

SELECTED MEDICAID AND MHSP ISSUES

A Report Prepared for the

Legislative Finance Committee

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This report presents issues related to Medicaid funded services and to administration of the Mental Health Services Plan (MHSP). One issue – provision of Medicaid estimates to the Legislative Finance Committee (LFC) – was initially discussed at the March LFC meeting and staff was directed to provide updates and options for consideration. A new issue related to public participation in the final meeting of the Governor’s Health Care Advisory Council (Medicaid redesign) and DPHHS other public meetings is presented. The last issue of MHSP mental health prescription coverage is related to the Medicare Prescription Drug, Improvement and Modernization Act (Act) recently passed by Congress.

Each topic raises issues with options for LFC consideration. Some options require follow up at a future LFC meeting, and potentially consideration of draft legislation for submission to the 2005 legislature. The no action option is always an option for committee action, but is not listed.

Because the final Medicaid redesign report was received in early June, a more detailed analysis of the entire proposal will be presented at a future LFC meeting.

DPHHS SUBMISSION OF MEDICAID ESTIMATES TO THE LFC

At the March LFC meeting, the committee reviewed a staff report about 53-5-110(4), MCA that requires DPHHS to provide Medicaid estimates to the LFC for its review, whenever the estimates are developed. The committee directed staff to work with DPHHS staff to suggest amendments to the statute.

Two options are listed for consideration. Option 1 is a version of language drafted by LFD staff and then reviewed and edited by DPHHS staff. Option 1 would preserve the status quo in that Medicaid estimates would be provided to the LFC for its review. However, the specific dates when estimates must be provided as well as the date of the expenditure data on which estimates must be based are included.

Option 2 includes additional data submission to the LFC besides Medicaid estimates. Option 2 would require that DPHHS provide a budget status report and Medicaid estimates for the current and prior fiscal years and year-to-date expenditures. DPHHS did not support the inclusion of these reporting requirements.

Option 2 is listed for consideration since DPHHS usually compiles both a budget status report and Medicaid estimates and shows those estimates compared to year-to-date and prior year expenditures. Additional reasons the language was included are:

- There may be significant fiscal issues in DPHHS programs other than Medicaid that would be of interest to the LFC
- Side by side evaluation of current and prior year data provides good benchmark comparisons
- Tracking prior year Medicaid expenditures may be of potential greater importance because Medicaid costs are not fully complete by fiscal year end and in a couple of instances, prior year Medicaid expenditures have exceeded estimates and appropriation authority available and resulted in a request for a supplemental appropriation. The most recent example of such an occurrence was in FY02. Despite an appropriation transfer from FY03 and multiple spending reductions to cover estimated Medicaid cost over runs in FY02, DPHHS requested and the 2003 legislature granted supplemental appropriations for Medicaid costs for both FY02 and FY03.

Option 1: Amend statute to read:

The department shall provide monthly to the Legislative Finance Committee an estimate of Medicaid costs for the current fiscal year beginning November 15 of each year through June 30 of the following year. The estimates must be based on expenditure data as of no later than the last day of the previous month. The Medicaid cost estimates must show estimates by major component of the Medicaid program and how projected expenditures are to be paid by each fund type and by each funding source within each fund type. The Legislative Finance Committee shall review the Medicaid cost estimate at its next regularly scheduled meeting.

Option 2: Underlined sections are the differences in language between options 1 and 2. Amend statute to read:

The department shall provide monthly to the Legislative Finance Committee an estimate of Medicaid costs and a budget status report for the entire department for the current and prior fiscal years and year-to-date expenditures beginning November 15 of each year through June 30 of the following year. The estimates must be based on expenditure data as of no later than the last day of the previous month. The budget status report must show projected expenditures by division, by second level of expenditure. The Medicaid cost estimates must show estimates by major component of the Medicaid program. The estimates must show how projected expenditures are to be paid by each fund type and by each funding source within each fund type. The Legislative Finance Committee shall review the Medicaid cost estimate and budget status report at its next regularly scheduled meeting.

MEDICARE PRESCRIPTION DRUG COVERAGE

Congress passed and the President signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the Act), which will introduce significant changes to Medicare benefits and impact state Medicaid programs and privately and publicly administered health care plans that include coverage for retirees. This report deals with one significant component of the Act – the transition plan prior to full implementation of the new Part D drug benefit, effective January 1, 2006, as part of the Medicare program.

The Act anticipated that state assistance pharmacy programs (SPAPs) could benefit from the transition program. Some states have required or auto enrolled SPAP participants in the transitional program and estimated savings up to 15 percent in program outlays.¹ DPHHS administers an SPAP as part of the Mental Health Services Plan (MHSP).

MENTAL HEALTH SERVICES PLAN

DPHHS administers a pharmacy program for adults with incomes below 150 percent of the federal poverty level (FPL) who also have a serious and disabling mental illness. Only psychotropic medications are covered and there is a benefit limit of \$425 per month per eligible person. Other MHSP mental health services, including eligibility determination, are provided through contracts with four community mental health centers (CMHCs). The pharmacy program is funded by \$3.25 million of

¹A 15 percent savings is associated with SPAPs that cover only aged persons and a wide range of covered drugs with open pharmacy enrollment.

tobacco settlement state special revenue each year of the 2005 biennium.² Some MHSP participants are also Medicare eligible and therefore eligible for benefits under the transition program.

DPHHS has decided that it will not require MHSP participants to participate in the transitional assistance plan. It did so without attempting to measure the savings that could be generated. While savings alone may not be a sufficient reason to require enrollment, this issue is presented for LFC consideration and discussion.

DRUG DISCOUNT CARD

The transition program allows certain Medicare beneficiaries to purchase a drug discount card.³ The transition program starts officially June 1, 2004 and runs through March 31, 2006. Most Medicare beneficiaries can purchase a drug discount card. The primary exception is Medicare eligible persons who are also eligible for a Medicaid outpatient drug benefit.⁴

A Centers for Medicare and Medicaid (CMS) notice published in the Federal Register on December 15, 2003 states that only non-governmental entities are eligible to apply to be endorsed Medicare drug card sponsors; on the CMS Medicare website, it says that as of March 2004 about 30 companies have applied for Medicare endorsement.

Enrollment fees are limited to no more than \$30 annually. Discounts and covered drugs vary by participating company.

TRANSITIONAL ASSISTANCE

The federal government pays the enrollment fee for Medicare eligible persons with incomes below 135 percent of the federal poverty level (FPL) and also adds a \$600 annual credit (called transitional assistance – TA) to the discount card for these low-income beneficiaries. During 2004, 135 percent of the FPL is \$12,569 annually for a single person and \$18,862 annually for a married person. Only income as reported by the applicant will be considered for TA eligibility determination; there are no resources tests. Persons eligible for Tri Care (military health benefits), federal health employee benefits, or certain other employer or group plans and health insurance are not eligible for TA.

In most instances, unspent TA credit from 2004 will roll forward into 2005, creating a total credit of \$1,200 over the life of the transition program. TA will be prorated over 2005 and if persons do not spend balances within a certain time frame a portion of the credit will expire. TA balances can be ascertained by phone or electronically at the point of service.

² SB 485 passed by the 2003 legislature temporarily diverted a portion of tobacco settlement proceeds to a prevention and stabilization fund for DPHHS and appropriated funds for certain services, including \$6.25 million over the biennium for drugs for MHSP participants. Effective July 1, 2005, the funds will flow into a tobacco prevention fund established by voter initiative in the passage of I-146 in the November 2002 general election.

³ Enrollment in the discount program started May 3, 2004, but discount cards become effective June 1, 2004.

⁴ If Medicare beneficiary with a discount card and transitional assistance, later becomes Medicaid eligible the card and assistance remains with the beneficiary. It is not revoked, there is no “look back”.

EXAMPLES OF SPAP SAVINGS

Pennsylvania administers the PACE program (Pharmaceutical Assistance for the Elderly) and Maine administers the Drugs for the Elderly program. Both states have auto-enrolled beneficiaries in discount card programs and provided electronic tapes to CMS to verify income eligibility for the TA and federal payment of annual enrollment fees. Both states will pay the enrollment fee for participants not eligible for TA. PACE savings are estimated to be 15 percent of gross outlays (\$150 million) from June 1, 2004 through March 31, 2006. Maine estimates it will save \$3 million.

POLICY CHOICE

DPHHS has concluded that it will not require Medicare eligible MHSP beneficiaries to obtain and use a discount card. DPHHS did not estimate potential savings if it were to require the enrollment in and use of a discount card for MHSP covered drugs prior to making the decision. Therefore, the decision did not include a complete evaluation of needs, interests, costs, and savings. A review of this policy choice is presented for LFC review.

The DPHHS rationale for its decision include these reasons⁵

- Enrollment in the discount card program is voluntary
- Automation of tracking the use of the discount card is cost and time prohibitive
- Many MHSP beneficiaries also have physical health problems and could use the card and TA for physical health drugs not covered by MHSP
- Many MHSP beneficiaries may have already obtained a discount card
- Plans may not cover the same medications as MHSP and difficulty in evaluating cards to find one that would cover psychotropic medications is difficult

The department recently received data from CMS that lists all Medicare eligible persons, including those with incomes below 135 percent FPL. DPHHS will run the tape against the MHSP eligibility files to determine how many persons might benefit from enrolling in and using the discount card. At that point, it would be possible to estimate the maximum savings from the discount card if persons were required to use it to purchase MHSP covered drugs and had not already acquired and used the card and credit. LFD staff has requested that the data from the CMS and MHSP file match be provided.

Process to Require MHSP Beneficiaries to Obtain and Use Discount Card

LFD staff met with DPHHS staff in an effort to explore the feasibility of requiring enrollment in and use of a Medicare discount card for MHSP covered drugs. During discussions, it became apparent that use of an automated system to “enforce” use of the card was not a realistic option because of the timing and cost, but most importantly because of the way that CMS would require drug card credit to be tracked and recovered. Persons may not use a discount card and the MHSP benefit simultaneously, thereby acquiring the discount for MHSP.

As part of the meeting, LFD staff in consultation with DPHHS staff did outline a process whereby DPHHS could require persons to enroll in and use a discount card prior to accessing MHSP drug benefits.⁶ The process and method for implementation are:

⁵ Lou Thompson, Mental Health Services Bureau Chief, Addictive and Mental Disorders Division; Jeff Buska, Senior Medicaid Policy Analyst, Director’s Office; Duane Preshinger, Acute Care Services Bureau Chief, and Daniel Peterson, Pharmacy Program Officer, Child and Adult Health Care Resources Division., May 27, 2004, personal communication.

- Require eligible persons to obtain a discount card and use the TA for MHSP prescriptions prior to accessing MHSP funds in order to be eligible for MHSP and decide on penalties for noncompliance – administrative rule change
- Evaluate different drug card options to identify the one(s) that cover the same drugs as MHSP and inform CMHCs – state administrative/management task
- Inform pharmacies, MHSP beneficiaries, and CMHCs of the new requirements – include in memorandum that currently is being prepared by DPHHS to ask for voluntary compliance regarding persons who may have a discount card and who later become Medicaid eligible
- Include compliance checks with policy to acquire and first use discount card through pharmacy post audit function – roll into Medicaid pharmacy audit contract

Issue: Should the LFC request that DPHHS revisit its decision and compare estimated savings with other advantages and disadvantages of requiring MHSP beneficiaries to enroll in and use any available credit from Medicare discount card toward MHSP pharmacy costs?

There are two options listed for LFC consideration, which are not mutually exclusive, and may require follow up reports at the next meeting.

Option 1: Direct LFD staff and DPHHS staff to estimate savings of eligible MHSP recipients' use of credit on a Medicare discount card toward MHSP prescription costs.

Option 2: Request that DPHHS staff work with LFD staff to refine a process that would limit administrative complexity and management cost and burden to require MHSP recipients' use of credit on a Medicare discount card toward MHSP prescription costs.

MEDICAID REDESIGN

Medicaid is a significant program in terms of state expenditures, services provided and impact to local economies. The legislature in recognizing the significance and importance of Medicaid and other public health programs passed HJR 13 to request that DPHHS review such programs and provide proposals to the 2005 legislature for consideration.

The LFC has monitored progress of the Health Care Advisory Council (Advisory Council) throughout the last year. The last planned meeting of the Advisory Council was held May 11. The Council reviewed a draft document that listed recommendations that had been adopted previously and draft recommendations for final Council action. Only Council members received copies of the draft report. None were distributed to members of the public in attendance at the meeting until after the meeting concluded and several persons voiced concern.

Without access to the draft document, the ability to understand and track Council deliberations was extremely confusing. The process used by the Council at its final meeting could be compared to a legislative committee taking action on a draft bill without allowing the public to view the draft bill or amendments and then inviting public comment on the bill and proposed amendments.

⁶ DPHHS does not necessarily agree with this approach and may have reservations about the workability or validity of some aspects of this process.

The ability of LFD staff, as well as the public, to understand, evaluate, and effectively comment on Council decisions was severely impaired by the final meeting process. The LFC and the legislature are not well served by such a process, especially since no other Advisory Council meetings are planned and the redesign report is final⁷. In addition, the report states that DPHHS will begin or has begun implementation of some Council recommendations.

DPHHS staff indicated that the entire redesign report will be presented to the 2005 legislature and some of the Council recommendations will be included in draft legislation. DPHHS staff has indicated that public comment on the recommendations can be incorporated during the legislative process. However, comment during a legislative session does not afford the public timely participation at the point that the recommendations were being finalized and it can be very difficult to require an agency to “undo” its actions if public comment provides an alternative that could have been more desirable had it been received in a timely manner.

Issue: Should the LFC request that DPHHS hold a public hearing on the final Medicaid redesign report with the objective that the department be open to receiving comments that might amend or augment some recommendations made by the Council?

The options are either yes or no. The obvious disadvantage of requesting such a meeting would be the additional workload and cost imposed on DPHHS. The advantage would be that the public could make informed comment on the report that might prove useful in resolving issues prior to the legislative session, thereby using legislative and DPHHS staff resources more efficiently during session.

POTENTIAL LEGAL IMPLICATIONS

LFD staff has requested a legal opinion regarding the action to withhold the draft report until after the final Advisory Council meeting was completed, as well as executive branch compliance with statutes and recent Montana Supreme Court Cases regarding open meeting laws and Article II, Sections 8 and 9 of the Montana Constitution (public right to know and participate in state government). That opinion may raise several other issues for LFC consideration.

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⁷ Legislative staff received a copy June 1, 2004.