AmeriHealth Mercy: Testimony concerning Proposed Pharmacy Carve Out.

Text of April 29 testimony.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
PUBLIC HEARING:
Office of Medical Assistance Programs
Department of Public Welfare
Proposed Pharmacy Carve Out
Tuesday, April 29, 2008

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

Chairman Oliver, Chairman Kenney, members of the Health & Human Services Committee, thank you for inviting me to testify today about the impact of the Governor's budget proposals for State Fiscal Year 2008-09 on Pennsylvania's Medicaid recipients and the Medicaid managed care plans serving this population.

My name is Sherry Knowlton. I am the Senior 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 400,000 Medicaid recipients in 20 counties in Central, Northeast, and Southeast Pennsylvania. We have been providing managed care services to Pennsylvania's Medicaid population for nearly a quarter of a century. I believe I bring a somewhat unique perspective to our discussion today since I formerly served as the Deputy Secretary for Medical Assistance Programs in Pennsylvania.

I would like to preface my comments today by advising you that I cannot discuss the RFPs that the Department of Public Welfare (DPW) recently released for the HealthChoices Program. AmeriHealth Mercy and Keystone Mercy have submitted proposals in response to these RFPs, and the rules for the procurement process preclude me from discussing these RFPs today. I will focus my comments on the Governor's Budget proposals and the state policy and budget implications of a pharmacy carve out from Medicaid managed care.

I am sure the Committee recalls that DPW proposed a pharmacy carve out in FY 2006-07 and FY 2007-08, and I thank you for rejecting this proposal each year. We are here discussing this issue again today because the Administration is making the same pharmacy carve out proposal for the third consecutive year. AmeriHealth Mercy and Keystone Mercy continue to believe that a pharmacy carve out would have a negative impact on:

· approximately one million Medicaid consumers – your constituents – who would be forced into a DPW-run pharmacy program;

· the Medicaid providers who would need to absorb the administrative cost of navigating back and forth between DPW and the Managed Care Organizations (MCOs) to coordinate care for their patients;

· the MCOs who will have to pay the price when one of their Medicaid enrollees is unable to get the medication they need and lands in the Emergency Room; and

· Pennsylvania's taxpayers, who will foot the bill if the cost of Medicaid prescription drugs increases under a DPW-run pharmacy program.

DPW has asserted that their pharmacy carve out proposal is about saving money. If you look at carve out from a broad financial perspective, taking into consideration the downstream impact of fragmenting the current integrated health care delivery model, MCOs believe that pharmacy carve out may actually increase the cost of Medicaid rather than produce savings.

But pharmacy carve out is not just about money. More is at stake than dollars under DPW's proposal – we are talking about the lives of chronically ill and disabled children and adults. I am confident that you will agree that caring for the Commonwealth's most vulnerable citizens requires not only that we look at annual budget targets, but also thoughtfully examine, implement and maintain programs, like the current HealthChoices and voluntary managed care programs, that improve health outcomes and reduce the long-term cost of care.

What is a Pharmacy Carve Out?

Simply put, a pharmacy carve out means that DPW would take over direct management of Medicaid pharmacy benefits for MA consumers enrolled in the private managed care plans that contract with DPW. Today, the MCOs receive a fixed amount of money per member from DPW to cover all medical and pharmacy services. Under a pharmacy carve out, the MCOs will still be responsible to pay for medical services, but DPW will be directly responsible to coordinate and pay for pharmacy services which today comprise approximately 25% of total MCO expenditures, and total $900 million annually.

Why Would DPW Consider a Pharmacy Carve Out?

Federal law allows state Medicaid agencies to get the lowest possible price on prescription drugs from drug manufacturers through what is called "best price rebates." The law currently does not allow MCOs to get these same low prices, although we are working to change that. So all things being equal - if DPW was able to do as good a job as the MCOs at making sure MA consumers get the right medications at the right time, then DPW theoretically could spend less than the $900 million MCOs spend today on the prescription drug component of MA expenditures.

So Why Is Pharmacy Carve Out a Bad Idea for Pennsylvania's Medicaid Program?

The reality is that all things are not equal between DPW and the MCOs in terms of our respective ability to manage the pharmacy benefit. And, saving money in the Medicaid program isn't as simple as maximizing "best price" drug rebates.

The first question is whether the projected savings in the Governor's Budget is realistic. Last year we all spent considerable time discussing DPW's study by Mercer Consulting, which concluded that the "best price" drug rebates available to DPW offset the lower overall prescription drug use of MA consumers enrolled in managed care plans, and the MCOs' higher use of low-cost generic drugs. However, the Mercer study made several assumptions that may have significantly overestimated potential savings. These include the overestimation of the total number of prescription drugs paid for by the MCOs, as well as incorrect assumptions about the proportion of generic versus brand-name drugs dispensed to MA consumers enrolled in the MCOs. In short, the MCOs d id a better job managing pharmacy benefits than Mercer anticipated, which reduces the potential carve out savings.

We are also concerned about whether DPW has accurately estimated the cost of administering pharmacy benefits under a carve out. In recent testimony before the Appropriations Committees, DPW indicated that that they will not need to add much staffing to support pharmacy carve out. This is puzzling. The MCOs manage pharmacy benefits for approximately one million MA consumers, and collectively we receive an average of 83,000 phone calls each month from our members, physicians, and pharmacies related to pharmacy benefits. DPW will be directly responsible to answer these calls under a pharmacy carve out.

Unless DPW budgets for and hires significant additional staffing, how will they answer 83,000 more phone calls each month related to pharmacy services from MA consumers, doctors, and pharmacists who need their help making sure your constituents get the prescription drugs they need in a timely manner? When it doesn't work, these calls will go straight to your offices – like they did during implementation of the Medicare Part D program.

Aside from the problems with assuming that pharmacy cost savings can be achieved simply by maximizing best price guarantees, pharmacy carve out is a bad idea because it dismantles the existing integrated health care delivery model, which is essential to improving health outcomes and reducing health care expenditures.

The MCOs cannot provide the best coordinated health care services if we don't have the opportunity to directly manage the pharmacy benefit. Our approach looks at the whole person and what it will take to improve their health. Sometimes that means paying for very high cost prescription drugs to help avoid an ER visit or a hospitalization. Often that means bending our own rules to meet the special needs of a particular member.

Take Ben for example. Ben (not his real name) is a young school-aged boy enrolled in AmeriHealth Mercy who has severe asthma. Ben's parents are divorced and have a shared custody arrangement. With all of the transitions between mom, dad, and school, Ben's asthma medicine was often left behind somewhere. As a result, Ben's asthma was not under control and he was making unnecessary trips to the ER. Ben's AmeriHealth Mercy case manager suggested that we bend our rules, which would normally allow for only one 30-day supply of his medicine at a time, and instead allow Ben to get three prescriptions filled at the same time so he could keep supplies at both homes and at school. To get this done, Ben's case manager walked over to our clinical pharmac ist, e xplained the

situation, and got his OK right then and there. No one had to make extra phone calls to DPW to make this happen. We just did it because it was the right thing to do for Ben, and because paying for three prescriptions at the same time would cost us a lot less than paying for an ER visit when Ben forgot to pack his medication and had an asthma attack.

Would DPW do the same thing under a pharmacy carve out? Perhaps. But the decision could not be made right then and there. At best, it would involve a series of phone calls between the MCO case managers, pharmacists, DPW, and the child's doctor. And certainly DPW would not have a financial incentive to make the same decision since it would increase their costs three-fold. We knew that by spending more on Ben's medicine, we were reducing the likelihood that he would end up with an even more costly ER visit.

Impact to MA Consumers

There are many other concerns with the pharmacy carve out proposal. Contrary to statements made by DPW, a pharmacy carve out will not be transparent, and in fact, would disrupt the way in which approximately one million MA consumers receive their pharmacy benefits. Yes, MA consumers will be able to get their prescriptions from the same pharmacy, but a significant number of MA consumers will need to change drugs to those covered under DPW's Preferred Drug List (PDL). We did a quick comparison last week between the AmeriHealth Mercy and Keystone Mercy covered drug lists, and DPW's published PDL, for three categories of drugs: antidepressants, atypical antipsychotics, and cholesterol drugs. Currently, 34,215 Keystone Mercy and AmeriHealth Mercy member s take one of eight drugs in these three categories that are not covered by DPW. All of these members will need to change medications, or receive approval from DPW to stay on their current medicine. However, each time DPW allows an MA consumer to stay on a medication indefinitely that is not on DPW's PDL, the projected carve out savings will be reduced.

Also, in many instances DPW's PDL covers brand-name medications instead of their generic equivalent. DPW charges MA consumers higher copays for brand drugs than for generics, so every MA consumer forced to switch from a generic to a brand drug because of a pharmacy carve out will have a higher out-of-pocket cost as a result.

Today, MA consumers in HealthChoices have a choice of MCO drug formularies. If they want, they can choose a Plan based on the medication they are taking. Under a carve out, consumers will only have one choice – DPW's PDL.

Impact to MA Providers

Medicaid providers will be impacted as well. Today, MA providers coordinate medical and pharmacy care for their patients through the managed care plans alone. Under a carve out, they will spend increased administrative time and money navigating back and forth between the managed care plans and DPW. Doctors who dispense medication during an office visit, such as chemotherapy or an adult vaccination, today submit one bill to the managed care plan for the office visit and the cost of the drug. Under a carve out, they will need to submit two bills - one to the managed care plan for the office visit, and one DPW for the cost of the drug. Coincidentally, DPW will have no record of the office visit

in their claims system that would tie to the admini strati on of the drug, which certainly opens the door wide for potential fraud and abuse.

AmeriHealth Mercy has negotiated payment rates for some specialty physicians and for the medications they administer that exceed Medicaid fee-for-service rates. We are very concerned that we may lose these critical physicians from our network under a pharmacy carve out that would both reduce their reimbursement and increase the administrative hassle to their offices.

Impact to the Commonwealth Budget and Taxpayers

The Commonwealth and its taxpayers will be directly impacted by a pharmacy carve out unless DPW demonstrates that it is able to manage pharmacy benefits more effectively than Pennsylvania's HealthChoices and voluntary managed care plans, which are among the highest rated health plans in the nation according to the National Committee for Quality Assurance (NCQA) and U.S. News and World Report. We find it hard to believe that DPW can take over responsibility for pharmacy benefits for approximately one million additional people, coordinate pharmacy care seamlessly with the managed care plans, physicians and pharmacies, and make sure consumers get the right medication at the lowest possible cost, and do all of this with no additional staff suppor t.

A review of DPW's Preferred Drug List (PDL) quickly turns up missed opportunities for cost savings because DPW's PDL includes several brand-name medications instead of their cheaper generic equivalents. For example, Zoloft, a commonly prescribed antidepressant, appears on the DPW PDL as "preferred" over Sertraline, its generic equivalent. If DPW has negotiated discounts of as much as 36% with the manufacturer of Zoloft, they would still be paying approximately $57 per Zoloft prescription, whereas generic Sertraline would cost approximately $10 per prescription.

We compared DPW's published PDL (which we know to be incomplete because it is missing entire categories of drugs) to our own list of covered drugs. Our list of covered medications includes 264 more medications than DPW's published PDL. And yet, DPW lists 414 brand name medications in their PDL, whereas our formulary includes 248 brands.

This current carve-in model provides financial incentives for the MCOs to make sure that MA consumers receive the medical care and prescription drugs they need. If we fail to do a good job coordinating care for our members and their health deteriorates, we have to pay the bill out of the fixed payment from DPW. If it costs us more than the fixed amount we get from DPW, then we lose money. We can't ask for a supplemental appropriation to cover the shortfall, or delay our current payment obligations into a future budget cycle . Under a pharmacy carve out, the Commonwealth and its taxpayers will need to cover the cost if DPW exceeds its budget.

If DPW has underestimated the number of prescription drugs that will be dispensed to MA consumers enrolled in managed care plans, and we believe they have, each 1% increase in the number of drugs dispensed would reduce projected annual carve out savings by as much as $8 million. Each time a brand-name drug becomes available as a

generic, the carve out savings will be reduced. And every time an MA consumer is unable to get timely DPW approval of a medication to treat an urgent or chronic health condition, we increase the risk of that individual having an unnecessary and costly ER visit or hospitalization, thereby increasing total MA expenditures.

DPW has asserted that they manage pharmacy benefit for approximately 800,000 Medicaid consumers. However, approximately two-thirds of these individuals receive most of their prescription drugs through Medicare Part D or reside in nursing homes. The MCOs manage the pharmacy benefit for approximately one million Medicaid consumers. DPW would need to execute an absolutely flawless transition of these individuals just to preserve the $9 million that they have estimated as savings in FY 08-09.

Conclusion

Helping people get quality health care reduces health care costs. That is what managed care plans do, and what we have done very effectively in Pennsylvania for the past 25 years. We emphasize preventive care and wellness, and help those with chronic health conditions take control of their own health. Prescription drugs are a critically important to helping people with chronic illness improve their health status, and avoiding unnecessary expensive ER visits and hospitalizations.

Pharmacy carve outs eliminate the financial incentive to care for the whole person in a way that reduces costs over the long-term. Instead, it creates incentives to make health care decisions based on short-term costs only, rather than what represents the best quality care and reduces costs over time.

Given the apparent flaws in the assumptions used to formulate the carve out study, the impact to MA consumers and providers, the need for DPW to execute a flawless transition to preserve the assumed savings, and the negative impact that pharmacy carve out will have on overall care coordination, we urge the Legislature to consider DPW's pharmacy carve out proposal very carefully. Is it really the best public policy decision for the Commonwealth to have DPW take direct financial responsibility for $900 million in Medicaid pharmacy expenditures and disrupt the existing integrated health care delivery model for one million Medicaid consumers?

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Conclusion

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Given the apparent flaws in the assumptions used to formulate the carve out study, the impact to MA consumers and providers, the need for DPW to execute a flawless transition to preserve the assumed savings, and the negative impact that pharmacy carve out will have on overall care coordination, we urge the Legislature to consider DPW's pharmacy carve out proposal very carefully. Is it really the best public policy decision for the Commonwealth to have DPW take direct financial responsibility for $900 million in Medicaid pharmacy expenditures and disrupt the existing integrated health care delivery model for one million Medicaid consumers?

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