Minnesota Department of **Human Services**

Memo

DATE: January 25, 2006

TO: **Senator Berglin** and members of the Senate Health, Human Services and Corrections Budget Division

FROM: **Steve Barta**
DHS Legislative Coordinator
651-431-2916

SUBJECT: **Responses to questions raised at committee hearings on 1/18/06 and 1/19/06**

At committee hearings on Wednesday and Thursday, January 18th and 19th committee members asked the Department of Human Services to follow up on the question(s) below. Accompanying the question(s) is the department's response. Please contact Steve Barta 651-431-2916 if you require further clarification.

Question, Senator Berglin: What are the facts surrounding the notices sent to some HIV/AIDS drug assistance beneficiaries in recent weeks about termination of their drug coverage because of their eligibility for Part D enrollment? Especially given the situation with Part D and the fact that many of these people are not eligible for Medicare Part B until July, is it not possible for the department to delay this termination until July?

The Department of Human Services has been in communications with all Medicare eligible HIV/AIDS clients in regard to the upcoming changes in their Prescription Drug and Insurance coverage through Program HH. Maintaining uninterrupted client care during the Medicare transitions has been our primary concern; Program HH has extended Medicare Part D deadlines for HIV/AIDS clients to January 31, 2006 rather than the December 31, 2005 transitions required by Medicare. We continue to work with clients that are unable to make the transition by January 31, 2006. Within the next week, a follow up phone call will be made to all Medicare clients to ensure they have made the transitions by the deadlines, and an individual case assessment will be made for each client.

With the help of Ryan White Title I fund, a fulltime benefit counselor is available at the Minnesota AIDS Project to help clients navigate the formularies and support them in the enrollment process. You should also be aware that the Centers for Medicare and Medicaid have mandated all 74 drug formulary plans to cover all HIV/AIDS drugs.

Fewer than ten clients have been discovered to be without Part B coverage and some clients will be given coverage extensions to February 28, 2006, depending on their personal circumstances. Their

Program HH insurance coverage will remain open until June 30, 2006 provided that they enroll in Medicare Part B during the open enrollment period from January – March. Their Part B coverage will

take effect on July 1, 2006. The DHS HIV/AIDS unit is working with all clients to assure they make the transitions by the deadlines. For those clients with unforeseen situations, we will make an individual assessment consistent with our policies and procedures.

Question, Senator Lourey: What is the impact of the collection of pharmacy cost-savings provisions included in the federal conference report and will that cost savings be felt by pharmacists or manufacturers? Will an effect of the cost-savings proposals be a reduction in pharmacy access?

There will be very little impact on pharmacies from the provisions within the Deficit Reduction Act of 2005 and pharmacy access should not be affected. Many of the pharmacy pieces within the bill are provisions to gather and disseminate pricing information. The bill would give states a monthly list of AMPs (Average Manufacturers Price) for single and multisource drugs. The bill also allows for the secretary to hire a vendor to survey nationwide pharmacy drug purchase prices. These provisions do not require that states use this data to change reimbursement formulas for pharmacies. The bill changes the way that the Federal Upper Limit is calculated; the new formula is 250% of AMP. This will probably lower the FULs for most drugs but as Minnesota already has an aggressive Maximum Allowable Cost program and the MACs are much lower than the current FULs, the new FULs would have little impact on Minnesota pharmacies. A detailed analysis of this is not possible because states currently do not have access to the proprietary AMPs.

The bill's effect on the manufacturers is also minimal. There may be some small increase in the rebate amounts that manufacturers will have to pay to the states because the bill redefines some aspects of the rebate formula. AMP cannot include prompt payment discounts and "best price" exclusions have been reduced. The bill also requires billing of rebates on multisource physician administered drugs by January 1, 2007. All these provisions could modestly increase drug rebates that Minnesota and other states collect under the Federal Rebate Program.

Question, Senator Berglin: What are beneficiaries to do to resolve enrollment and cost-sharing issues regarding their new federal Part D pharmacy coverage?

The following four steps are from is a communication that went to counties early recently, educating them about what they and beneficiaries can do to improve the time it takes to resolve pharmacy discrepancies related to their Part D pharmacy coverage. These instructions are relevant to legislators' constituents as well.

There are steps a beneficiary can take prior to going to the pharmacy, to help avoid a problem with their Medicare prescription drug coverage:

1. If the beneficiary received a drug plan ID card and/or a letter from the drug plan, they should bring it to the pharmacy.

2. If the beneficiary did not receive an ID card or letter, but knows the name of the plan they chose or were assigned to, contact the plan directly. Verify with the plan that they are enrolled, and ask for their "4 RX" numbers. These are the numbers the pharmacy needs to bill the drug plan for their prescriptions. The 4 RX numbers include:

    - RX ID number,
    - RX Group number,
    - RX Bin number, and
    - RX PCN Number.

3. If the beneficiary does not know what plan they are enrolled in and have no documentation of any plan enrollment, they can obtain this information in several ways:

    - call 1-800-Medicare; or
    - go online to determine their plan through the prescription drug plan finder online at www.Medicare.gov . (Click on "Compare Medicare Prescription Drug Plans" and "Find a Medicare Prescription Drug Plan." Enter the information to do a personalized plan search. You need a Medicare Claim number, last name, DOB, Medicare A or B effective date and zip code.); or
    - call the Minnesota Health Care Programs (MHCP) Member Helpdesk at 651-431-2670 or 1-800-657-3739. The Helpdesk can provide the name of the plan, if any, Medicare reported to the Department for an enrollee in December. (Changes may have occurred since the report was received, so if the enrollee changed plans or signed up for a plan in December, the information we have may not be correct.)

4. Bring documentation of their low-income subsidy eligibility, if possible, to the pharmacy. This would include their MHCP card, the letter they received from the Centers for Medicare & Medicaid Services that states the name of the drug plan they were initially assigned to, or the letter they received from the Social Security Administration that states the Medicare copays that apply to them.

Correction, budget reconciliation testimony on TANF:

The department's testimony summarizing the TANF provisions in the federal budget reconciliation report asserted that child-only TANF cases would now be counted in the work participation calculations. The federal language is actually slightly more permissive, allowing the federal agency to regulate what portion of a state's child-only caseload should be included in work participation calculations.

Question Senator Berglin: What is the current wait time for admission to AMRTC and what has the longest time been in the last six months?

Current wait time is approximately 16 days and the longest wait time within the last six months has been 21 to 24 days.

Deficit reduction on backs of poor

Millions will pay more or drop out of Medicaid, analysts say

NEW YORK TIMES

WASHINGTON — Millions of poor people would have to pay more for health care under a budget bill worked out by Congress, and some of them would forgo care or drop out of Medicaid because of the higher co-payments and premiums, the Congressional Budget Office says in a new report.

The Senate has approved the measure — called the Deficit Reduction Act — the first major effort to rein in federal benefit programs in eight years, and the House is expected to vote Wednesday, clearing the bill for President Bush.

Overall, the bill is estimated to save $38.8 billion in the next five years and $99.3 billion from 2006 to 2015, with cuts in student loans, crop subsidies and many other programs, the budget office said. Medicaid and Medicare account for half of all the savings — 27 percent and 23 percent over 10 years.

The bill gives states sweeping new authority to charge premiums and copayments under Medicaid.

"In response to the new premiums, some beneficiaries would not apply for Medicaid, would leave the program or would become ineligible due to nonpayment," the Congressional Budget Office said in its report, completed Friday night. "CBO estimates that about 45,000 enrollees would lose coverage in fiscal year 2010 and that 65,000 would lose coverage in fiscal year 2015 because of the imposition of premiums. About 60 percent of those losing coverage would be children."

The budget office predicted that 13 million poor people — about a fifth of all Medicaid recipients — would face new or higher co-payments for medical services like doctor's visits and hospital care.

It said that by 2010 about 13 million poor people would have to pay more for prescription drugs, and that this number would rise to 20 million by 2015.

Hennepin County Adult Mental Health Advisory Council

January 26, 2006

Senator Linda Berglin
75 Rev. Martin Luther King Blvd.
309 Capitol Building
St. Paul, MN 55155-1606

Dear Senator Berglin:

The Hennepin County Adult Mental Health Advisory Council advises the Hennepin County Board of Commissioners on Adult Mental Health issues within Hennepin County. The Advisory Council was mandated by the 1987 Comprehensive Mental Health Act and monitors, studies and comments on mental health issues at federal, state and local levels. The membership of the Hennepin County Adult Mental Health Advisory Council consists of 32 voting members, including mental health consumers, family members, mental health service providers, and individuals representing mental health advocacy organizations.

At the November 17, 2005 meeting, the Council was briefed on the plans for the Mental Health Payment Model proposed by the Minnesota Department of Human Services. The Council raised questions about the changes implicit in these plans and the potential dramatic shift in service models. The Council sought more information on the proposal. As more information was obtained, more questions and concerns emerged.

At the January 2006 monthly meeting, the Council passed the following resolution:

> *The Hennepin County Adult Mental Health Advisory Council hereby expresses concerns about the implementation of the Minnesota Department of Human Services proposed Mental Health Payment Model.*
>
> *Whereas, there has been inadequate time and information for consumers, family members and the mental health community as a whole to review and respond to the Mental Health Payment Model being proposed by the Department of Human Services, the Hennepin County Adult Mental Health Advisory Council recommends a "Slow Down" in the process and the involvement of more stakeholders, especially consumers, family members, advocates and community providers.*
>
> *Adopted unanimously on January 19, 2006*

We would like to discuss this issue further with you and hope you will contact us.

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Co-Chair
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Co-Chair
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Testimony to the Senate HHS Committee Hearing on the Health Impact Fee
By Sanne J. Magnan, M.D., Ph.D., vice president and medical director, consumer health Blue Cross and Blue Shield of MN
January 31, 2006

Madam Chair, members of the Committee my name is Sanne Magnan and I am vice president and medical director of consumer health at Blue Cross and Blue Shield of Minnesota. Prior to joining Blue Cross, I worked as a Doctor of Internal Medicine at Ramsey Hospital (now Regions Hospital) in St. Paul. I continue my clinical work as a volunteer physician at the tuberculosis clinic at St. Paul Ramsey County Department of Public Health. As a physician I have seen first hand the devastating impact of tobacco use, and I am here today to ask you to remember the human toll that tobacco use takes in our state and to consider the positive health impacts that result from increasing the price of cigarettes.

A significant increase in the price of cigarettes is one of the most effective public policies to prevent kids from smoking and to help adults quit. By passing a 75 – cent per pack increase in the price of cigarettes in 2005, the Minnesota Legislature took a significant step toward tackling the number-one cause of preventable death in Minnesota—tobacco.

The impact of the passage of the legislation was felt in Minnesota as soon as it was implemented. At Blue Cross, we saw an immediate increase in calls to our telephone counseling program for people who want to quit smoking following the implementation of the Health Impact Fee. Calls increased 65% the first two weeks after the fee was implemented. Put simply---this health policy works.

But most important is the impact on our kids. The 75-cent per pack increase in the price of cigarettes is preventing tens of thousands of Minnesota kids from starting to smoke. Kids are 2 to 3 more price responsive than adults and are more likely never to start smoking to avoid paying the higher cigarette price. Research shows that every 10 percent increase in the price of cigarettes reduces the number of kids who smoke by 6-7 percent. Stopping kids before they ever start smoking is key to halting the tremendous toll that smoking takes on our state. 90% of adults who smoke began their addiction before their eighteenth birthday.

And, Minnesota youth and young adults are at great risk for tobacco addition. Minnesota's high school students are smoking at higher rates than the national average and 18-to-24 year old are two times as likely to smoke as their older counterparts.

The 75-cent increase in the price of cigarettes is projected to stop over 54,000 Minnesota kids from becoming smokers, saving 17, 500 of those kids from a future smoking related death.

The impact of tobacco on health also impacts our pocketbooks. At a time when health care costs are the number one concern of many Minnesota families, some of the most costly diseases are also some of the most preventable. Tobacco use costs Minnesota nearly $2 billion annually. Think of it this way, one of every eleven dollars spent on health care in this state is spent on smoking related illnesses. Preventing kids from smoking and helping Minnesotans kick their addition to tobacco though policies such as the Health Impact Fee will produce $1.1 billion in long-term health care savings.

I urge you to remember that the Health Impact Fee is first and foremost about health. By passing the Health Impact Fee, you took an important step toward reducing the power of our state's number cause of preventable death—tobacco. In the best interest of the health of our kids, I encourage you to stay committed to a cigarette price increase.

For Legislators

Minnesota Department of Health January 31, 2006

Improving Health Care for Immigrant Families

A Public Health Challenge

Local public health officials are facing two significant challenges regarding Minnesota's immigrant population: hepatitis B and tuberculosis (TB). Persons born outside the United States are much more likely to be affected by these diseases. The proposed initiatives will result in the following:

- Foreign-born persons will receive better health care and be healthier workers, students, and community members.
- Communities will be better protected against infectious disease because the likelihood of diseases being transmitted to the general public will be reduced.
- Healthcare costs will be reduced.
- Healthcare providers and local public health professionals will be better trained about the health concerns of foreign-born persons and will have resources to help them offer culturally sensitive and medically appropriate care.

Hepatitis B

If not treated with vaccine immediately after birth, a child born to a mother with hepatitis B infection has a 90% chance of developing chronic hepatitis B, resulting in a variety of chronic and costly health problems including liver cancer, possible death, and likely transmission to others. However, treatment initiated within 12 hours after birth is up to 90% effective at preventing this serious infection.

Over the past few years, Minnesota has seen an increase in the number of women with hepatitis B infection who are giving birth. During 2004 and 2005, there were 861 infants born to hepatitis B infected women in Minnesota. In Hennepin County alone, between 2002 and 2005, the number of infants born to hepatitis B infected mothers increased by 25%. In addition, each year in Minnesota, more than 99% of births to hepatitis B infected women occur among non-white or Hispanic mothers, 44% of whom do not speak English.

The hepatitis B reduction initiative will increase education to birthing hospital staff and provide technical consultation to local public health to ensure proper case management, resulting in more at-risk infants being identified and treated. The initiative will also help deliver immunizations to targeted geographic and ethnic communities, particularly to the immediate household contacts of these infected women. Both of these activities will help prevent chronic hepatitis B infection.

A 1995 Centers for Disease Control study found that for every dollar spent on perinatal hepatitis B prevention, over three dollars are saved in long-term costs. The benefits of this cost-effective strategy are:

- The prevention of potential long-term health consequences for the child.
- Elimination of a potential source of infection to others in the future.

Tuberculosis (TB)

The majority of TB cases in Minnesota (85%) occur among foreign-born persons, particularly newly arriving refugees and immigrants.

On average, nearly 30 of Minnesota's TB cases per year are resistant to at least one of the common TB drugs, necessitating treatment

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with costlier drugs for longer periods of time. Medications to treat a "simple case" of TB cost approximately $800, while costs for a multidrug-resistant TB case can be as high as $25,000. Part of this new funding will ensure that medications are available to treat those infected with TB.

MDH does have funding in its budget for TB medications. These funds are used to provide outpatient medications for persons residing in Minnesota with active TB disease or those with latent infection (to prevent occurrence of active TB disease). Insurance is billed when available.

A cost-benefit analysis published in 1995 in the Journal of the American Medical Association estimated the cost to local health departments of conducting a TB contact investigation at $1,696 per case. Costs in 2006 dollars and for cases needing language interpreters would be significantly higher.

Using federal TB grant funds and state Eliminating Health Disparities funds, MDH currently provides modest grants to some local public health agencies to assist with costs related to contact investigations, as well as TB outreach and TB case management. These funds cover only a small percentage of the potential costs to the agencies, leading to a restriction in the level of services they provide. Many counties not receiving such grants are unable to fund even critical basic services. These include ensuring that refugees with latent TB infection receive treatment to prevent them from developing active TB disease and that the close contacts of infectious TB cases are identified and evaluated for signs of TB.

This TB reduction initiative will target specific immigrant populations for outreach and case management at the state and local level to improve the expertise and capacity of Minnesota's local public health clinics to provide culturally appropriate services to persons with TB. Managing and treating a case of active TB, including contact investigations, is a very complex and time-consuming process, especially when language and cultural barriers exist. If MDH does not have the funds to provide grants to local public health for TB case management and follow-up, the state could face even higher costs related to an increase in future TB cases. If TB cases are lef unchecked, TB could become widespread in the community.

This proposal is a cost containment measure that will reduce future costs by investing in the prevention of a widespread TB epidemic. Proper administration of TB medications also prevents the emergence of drug-resistant strains of TB, which are challenging and costly to treat.

A cost-benefit study published in the Journal of the American Medical Association in 1995 estimated the cost of outpatient treatment (i.e., clinical care and medications) at $14,696-$22,957 per case. Costs in 2006 dollars would be higher. The cost to local public health agencies of providing necessary support for ensuring adherence to treatment (i.e., "directly observed therapy," transportation, language interpreters, incentives, etc.) can easily exceed $15,000 per case in Minnesota. Therefore, the savings resulting from preventing a single case of TB would be at least $34,000. Preventing a case of multidrug-resistant TB would save many times that amount because of the need for longer treatment with costlier medications.

The Proposal

Hepatitis B ($210,000) will include funding for a public health nurse advisor for case management and follow-up statewide ($85,000), grants to local public health agencies to ensure that staffing is available for outreach to infants born to hepatitis B positive mothers ($60,000), and incentives to encourage completion of appropriate therapy ($5,000).

TB ($290,000) will include funding for TB medications ($90,000) and grants to local public health agencies to provide outreach and case management for individuals with TB infection or disease ($200,000).