

**HOUSE HEALTH AND HUMAN SERVICES
COMMITTEE**

PUBLIC HEARING:

Office of Medical Assistance Programs
Department of Public Welfare

*Proposed Pharmacy Carve Out
and
Transition to ACCESS Plus*

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*Sherry Knowlton
Senior Vice President and General Manager
AmeriHealth Mercy Health Plan*

Chairman Oliver, members of the Health & Human Services Committee, thank you for inviting me to testify today about the impact of the Department of Public Welfare's budget proposals for State Fiscal Year 2007/08 on Pennsylvania's Medicaid recipients and the Medicaid Managed Care Plans serving this population.

My name is Sherry Knowlton. I am the Sr. Vice President of AmeriHealth Mercy Health Plan. I am here today on behalf of both AmeriHealth Mercy and Keystone Mercy Health Plan. Our two plans serve nearly 360,000 Medicaid recipients in 25 counties in Central, Northeast, and Southeast Pennsylvania. We have been providing Managed Care to Pennsylvania's Medicaid population for nearly a quarter of a century.

I am here today to express our concern about two DPW proposals: to Carve Out Pharmacy from HealthChoices managed care and to eliminate Voluntary Managed Care. We believe that these proposals will have a negative impact on Medicaid consumers, Medicaid providers, Managed Care Organizations (MCOs), and, ultimately, Pennsylvania's taxpayers. I believe I bring a somewhat unique perspective to this discussion since, at one time, I was a Deputy Secretary for Medical Assistance Programs.

Since the early 1980's, Pennsylvania's Medicaid Managed Care Program has been recognized as a national model. MCOs have improved access to quality care for Medicaid recipients and slowed the rate of growth in Medicaid expenditures by saving the Commonwealth billions of dollars.

These two proposals are the latest, and most troubling, in a series of recent DPW policies that turn back the clock on the State's longstanding commitment to the Managed Care model for Medicaid. DPW plans to directly manage pharmacy benefits for all Medicaid recipients and to manage the delivery of health care to Medicaid recipients currently enrolled in Voluntary MCOs through the ACCESS Plus Program.

DPW has assumed State fund savings in FY 2007/08 of \$45 million for a Pharmacy Carve Out and \$23 million for the elimination of Voluntary Managed Care. However, these estimated savings are based on flawed reports commissioned by the Department through its consulting actuaries. The significant shortcomings of these reports raise considerable doubt that DPW could actually achieve any meaningful savings through these proposed initiatives. Proceeding with carving out pharmacy benefits and eliminating Voluntary Managed Care would disrupt the delivery of health care for 1.1 million Medicaid consumers with the possibility of no meaningful savings. That's taking quite a risk at the expense of many of the Commonwealth's most vulnerable citizens.

Pharmacy Carve Out

DPW's first major proposal is to carve pharmacy services out of HealthChoices. DPW proposed a Carve Out in the FY 2006/07 budget, but the Legislature included language in the final budget that prohibited Carve Out during the current fiscal year.

Integration of services and coordination of care is integral to the model of MCO managed care. If the Carve Out proposal is implemented, one million Medicaid consumers will be forced into a fragmented service delivery model – with the MCOs responsible for their medical care, but DPW directly responsible for their prescription drugs. This would include carving out the injectibles and other prescription drugs administered in the physician's office – the physician who is otherwise credentialed and contracted with the MCOs. We are also concerned that the proposed weekly transmission of pharmacy data to the MCOs would hinder patient care, as the need for real-time pharmacy data is critical to ensuring effective case management on a daily basis.

DPW commissioned a study on the Pharmacy Carve Out from its contactor, Mercer Consulting. The Mercer study actually states that the MCOs have **more effective** pharmacy utilization management programs. All of the assumed savings from a Pharmacy Carve Out come from pharmacy rebates DPW says that it will collect. The report acknowledges that, without the DPW rebates, pharmacy costs would **increase** under a Carve Out.

With this as background, it is important to scrutinize the Mercer study's assumptions. There appear to be several flaws that may significantly overestimate the savings potential of Pharmacy Carve Out.

- The study used 2004 MCO pharmacy experience that was trended forward, not actual 2006 data. In the past two years, MCOs have continued to improve their

pharmacy management strategies and have successfully managed low pharmacy cost trends.

- The study appears to have over-estimated the actual MCO net cost per prescription (net of rebates) by 11.3%. At the same time, it inflates the assumed rebate savings under a Carve Out by projecting brand rebates for at least 11 % of MCO drugs that are actually generics.
- The study appears to have under-estimated the actual MCO generic dispensing ratio. MCO generic utilization continues to increase rapidly. This issue alone results in an approximately \$156 million over-estimation of total MCO pharmacy costs. This both skews the difference between MCO and DPW pharmacy costs as well as the projected savings.

The report did not estimate the reduction in rebate savings from several key brand drugs that are scheduled to come off patent in the next 12-36 months (i.e., Norvasc, Coreg, Clarinex, Fosamax, Advair, Effexor XR, Risperdal).

- The report estimates a rebate collection figure that is 40% higher than DPW's estimates at this time last year.
- DPW's assumed savings from supplemental rebates appears to be higher than the savings other states have achieved in their supplemental rebate programs. This

includes states like Florida, which have a national reputation for their successful results in rebate collection.

- The report also assumes DPW's management of the Carve Out will maintain the same pharmacy utilization patterns and generic dispensing rates currently achieved by the MCOs. This is a faulty assumption, since the report acknowledges that the MCOs manage pharmacy utilization better.

DPW plans a 90-day transition period at the beginning of the Carve Out, during which they will fill existing prescriptions for consumers, whether or not the drug is on DPW's Preferred Drug List. AmeriHealth Mercy's Pharmacy division recently managed a similar transition during the start of Medicare Part D when the Medicare Program instructed us to stop doing pharmacy edits and prior authorization. In that 90-day period (fourth quarter, 2006), our Medicare prescription drug usage jumped 34%. It is unclear whether DPW has planned for a similar utilization and cost increase in its projected savings figure.

And, remember the upheaval and confusion during the implementation of Medicare Part D? DPW needs to be very well-prepared for an influx of calls, complaints, letters and appeals from the million members and their families who will be affected by the Carve Out.

What does all this mean? We believe it calls into serious question whether DPW can meet the savings projections outlined in the Governor's budget.

If DPW and Mercer have underestimated the pharmacy utilization under a Carve Out, each 1% increase in utilization would reduce projected annual savings by as much as \$8 million. If they have overestimated the amount of rebates they can collect, this would also reduce the savings. If they have underestimated the financial impact of the three-month transition period, this would reduce the savings. As major drugs go from brand to generic, this will reduce the savings. Today, DPW manages the pharmacy benefit for 290,000 ACCESS Plus consumers. The MCOs manage the pharmacy benefit for more than a million Medicaid members. DPW would need to execute an absolutely flawless transition of these one million people in order to preserve the \$45 million that they have estimated as savings from Carve Out.

Elimination of Voluntary Manned Care

The proposal to eliminate Voluntary Managed Care is the latest in a series of puzzling steps that DPW began with the launch of the ACCESS Plus Program. For many years, through both Democratic and Republican Administrations, the Commonwealth's plan for Medicaid had been to expand HealthChoices statewide. Voluntary Managed Care was an interim measure until HealthChoices could be phased in across the State. Then, DPW abruptly changed direction and introduced ACCESS Plus. Even then, however, consumers in 26 counties could still choose a Voluntary MCO.

With this new proposal, DPW is eliminating that consumer choice. The immediate impact will be a disruption in care for 71,000 Medicaid recipients. Consumers with disabilities and chronic care needs will lose their current nurse case managers.

Consumers could be forced to change prescription drugs. Many will receive fewer benefits than they get today from Voluntary MCOs. Many will pay higher copays for doctor visits. DPW acknowledges that fewer primary care physicians, specialists and dentists participate in ACCESS Plus than with the Voluntary MCOs, so consumers' access to care will also suffer.

Providers will be affected. AmeriHealth Mercy has been able to offer higher compensation to physicians and hospitals, which is offset by the savings from our care coordination and case management programs. This will end with ACCESS Plus.

Once again, in this proposal to eliminate Voluntary Managed Care, DPW is relying upon a report prepared by Mercer. On one hand, this report says that ACCESS Plus is more cost effective than Voluntary Managed Care. At the same time, the report contains an entire chapter of "caveats" that describe why the results are not conclusive. In fact, the authors caution that more data is necessary before a decision is made.

"With additional data and experience, the Commonwealth can make informed decisions about the future of both the ACCESS Plus and voluntary managed care programs and measure progress over time.

DPW has said recently that ACCESS Plus offers quality of care comparable to that provided by the MCOs. There appears to be little evidence to back up that statement. The Mercer study specifically says it does not address quality. DPW has provided some comparison information in public meetings. In that data, ACCESS Plus scored lower than all the Voluntary Managed Care Plans on 14 quality measures, and approximately equal to the Voluntary **MCOs** on only two. Furthermore, all of the Voluntary Managed Care Plans are accredited by the National Committee on Quality Assurance (NCQA) and rank among the nation's top Medicaid Health Plans according to *US News and World Report*. ACCESS Plus is not an NCQA accredited program, the "gold standard" for managed care.

Aside from the significant deficiencies in the Mercer cost comparison, the Department's struggle to effectively manage the delivery of health care services to its existing ACCESS Plus and Fee for Service population should be a cause for concern. AmeriHealth Mercy routinely receives phone calls requesting our help in coordinating care for ACCESS Plus and Fee for Service members. Often, it is DPW staff making these requests. Some very recent examples are:

- **Case #1:** The DPW Special Needs unit contacted us in late February for assistance with a 53 year-old diabetic ACCESS Plus enrollee. The individual was scheduled to enroll in AmeriHealth Mercy. He needed refills on insulin and narcotic medications before then. ACCESS Plus was unable to find a physician who would see the individual and prescribe his

medications. We were able to coordinate an emergency appointment with one of our participating physicians, on behalf of ACCESS Plus.

- **Case #2:** Children and Youth contacted us for assistance coordinating care for two children, ages 15 and 16, enrolled in ACCESS Plus who were placed in foster care. The Children and Youth staff reported not having support from ACCESS Plus to assist with complex cases and medical interventions.
- **Case #3:** Clinical staff from our affiliated Medicare Managed Care Program have been looking for a Medicaid Fee for Service contact person to help coordinate care for the elderly and disabled dual eligibles. DPW staff reported last week that there is no one designated within DPW to do that coordination.
- **Case #4:** DPW has repeatedly asked the MCOs to help them convince our participating dentists to enroll in the ACCESS Plus/Fee for Service network. They are having considerable difficulty in recruiting dentists on their own.

Conclusion

What is the combined impact of the two proposals from DPW? The quality and continuity of health care for 1.1 million of our most vulnerable citizens will be disrupted. The Commonwealth will assume direct financial risk for \$1 billion in HealthChoices pharmacy costs and approximately \$200 million in Voluntary Managed Care costs that are currently borne by the MCOs.

These proposals also have the very real potential to destabilize MCO Managed Care in Pennsylvania. Pharmacy accounts for a very significant portion of the revenue the HealthChoices MCOs receive (25% for AmeriHealth Mercy; 19% for Keystone Mercy). Voluntary Managed Care also represents a significant source of revenue for several MCOs.

Whether intentional or not, the Department is undermining Pennsylvania's Medicaid Managed Care Program. Last year it was the dual eligibles. This year it is Voluntary Managed Care and Pharmacy Carve Out. A brick here, several bricks there and, eventually, the whole wall will crumble.

Given the apparent flaws in the assumptions used to formulate both studies, the need to execute a flawless transition to preserve the projected savings, DPW's difficulties in providing access in the current system, and DPW's relative inexperience collecting supplemental pharmacy rebates, we would urge the Legislature to consider these two proposals very carefully. Is it really the best public policy decision for the

Commonwealth to assume financial risk for an additional \$1.2 billion in Pharmacy and
Voluntary Managed Care expenditures and disrupt the care of nearly 1.1 million
Medicaid recipients?