REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Report of the Technical Advisory Panel of the Virginia Indigent Health Care Trust Fund Pursuant to HJR 225, 2000

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Department of Medical Assistance Services

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TO: The General Assembly of Virginia

Pursuant to a letter from Speaker S. Vance Wilkins conveying the issues raised in House Joint Resolution 225, the Department was requested to review the material contained in the resolution and respond. The original resolution, although not passed, directed DMAS to submit findings and recommendations to the Board of Medical Assistance Services, the Board of Health, and the Joint Commission on Health Care and to the Governor and the 2001 Session of the General Assembly.

This report summarizes issues and actions regarding the establishment of a pilot program for meeting prescription drug needs of the elderly and other uninsured.

The Department incurred $400 in staff time costs in preparation of this study.

Respectfully submitted,

Dennis G. Smith
Department of Medical Assistance Services

Pilot Prescription Drug Program Issues

The General Assembly entertained House Joint Resolution 225 during the 2000 session. Although the resolution was passed by in committee, a letter dated March 10, 2000, conveying the sense of the House was signed by Speaker S. Vance Wilkins and delivered to the Department of Medical Assistance Services. This letter requested that the Technical Advisory Panel of the Virginia Indigent Health Care Trust Fund and the Department review the issues raised in the resolution. The resolution required that the TAP, in cooperation with the Virginia Department of Health, develop a pilot indigent pharmacy program as a means of improving access to prescription medications for the indigent and uninsured.

Prescription drug assistance was addressed in a number of bills and resolutions presented to the General Assembly during the 2000 session. House Bill 661 would have established a Prescription Drug Payment Assistance Program at DMAS using money derived from the Master Settlement Agreement with tobacco product manufacturers. House Bill 1551 would have established a two-year pilot program at DMAS, the Virginia Prescription Drug Payment Program, funded by the Virginia Health Care Trust Fund created with tobacco Master Settlement Agreement money. House Bill 1403 and Senate Bill 470 would have created a Prescription Assistance Fund to be administered by DMAS with money from the Master Settlement Agreement. Senate Bill 539 would have established the Virginia Pharmaceutical Assistance Program at the Department of Health, to be piloted in 2000-2002 biennial budget. The House Joint Resolution 167 resolved to establish a joint subcommittee to "study the feasibility of strengthening the Commonwealth's pharmacy purchasing ability for state programs and using savings generated to create and fund a pharmacy benefits program for low-income and uninsured elderly persons."

Background

The Technical Advisory Panel of the Virginia Indigent Health Care Trust Fund was established to recommend to the Board policy and procedures for administration of the Trust Fund. The Panel is to also advise the Board on establishment of pilot health care projects for the uninsured. The Panel, in accordance with Board regulations, may establish pilot health care projects for the uninsured and shall administer any money voluntarily contributed or donated to the fund by private or public sources for the purpose of subsidizing pilot health care projects for the uninsured.

As the cost of pharmaceuticals has increased and the number of full-time employed individuals with access to health care has declined; the net effect is a growing

concern over how to provide necessary medicines to individuals without the financial resources to afford them. Pharmacy needs of uninsured Virginians are met through a patchwork of funding sources and locations across the Commonwealth. For elderly Virginians, the lack of prescription drug coverage as a component of Medicare creates a large financial burden. Unless a person in the community has income of no more than $540 per month for a single person, Medicaid is not an available option for coverage of prescription drugs. Higher-income eligibility groups such as Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries only cover Medicare-related costs or premium costs. The "medically needy" component of Medicaid may help, but the consumer must incur a large financial burden of medical costs before establishing eligibility for time-limited coverage. Some Medicare HMO's offer a limited prescription drug benefit as part of the range of services they provide. However, some Medicare HMOs are leaving the state or are no longer accepting new enrollees, reducing or eliminating this option for many retirees.

Three standard Medicare supplemental policies offer limited prescription drug coverage. Plans H and I have a $250 deductible per year and cover 50% of prescription drug costs up to a maximum amount of $1, 250. Plan J has a $250 per year deductible and covers 50% of prescription drug costs up to a maximum of $3,000 per year. The premium cost for these plans is beyond the reach of some of the elderly.

For individuals over age 21 but under age 65, Medicaid provides the only statewide governmental source of coverage for prescription drugs. An individual must be totally disabled and unable to work, or must be pregnant, or must be a caretaker of children in a low-income family in order to receive coverage. There is no provision for coverage of the uninsured who are temporarily disabled or who work but have a chronic condition requiring medical treatment.

Prescription drug needs can be either short-term or long-term. For short-term needs, some resources exist within local communities to take care of an immediate need for a drug to address a specific disease or illness that can be treated or resolved. Often these needs are covered by single grants to cover a prescription from a local aid organization, church fund, or General Relief emergency fund. Physicians also address patient needs by giving out samples to patients who cannot afford to fill a prescription.

Chronic disease treatment is a long-term need that cannot be addressed by one-time grants. Conditions such as diabetes, high blood pressure, depression, gastrointestinal problems, and seizure disorders require ongoing treatment to prevent a worsening of the disease or to prevent other organ damage. New drugs continue to be developed and to enter the market to address these health needs. The cost of these drugs can be beyond the economic reach of the patients.

Activities of the TAP

The last formal meeting of the Technical Advisory Panel was held on November the 3rd, 1999. At that time the issue of a pilot pharmacy program was discussed, with options being presented to the TAP for their consideration. However, some issues remained unresolved. One issue raised was that regardless of any model for distribution of pharmacy assistance, funding must be found. The TAP determined that no additional money would be forthcoming from the General Assembly to address pharmacy assistance. In response to House Joint Resolution 675 of the 1999 General Assembly, the TAP indicated that is it feasible to establish a pilot pharmacy program but that the cost of such a program would depend on the scope of benefits, the eligibility criteria and income limits, and the involvement of community organizations in supporting the program.

Local Departments of Social Services are not a likely source of additional money, as some of them do not fully match their State/Local Hospitalization allocation due to funding constraints. Outside grants from foundations and drug companies are the remaining likely funding source. Grants from drug companies may be suspect because of the inherent interests of the manufacturers in establishing market share.

Four model indigent pharmacy programs were presented to the TAP for review and discussion. A prototype design developed by DMAS with the assistance of VDH was presented to the TAP. It incorporated program, administrative, and funding design. This framework would be adaptable to local community needs and available funding. The TAP did not come to consensus on recommending any particular type of pilot plan or funding source.

Model Description	Pros	Cons
Benefit/Voucher Program	Drugs not limited to samples or pharmaceutical company pharmacy assistance programs. Discounts or rebates frequently available. No delays. Use any participating pharmacy.	High direct cost; may be difficult to find funding source. May be difficult to coordinate appropriate medical care.
Free Pharmaceutical Assistance (Drugs from pharmaceutical company programs or samples)	Only costs are administrative. Adaptable to many types of organizations.	Drugs are limited to type and quantity. Eligibility for pharmaceutical company programs is variable. Frequent reapplication usually necessary.
Temporary Assistance	Meets immediate need. Cost effective alternative to admitting patients to hospitals or to facilitate hospital discharge.	May only postpone problem.
Indigent pharmacies (associated with health departments, free	Drugs not necessarily limited to samples or pharmaceutical company pharmacy assistance programs. Discounts or rebates	High direct costs; may be difficult to find funding source. Limited locations

Model Description	Pros	Cons
clinics, community health centers, etc.)	frequently available. No delays. Linked to medical care. Close oversight.	and possible stigma.

A pilot program, by definition, should be a means to field-test a program that is expected to expand regionally or statewide. In the case of prescription drug coverage, the unmet needs of the uninsured population are so great as to make any pilot feasible only as a limited demonstration that cannot be sustained on a regional or statewide basis, even if undertaken with a disease-specific limitation. The creation of a pilot program would serve a limited location and population, but will have no lasting effect on the health needs of the uninsured throughout the Commonwealth unless a major commitment funds is made. Any voluntary contributions would likely come from sources already participating in health care delivery such as free clinics and community health centers and could affect the funding currently in place.

As set forth in House Joint Resolution 225, one of the responsibilities of the Technical Advisory Panel is to administer any money voluntarily contributed or donated to the fund by private or public sources for the purpose of subsidizing pilot health care projects for the uninsured. There are complications in locating funding through voluntary contributions. The private sector may not see the benefit of making contributions because donations would be funneled through a state fund. The TAP initiated a project in 1994 to establish an insurance program for the working uninsured. However, the TAP and the Department were unable to convince any stakeholder to contribute towards the pilot program.

The members of the TAP raised other issues for further consideration. One concern was recommending a specific pilot program without first examining the utilization of existing resources. Questions were also raised about whether utilizing the Indigent Health Care Trust Fund was appropriate. The trust fund has been a mandatory program for redistributing hospital charity care. Expanding the trust fund's mission would potentially take away from those indigent citizens requiring assistance with their hospital bills.

Examples of current operational assistance networks can serve as best practices for localities to replicate in assisting the uninsured in obtaining prescription drug benefits. In a number of localities across the state, creative uses of staff and funds have led to solutions tailored to local resources. Two examples follow, each uses a proprietary software database called The Pharmacy Connection as a component.

The Pharmacy Connection is a database created and maintained by the Virginia Health Care Foundation (VHCF). This Access database is made available to entities by a

$300 annual subscription. The database stores all the eligibility rules for the various pharmaceutical assistance programs. When an individual seeks assistance for coverage of a particular drug, necessary personal information is loaded into the database and a decision is made. A pre-printed application for the specific manufacturer is produced. The database also creates necessary recertification material when prescriptions must be re-authorized. VHCF maintains an up-to-date inventory of assistance programs and the eligibility criteria for each and forwards updates to the subscribers when they occur. VHCS keeps track of the amount of free pharmaceuticals obtained through use of this program. In the last fiscal year, the amount was over $10 million.

The $10 million in free drugs to Virginia's citizens ranks the state in the top tier of states using pharmaceutical manufacturers' assistance programs. Use of the Pharmacy Connection is scattered throughout the state. An obvious recommendation for the TAP is to encourage the use of the Pharmacy Connection by free clinics, health departments, and community service agencies throughout the state. One caveat that must be stressed is that the pharmaceutical assistance programs are run voluntarily by the industry. Thus, any coordinated effort to make these programs a standard component of a state's response to the uninsured could lead to the industry tightening up or eliminating the programs entirely.

The resolution notes that the Indigent Health Care Trust Fund receives moneys appropriated by the Commonwealth and contributions from certain hospitals for the purpose of reimbursing hospitals for unreimbursed inpatient and outpatient medical care provided by certain hospitals. In state fiscal year 1998, private acute care hospitals provided $72 million in charity care, including spending on drugs.

Hospitals already support free health clinics because they reduce uncompensated hospital care. The Virginia Association of Free Clinics reports that 48 Virginia hospitals provided approximately $2.9 million of in-kind services to free clinic patients in 1998.

Many hospitals provide free pharmaceuticals to the indigent as part of an emergency room visit. It is cheaper to give patients a 3-5 day supply of drugs than to admit them to the hospital. At least one hospital, Danville Regional Medical Center, will provide a month's supply of a prescription at discharge for indigent patients. The hospital's social worker staff identifies indigent patients without insurance. Indigent patients are also referred to pharmaceutical company patient assistance programs. The month's supply at discharge will usually last until the patient begins to have the prescription filled through the pharmaceutical company. Danville spends approximately $50,000 a year on free drugs for ER patients and discharged patients.

Some hospitals also have hired staff to assist outpatients and sometimes inpatients in applying for drugs through pharmaceutical company patient assistance programs. The

administrative cost is relatively small with a great potential to reduce unnecessary admissions or ER visits. Twelve hospitals use the VHCF Pharmacy Connection to access pharmaceutical company patient assistance programs. Carilion Giles Memorial Hospital assists approximately 200 outpatients in obtaining medicine with an estimated monthly value of $20,000.

Pharmacy assistance saves health care dollars by reducing unnecessary care, especially unnecessary hospital care. Carilion Health System estimated that an indigent pharmacy program would reduce emergency room visits and unnecessary hospital admissions for diabetes, heart disease and hypertension by 10%. The Senior PHARMAssist program in Durham, North Carolina, estimates that participants in the program have 31% fewer ER visits and 29% fewer inpatient admissions after one year in the program.

The Virginia Primary Care Association is a trade association representing community health centers and other not-for-profit medical providers. A $125,000 appropriation to the VPCA allowed the centers to expand use of The Pharmacy Connection, to purchase medications when otherwise not available, and to assist in management of the centers. As a result, in FY 1999 and FY 2000, approximately 14,000 patients received prescription drugs, accounting for over $3.3 million in drug benefits.

Virginia has 35 Free Clinic sites serving patients with use of volunteer medical professionals. Fifty-two percent (52%) of the value provided by Free Clinics is in the form of prescription medication. These clinics are heavy users of The Pharmacy Connection in locating assistance for their patients. Free Clinics dispensed nearly $13 million in drug benefits, aided in part by $600,000 in state funds in FY 2000.

The Virginia Department of Health in its "Study of Ways to Support Free Clinics and Community/Migrant Health Centers" in response to SJR 112 (1998) recommended the TAP examine the feasibility of establishing a pilot pharmacy program for the indigent. The lack of access to pharmaceuticals for the indigent and uninsured was identified as one of the three highest priorities for free clinics and community/migrant health centers. Free clinics alone provide free pharmaceuticals through use of pharmaceutical company patient assistance programs, free samples donated by physicians and pharmaceutical companies, and direct reimbursement. Community/migrant health centers provided similar services.

While the VDH free clinic study did not recommend any general fund moneys, the General Assembly subsequently appropriated $600,000 to the Virginia Association of Free Clinics and $125,000 to the Virginia Primary Care Association for the purchase of pharmaceuticals and medically necessary pharmacy supplies, and to provide pharmacy services to low-income, uninsured patients (with family incomes no greater than 200

percent of poverty) of the free clinics and community and migrant health centers. The associations were to set up accounting and reporting mechanisms to track expenditures and to report to VDH on the expenditure of these funds and the number of low-income, uninsured persons receiving pharmaceuticals.

Thus, looking only at these two groups who received General Assembly appropriations, not including other organizations which access pharmaceutical assistance, over $16.3 million yearly has been realized in pharmaceutical benefits.

Planned Actions

The VHCF has been asked to invite members of the TAP to a statewide "best practices" session regarding prescription drug coverage approaches across the state. This will serve to educate the TAP in various programs operating at present. TAP members can then hear directly from the administrators of these programs. Following this statewide conference in Charlottesville in October, a TAP meeting will be held in November. By the November TAP meeting, additional information should be available for the members to review and discuss.

Because of concerns about individuals with high medical costs who could not access Medicaid due to the low income limits used to determine eligibility, the 2000 Session of the General Assembly directed that two significant actions be taken. Effective July 1, 2001, Virginia's Medicaid program will provide coverage for a new group of elderly and disabled individuals whose income does not exceed 80% of the federal poverty level. Adoption of this group will extend full Medicaid benefits, including pharmacy services to individuals with income up to $557 per month. Many individuals who are currently eligible for Medicaid as Qualified Medicare Beneficiaries and whose coverage is limited to payment of Medicare premiums, coinsurance and deductibles on Medicare services will benefit from this new category and become fully eligible for Medicaid (including pharmacy and other services not covered under Medicare). In addition, there may be an increase of new eligibles. The total number effected by this action is estimated to be approximately 5,725. These individuals will qualify for full Medicaid benefits, including prescription drug coverage.

The second action, also effective July 1, 2001, increases the medically needy income limits for the Medicaid program by the annual percentage change in the Consumer Price Index. This action will increase the income limit that is used to determine Medicaid eligibility for individuals who must spend down their excess income by sustaining medical expenses in order to qualify for Medicaid. It is estimated that the change in the medically needy income limits will enable an additional 337 individuals to qualify for full Medicaid benefits, which includes prescription drugs.