease management they would want to use in other areas of the budget instead of expanding prescription drug coverage.

It is always great when you bring in a fiscal note bill and you bring in a suggestion of how you can pay for it, and they say, fine, we'll take the suggestion of how to get the money; but we are going to use it for something else. So that kind of took the funding away. However, disease management is still something that the department should aggressively do, and this gives them statutory direction that we want to go into that direction and use the funds however they feel they need to within their budget.

The third part of this bill establishes a three-year task force to study the increasing access to prescription drugs for our citizens. The original bill just talked about needy seniors. We amended it to be a prescription drug access for all seniors. That is a policy part of this bill whether there is any money attached or not, that should more forward so that there would be a continuing Study Committee on this issue. This house, the Senate passed Senator Larsen's prescription drug bill; but I can tell you that the house recommendation is that for to be ITL'd because it has a very questionable suggestion of funding mechanism that we don't believe will hold up to constitutional muster, and it's currently in the courts right now.

So why pass this bill? Because of the potential savings if there is a way to change our Medicaid-Medicare match to allow the ongoing study committee to be in place if dollars whether they be federal, state or private donations become available and satisfaction to the Department of Health & Human Services to be aggressive about doing disease management.

If you do disease management studies you see that three diagnoses account for over 30% of the spending that we do just in diabetes and ashema and those are very easily managed with disease management which can save significant dollars throughout the budget.

So that in essence are the highlights of this bill, I won't take anymore time, I know you are running late already, and I appreciate you being able to hear this bill today, and I would be happy to answer any questions that you may have.

Senator Andre Martel, D. 18: Thank you, and I have just a few questions for you. When you were talking about Medicaid people, we have a responsibility to take 50%, so by transfering them back to Medicare we could save up front, who is we?

Representative Wendelboe: The state. That is something I am looking at, it is not part of this bill, but I am trying to work numbers and see how the feds would view us changing that mix. Medicare people, the State of New Hampshire pays nothing for, but Medicaid people would pay 50%.

Senator Andre Martel, D. 18: The attachment that you want to put together for studying a prescription drug plan. Haven't we already had two studies in prescription drugs in the House and how many others in the Senate that have gone through this already?

Representative Wendelboe: Yes, Senator there have been, but the House Policy Committee felt very strongly that they wanted to continue studying and that they felt that the task force in a long-term study was still needed particularly until the congress acts on the Medicare Prescription Drug Coverage and their concern was not only senior citizens but also other people. One thing that they are looking at is that several states are talking about forming a cooperative to act as a non-profit pharmacy benefit management program. We currently have a contract that we pay a couple of million dollars for through a PBM, for our drug purchases for our Medicaid population. We buy approximately 120 million dollars a year in pharmaceuticals. They are suggesting perhaps there could be some savings going through if a non-profit was formed and they felt that this would continue them to look at that as a task force.

Senator Andre Martel, D. 18: Senator Boyce.

Senator Robert K. Boyce, D. 4: A couple of things, I see that the House put $3.00 dollars in it, you know as well as I do that I am talking about how the budget is this year. I thing Senator Gatsus heard about this $3.00, and he put $10.00 is one of ours, and on the floor I recommended that we bump it back up to $16 million. My question on this is, there are some of us that don't like programs that get started for no state money and then some grant comes in and funds them, and they get funded for 2-3 years and then all of a sudden it's general funding is being withheld. Would you have any problem if we amended this to put in that this program will only operate so long as there is no general fund money going into it?

Representative Wendelboe: Senator Boyce, I think you know that I am very conservative and I share your concerns. However if you do an analysis study you will find that if you don't...well prescription drugs have increased drastically in cost in utilization. They have significantly impacted the in-patient services and you save money in the long run. Particularly in poor populations and I really thing that there is an off-setting cost savings by treating people with the appropriate drugs so that they don't end up in the emergency room or as an in-patient in the hospital. So in a way it does save dollars. One of the requirements is the Federal 11:15 waiver to do this for the feds to pay 50% of the prescription costs of the non-Medicaid population is that it has to be considered and proven to be cost neutral. So that we have to demonstrate that there would be savings to off-set the increase in the federal part.

Senator Robert K. Boyce, D. 4: You said that there is long-term cost savings but I look back at when lawyers started paying for the cost of their employees medical care. That is when medical care started to go through the roof, because there was the disconnect between the person actually paying for the service and the person getting the service. There was no reason for people to not go for a cold to their doctor or an emergency room or whatever. I'm concerned that the more we add onto that with prescription drug benefits for whoever, that we are just increasing that, and we are going to end up pushing the cost of medical care to the point where _(inaudible)_ care will be the only option left.

Representative Wendelboe: Well Senator, I take your points to heart. However QMBs and SLMBs, when you make up to 120% of the poverty, I think that comes out at approximately $11,000 a year income, plus a $2,500 asset, and if these people aren't served they end up on our tax rows for these services, and we want to encourage cost savings build into this bill. I don't go into depth because of the time constraint.

There is a maximum allowable benefit of $2,000, plus there is a co-pay requirement as well. I think people would spend wisely in fear of running out of their allocation, part of the way through the year. So I think that would tend to have people conserve as much as possible on their pharmacy issues.

Senator Andre Martel, D. 18: Senator Estabrook.

Senator Iris Estabrook, D. 21: Thank you Mr. Chairman. I wanted to ask about the eligibility language of the bill.

On Page II, it says as you described the eligibility requirements they shall be entitled to the Medicaid Depth coverage that you outlined here. Then in the fiscal note they say that the cost of _(inaudible)_ were based on one assumption, third one down, that a waiting list would be established in order to limit expansion of the program. So first of all, are they entitled, or do they go on a waiting list, and do we have other programs that are funded through Medicaid where we have waiting lists for those programs?

Representative Wendelboe: They are other states that have these programs and they do have waiting lists as part of them because these are optional services. Technically, believe it or not, pharmacy coverage under Medicaid is optional, and the state has a waiver. Every state in the union requested a waiver to pay for pharmacy, as part of Medicaid, so flexibility is given to states in 1115 waiver, so they can put parameters on a pharmacy benefit. That language does sound like it's a little bit in disarray between the two of them, but that might be a drafting problem and perhaps I could see Mr. Dickey to see if he could comment on it because those two are inconsistent.

Senator Iris Estabrook, D. 21: The 1115 Waiver that it is based on, could you explain what that is?

Representative Wendelboe: That is a waiver mechanism that the federal government allows. Matter of fact we had applied for a 1115 Waiver several years ago, last year and two years ago in the budget there was an line item for about $17 million dollars a year that Commissioner Shumway put in for under the theory that there would be no state dollars, but that it would be federal dollars and pharmaceutical rebates and discounts to pay for it. So this is not a new concept. However, that was struck down as being unconstitutional and they refused to accept that 1115 Waiver.

Senator Larsen's bill was also structured with the idea of getting 1115 Waiver, but only putting in a certain percentage of money. Maine is doing it with 2%. We are anticipating that is going to be struck down, because 2% of

state dollars is not enough ownership in the program for them to find it allowable. This program does put in that there would be at least a 25% match, whether it comes through the state or other as part of it.

Since we don't define it as a different percentage it would be the standard match for it.

Senator Iris Estabrook, D. 21: So this is the same way we had the Senate bill based on?

Representative Wendelboe: Correct, but the Senate bill waiver was to 200% of poverty and there was no asset test to it. So this very narrowly targets the poorest of the poor where the other one was so broad and only suggested putting in a very small percentage and it was more of a discount than a program that provided coverage to the extent that this one does, where there is only a very small co-pay.

Senator Iris Estabrook, D. 21: There sounds like there is enough similarities, but I am wondering why the statement that is in the House Calendar this week on the ITL for Senate Bill 96, would not also apply to this where it says that the $10.00 a year, is going to fund the program and that there was a lot of testimony that the lack of an appropriate appropriation and the way that it was requested would make it unlikely that the waiver would be acceptable. So why is this similarly different?

Representative Wendelboe: Senator Larsen's bill had a 5 million dollar general fund cost attached to it, initially and it was felt that there was just no way that that was going to pass and it was also modeled after the Maine Program, which is in the courts, this is not modeled after the Maine Program. That was with the state putting in, or some entity putting in a very low percentage like 2%. As far as the costs basis, and the basis of the other amount being through expanded drug rebate. This does not rely on drug rebates as far as the funding mechanism.

Senator Andre Martel, D. 18: Any other questions. Thank you very much.

Representative Wendelboe: Thank you very much Senator.

Senator Andre Martel, D. 18: Representative Rodgers Johnson.
Those are the only three speakers that I have on the bill, is there anyone else that wants to speak.

Representative Johnson: Good afternoon Mr. Chairman, and members of the committee. For the record my name is Rodgers Johnson, I am State Representative from District 83, with representative towns of Stratham, North Hampton, and Exeter. I am here to testify in favor of HB 735.

I find myself in an interesting position. I did not testify on behalf of this bill in the house. What had happened though, information was presented by the Department of Health & Human Services that this bill couldn't possibly work mainly because of the concept of chronic disease management has not been a proven concept. Meaning that there is no real benefit from that process which is one of the real mechanisms that actually makes this bill work.

I am somewhat troubled by that and I will tell you why. I think most of the members of this committee know, but I will state it again, my background is in healthcare as an insurance consultant. I spent 21 years in insurance consulting. I started out as a healthcare actuary for a large insurance firm, and I do large data analysis for healthcare providers innovated delivery systems, hospital systems and in the like, I have a masters in health policy from the University of New Hampshire, my major thesis was in health care quality and data analysis, and chronic disease management.

The base statement that you may have seen from the department on the concept that Chronic Disease Management doesn't work is false. I am in the process right now gathering data from the Commonwealth of Virginia.

The Commonwealth of Virginia is often called the VHOP, the Virigina Health Outcome Practice. What they are doing within that program that they are reducing the amount of medical claim to their Medicaid population through chronic disease management. The State of Virginia is fairly large but they have reduced in the last 2 ½ years their overall expenditure by 9% per year. Their e-mailing that information, the moment I have it I will give it to you. One of the things that they have also done with the same data, the same process is applying their Chronic Disease Management to their uninsured population that goes to the hospitals and is paid for through their portion share energy care programs. They have saved additional monies there, they are providing me that data, as soon as I get it I will provide it to you.

The base underlying concept for this bill has been proven by the State of Virginia and others so the concept that the department would like you to believe that it doesn't work, is simply isn't true. The reason why I am here today, I am telling you that this is another mechanism that we may investigate and going forward not just for this program but for our entire

healthcare delivery system through the Medicaid Program.
I will be testifying in front of the Senate Finance through the budget process representing the same data so that they know that this is another mechanism that they can use in order to overall reduce cost.

Hence to reiterate the base premise on this bill has been established is valid. You may hear otherwise from the department. I will give you direct data from a state that is actually doing it and has been from 2 ½ years.
I would be happy to answer any of your questions?

Senator Andre Martel, D. 18: Any questions of this witness?
Senator O' Hearn.

Senator Jane E. O'Hearn, D. 12: Representative Johnson, isn't this just a study bill. There is no money in it, it's really just a study bill?

Representative Johnson: You may want to view it as a study bill, but after I just gave you that information perhaps you may want to change your mind.

Senator Andre Martel, D. 18: Do you have any idea how long it will take that information to come to us?

Representative Johnson: I should have it this afternoon, and you should probably have it by this time tomorrow. The initial part of VHOP, the information relative to the indigent care populous that is uninsured may take a little longer, probably Thursday.

Senator Andre Martel, D. 18: Thank you, any other questions? Thank you very much, Don Dickey.

Don Dickey: Good afternoon Mr. Chairman and members of the committee. My name is Don Dickey and I represent the Department of Health & Human Services, I work in the Office of Health Planning and Medicaid.

I would like to address the issue that Representative Johnson just raised. First about chronic disease management. The department's position in our earlier testimony wasn't that it didn't work, it was simply that to some extent the jury is still out in Medicaid populations of how much savings you can get. The operative question was, would the savings be enough to finance this bill. We are saying don't over estimate the savings. As Representative Wendelboe

pointed out, and she has worked very hard on this bill and really did some wonderful work on it. She pointed out to us that our chronic disease estimate is based on a few long distance phone calls and not on an in depth study. Because although the department has been following the field for a long time we had not gone forward to invest in it.

Please rest assured that we do believe that it works, in fact we have an RFP coming out and I believe that's being discussed in Senate Finance or maybe it will be soon, but we are pursuing it. In the governor's budget there was initial estimates for this year, I believe $400,000, and we hope to increase those estimates based on our ongoing discussions with contractors, vendors of disease management services, we do believe that it works.

There was a question about the amount of cost savings but the more important question in the testimony was how will those cost management savings be used and we were saying, because of the deficits in Medicaid provider payments we didn't see that you could get the governor's office or the budget process would make this available to an extension program. We support the intent of the legislation that it would be the demands of the Medicaid Budget were as such that we had budgeted those amounts for the cost savings to offset the demands on the Medicaid budget.

I believe that our Medicaid director, Laurie Riel, I think if you want to find out more information about disease management or VHOP, I encourage you to call her and she could give you an update. I'm not sure if Representative Johnson could obtain the same.

Again, I recognize the work that Representative Wendelboe has done on this bill, she has done a nice job of shaping it, and focusing it on a specific group which is the poorest of the poor. The idea of providing a fairly substantial significant benefit to that group of people at a cost, in the fiscal note that she pointed out, was I thing $3.2 million. Which is much less than some of the other options that have been out there. This is the kind of benefit that provides a $5 co-pay so a very substantial benefit for low income persons. Again this is a very allowable proposal. The concern that the department has again is with funding, being able to have a sustainable funding source. As Senator Boyce pointed out, you don't want to begin a program with start-up money and then not being able to have funds in year 2 or year 3, year 4 to sustain the programs. Given the current restraints on budget-fiscal growth, we are concerned about where that funding would come from in future years. The concept of waiver is in here for one reason; and that is if you have a waiver it enables you to get a 50% match. You could do as many states did before these waivers become more available, they just did their state only programs, a 100% state funded. There is different ways you can flip these

waivers, as you discussed with your own bill SB 96, the Maine waiver, that was one that was really trying to leverage, there is no state money. This would use ½ a 50% savings of state money, so I believe, if my memory is correct, if it is 3.2 million, it would be about 1/6 million. The point again, is the need to have that money in the budget. The concern we have as the bill is written, on line 8 on page 2, says, "The department shall appl;y for a federal Medicare 1115 demonstration waiver" and then in line 12, Section II, "shall attempt to obtain donation, grants or fees.."

One thing we wouldn't want to have is having problems with the bill, in passing the bill again, but we wouldn't want to be required to do something until there is money available. Representative Wendelboe mentioned potential funding for us, such as federal money, and more specifically the do-eligible's, and there is a lot of talk at the federal level of getting do-eligible's of the feds taking full responsibility for the do-eligible population so that they would cover them under Medicaid fully, but the Bush administration is not flirting with that idea currently. That would be one of the ways that congress could provide state fiscal relief, and again Bush administration is opposing any kind of state fiscal relief because of the federal budget deficit.

So we don't see any immediate funding sources on the horizon. Again, we don't have any opposition to passing this bill, it has come good points to it, but we wouldn't want to be required to apply for a waiver or attempt to get grants without substantial significant state funding. These are the points that I needed to cover, and if you have any questions, I am up to answering them.

Senator Andre Martel, D. 18: Thank you very much, any questions, Senator Estabrook.

Senator Iris Estabrook, D. 21: Thank you Senator Martel, do you think without state funding in the budget in the bill whatever, the waiver would likely be granted?

Mr. Dickey: No it's very clear that I actually talked with CNS officials and for instance they recently approved a bill in Indiana, where what held up the bill was that Indiana was not able to identify their state funding. They absolutely require there to be identified state funding, my understanding.

Senator Andre Martel, D. 18: Any follow-up?

Senator Iris Estabrook, D. 21: No thank you Mr. Chairman.

Senator Andre Martel, D. 18: Senator O' Hearn.

Senator Jane E. O'Hearn, D. 12: Would you comment on the Medicaid Best Practices, did the department and legislation do this?

Mr. Dickey: The answer is no, that's a very good question because the department has been moving ahead. This bill was introduced by Representative Wendelboe last session and at that point, and it did provide some stimulus with discussions within the department about moving ahead with disease management. So I had a very positive affirmative affect on these discussions and as I said we are moving ahead with an RFD. It takes time to address those kinds of issues and to talk to all the right people and figure out how to get all those things going. We are on track on getting an RFD out, I believe this summer.

Senator Andre Martel, D. 18: Thank you very much.

Mr. Dickey: the only other thing that I would mention, is one of the things, I believe that Representative McKay is trying to add hawk group in the House to look at if there is money available next year to look at this issue of what kind of waiver and where to go.

Senator Andre Martel, D. 18: Thank you very much. I will now close the hearing on HB735-FN.

Hearing concluded at 4:45 p.m.

Respectfully submitted,

Livia Acdan

Recorded by Meredith Chandler
Transcribed by Livia Acdan
8/7/03

Speakers

SENATE PUBLIC INSTITUTIONS, HEALTH & HUMAN SERVICES COMMITTEE

Date: **05/06/03** Time: **3:30 PM** Public Hearing on **HB 735-FN**

relative to prescription drugs and medicaid best practices.

Please check box(es) that apply. SPEAKING	FAVOR	OPPOSED	*NAME (Please print)*	*REPRESENTING*
1. ~~X~~	X	☐	Rep. Wendelboe	Prime Sponsor
2. ☐	☐	☐		
3. ☐	☐	☐		
4. ☐	☒	☐	Janet Monahan	NH Medical Society
5. ☐	☒	☐	Jim Allard -	Rep. Dist 3, Belknap
6. ~~☒~~	~~☒~~	☐	~~Rep Fran Wendelboe~~	~~District 29~~
7. ☐	☒	☐	Rep. Larry Emerton	Dist. 48
8. ~~☒~~	☒	☐	Rep. Roger J. Ide	Dist 53
9. ~~☒~~	☐	☐	DON DICKEY	NH Dept of HHS
10. ☐	☒	☐	Rep Jim Wilcox	Wilton 32
11. ☐	☒	☐	Sen André A. Martel	Dist. #18
12. ☐	☐	☐		
13. ☐	☐	☐		
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Testimony

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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Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: May 15, 2003

THE COMMITTEE ON Public Institutions/Health and Human Services

to which was referred House Bill 735-FN

AN ACT relative to prescription drugs and medicaid best practices.

VOTE: 4-0

Having considered the same, report the same with the following resolution:
Resolved, that it is: **INEXPEDIENT TO LEGISLATE.**

Senator Andre Martel
For the Committee

HB735 Docket

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Bill Title: relative to prescription drugs and medicaid best practices.

Date	Body	Description
1/9/2003	H	Introduced and ref to Health HS&EA; HJ 12, p206
1/30/2003	H	Report due 3/6/2003
2/3/2003	H	Hearing Feb 14 9:00 RM205,LOB
2/14/2003	H	Subcom Work Session Feb 19 noon RM205,LOB
3/3/2003	H	Subcom Work Session Mar 4 12:15 RM207,LOB
3/4/2003	H	Maj Report OTP/AM for Mar 12 (Vote 17-0;Reg)
3/4/2003	H	Prop Comm Am{0492}; HC20, p477-478
3/12/2003	H	Comm Am, AA VV; Passed with Am and ref to Exec Depts & Admin VV; HJ23, p565-566
3/18/2003	H	ED&A Maj Report OTP/AM for Mar 25 (Vote 15-0;CC)
3/18/2003	H	ED&A Prop Comm Am{0815}; HC26, p748-749
3/25/2003	H	Reps Hess & Nordgren Susp Rules for late ref to Finance, MA 2/3VV; HJ 29-pt 1, p896
3/25/2003	H	Passed with Am and ref to Finance; HJ 29-pt 1, p872-873
3/25/2003	H	Fin Div III Subcom Work & Exec Session Mar 31 9:00 RMs210-211,LOB
4/2/2003	H	Fin Maj Report OTP/AM for Apr 10 (Vote 21-2;Reg)
4/2/2003	H	Prop Fin Comm Am{1106}; HC31, p1042-1043
4/10/2003	H	Fin Am, AA VV; Passed with Am VV; HJ 34, p1126-1127 + 1143
4/17/2003	S	Introduced and Ref. to Public Institutions, Health & Human Services; SJ 13, Pg.331
4/23/2003	S	Hearing; May 13, 2003, Room 101, LOB, 3:00 p.m.; SC20
4/29/2003	S	Hearing; === RESCHEDULED === May 6, 2003, Room 101, LOB, 3:30 p.m.; SC21
5/15/2003	S	Committee Report; Inexpedient to Legislate [05/22/03]; SC23
5/22/2003	S	Inexpedient to Legislate; SJ 17, Pg.475
5/22/2003	S	Sen. Morse Moved Laid On Table, MA, VV; SJ 17, Pg.475-476

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Docket Abbreviations