PENNSYLVANIA STATE HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

PUBLIC HEARING: *MANAGED CARE PANEL*

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Ms. Mandarino, members of the 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 going to focus my testimony today on DPW's proposal to Carve Out Pharmacy from HealthChoices managed care. We are also concerned about the plan to eliminate Voluntary Managed Care and delay payment to MCOs. I am submitting information in my written testimony that touches on those two issues. We believe that the combined DPW 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.

Pharmacy Carve Out

DPW's proposal to carve pharmacy services out of HealthChoices is not a new one. 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, over 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 $45 million in State fund 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.
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- 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.

AmeriHealth Mercy and Keystone Mercy are also concerned that we, as MCOs, will be at financial risk for the medical expenses if our members do not get prescription drugs that are timely and medically appropriate. We are concerned that if members have difficulty, both during the transition period and after, in getting the right medication, it could result in unnecessary Emergency Room visits and hospitalizations. We do not believe that DPW has budgeted for those costs in the MCO rates. And, these are real concerns.

For example, just this past Sunday, DPW's pharmacy claims adjudication system was down from at least 9am until just before 1pm. During that time, one pharmacy in Chambersburg with a high volume of ACCESS Plus patients had more than 45 prescriptions it could not fill. Two of these patients needed their medication urgently, so the pharmacist was kind enough to dispense a few tablets and ask the patients to return later for their full prescription. When the pharmacists called the phone number for DPW pharmacy claims issues, there was a recorded message stating DPW's business hours (weekdays only). The call was then auto-disconnected.

In this example, a crisis situation may have been averted by the willingness of the pharmacist to dispense a limited supply of urgently needed medication with no guarantee of payment. Whether a different pharmacist would have been as accommodating is unknown. Given the circumstances of many MA recipients, it could be very difficult for them to return to the pharmacy at a later time for their prescriptions. The inconvenience to the pharmacist and patients is clear, but is mild in comparison to what could have occurred, and indeed may still occur, when a patient encounters these roadblocks to obtain life-sustaining medication.

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. And, it is impossible to put a price tag on the potential human cost that a disruption in health care could bring to consumers.

Today, DPW says it manages the pharmacy benefit for 800,000 total recipients. However, most of those are in long-term care arrangements and/or are Dual Eligibles whose primary pharmacy benefits are through Medicare Part D. The bulk of DPW's current pharmacy management is for 290,000 ACCESS Plus consumers. In comparison, the MCOs manage the pharmacy benefit for more than a million Medicaid members. Adding the pharmacy benefits for the 71,000 proposed to move from Voluntary Managed Care to Access Plus, raises the total affected by a pharmacy transition to 1.1 million.

DPW would need to execute an absolutely flawless transition of these 1.1 million people in order to preserve the $45 million that they have estimated as savings from Carve Out and the $23 million they have estimated from eliminating Voluntary Managed Care.

Conclusion

What is the impact of this proposal 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 over $1 billion in HealthChoices pharmacy costs that are currently borne by the MCOs.

This proposal, especially when combined with the other MCO-related budget proposals, has 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.

These proposals are the 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. 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.

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 Pharmacy Carve Out, Voluntary Managed Care and a payment delay. A brick here, several bricks there and, eventually, the whole wall will crumble.

Given the apparent flaws in the assumptions for the Pharmacy study, 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 this proposal very carefully. Is it really the best public policy decision for the Commonwealth to assume financial risk for more than one billion dollars in Pharmacy expenditures and disrupt the care of nearly 1.1 million Medicaid recipients?

Attachment A
Elimination of Voluntary Managed 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 *U.S. 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 report 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.

DPW has assumed a $23 million State fund savings from the elimination of Voluntary Managed Care. However, much of that comes from cash flow savings so that the second year savings projection drops to $12 million. The estimated savings are based on a flawed report with significant shortcomings that raise considerable doubt that DPW could achieve any meaningful savings. However, 71,000 consumers would have their health care delivery compromised. That is taking quite a risk at the expense of many of the Commonwealth's most vulnerable citizens.

Attachment B
MCO Payment Delay

DPW is proposing to delay payments to the MCOs in FY 2007/08. DPW is characterizing this proposal as a "contract change"; however, the effect is that MCOs would receive payment for only 11 of the 12 months in the fiscal year.

DPW has advised the MCOs that it will make a one-time payment to the MCOs to mitigate the cash-flow impact of the payment delay. However, the details of this plan have not been shared with the MCOs.

Delaying payments to the MCOs will likely result in the MCOs needing to borrow money to be able to make timely payments to physicians. We find it ironic that we are legally obligated to make timely payments to physicians, yet DPW does not feel obligated to extend the same courtesy to its contracted MCOs. This is illustrative of what has become everyday practice by DPW. At any given time, AmeriHealth Mercy and Keystone Mercy have outstanding receivables from DPW totaling millions of dollars. While DPW has made efforts to resolve issues with outstanding receivables, the problem remains. DPW's proposal to delay payments to the MCOs will further compound this issue, and make it increasingly difficult for us to manage our business effectively and efficiently.