

MERCER



MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Senate Public Health and Welfare Committee

April 29, 2008 Public Hearing

Department of Public Welfare's Medicaid Pharmacy Transition Proposal

Testimony Presented by:

Frederick Gibison, MBA

Principal

Mercer Government Human Services Consulting,
a part of Mercer Health & Benefits LLC

Mr. Chairman and other Committee members, thank you for the opportunity to present my testimony regarding the Department of Public Welfare's proposed initiative to transition the Medicaid drug benefit from the capitated managed care plans to the Department.

My name is Fred Gibison, a Principal with Mercer Government Human Services Consulting, a part of Mercer Health and Benefits based in Phoenix, Arizona. My primary role is to lead Mercer's actuarial/financial engagement with the Department, which I have done since 1999.

Mercer specializes in assisting state governments in becoming more efficient and effective purchasers of health care services. We currently work in over 20 states, including Florida, New York, New Jersey, California, Massachusetts, Arizona, Georgia and Pennsylvania. We employ a variety of professionals, including actuaries, accountants, pharmacists, clinicians, IT systems staff and other related subject matter experts.

Mercer has been the Department's actuarial/financial consulting partner since 1995; working together to implement a variety of programs and initiatives, including the implementation of the HealthChoices and ACCESS Plus programs. As an independent consultant, our role is to advise the Commonwealth on matters pertaining to the MA program, provide technical expertise and help the Commonwealth overcome its challenges.

One such challenge, is sustaining an efficient and effective MA program that today consumes 20 percent of the Commonwealth's general fund and serves nearly 2 million

Pennsylvanians. This pharmacy initiative is one such solution to save taxpayer money, simplify the administration of the Medicaid drug benefit and avoid having to reduce eligibility or benefits.

As the Department's consultant, Mercer has been significantly involved in this initiative. We provided two separate reports; the first being a December 2006 comprehensive comparative financial analysis, and then a March 2008 supplemental report. Please allow me to highlight key points in each report.

As it pertains to Mercer's December 2006 report:

- This was a highly technical and complex report. Significant time was invested by both Mercer and Department staff.
- Our 2006 report was intended to estimate, evaluate, and analyze the financial differences between the MCOs and the Department as payers of the Medicaid drug benefit.
- Using the MCOs' own reported pharmacy price discounts, dispensing fees and rebates, applicable to the SFY 06–07 time period, Mercer estimated the MCOs' projected pharmacy spend at approximately \$810 million.
- Using the Department's applicable pharmacy price discounts, dispensing fees and rebates, Mercer estimated the Department's projected pharmacy spend at approximately \$513 million.

- In producing this financial comparison, the following key observations became apparent:
 - There is not a significant difference in the per prescription cost between the Department and the MCOs before rebates are factored into the equation
 - When rebates are accounted for, the difference between the MCOs' and the Department's total cost is substantial, which is evidence of the Department's superior advantage in collecting significant savings from rebates
 - Due to current federal law, drug manufacturers are required to give the Department rebates. This requirement does not extend to the MCOs.
 - Accordingly, the MCOs average about 4–5 percent in rebate savings as compared to the Department's total rebate savings that average in the high 30 percent range.
- Based on the methodology used, I believe our 2006 report was sound and is useful for evaluating options such as the one proposed by the Department.

As it pertains to our March 2008 supplement report, (copies of which have been provided):

- This was not intended to be another technical report, nor a redo of our 2006 analysis. Our 2006 report stands on its own merits.
- Our supplement report reiterates that the Department, as a good steward of the MA program, is obligated to explore options that will maximize the Commonwealth's limited resources to serve those who depend most on the MA program.

- We also wanted to address the primary objections received from interested parties concerning our 2006 technical analysis. Specifically:
 - Focusing solely on generic drug use is not always the best strategy for a purchaser like the Department. Instead, the Department has pursued a more optimal strategy aimed at producing the lowest total drug cost, while maintaining quality and access.
 - The MCOs may constrain drug costs by promoting generics, but the Department has leverage and purchasing power that the MCOs do not have, thus focusing the discussion on just promoting generics is erroneous.
 - The Department has shown its ability to collect millions of dollars in supplemental rebates – beyond the mandatory federal rebates – from drug manufacturers, representing real savings to the program with no negative impact on the Medicaid consumer.
 - Pharmacy data is generally considered the easiest data to transmit electronically and the Department has already implemented steps to make data readily available to the MCOs to ensure continuity and positive patient care practices.

- In the 2008 supplement, we wanted to present more current information on the financial advantage the Department has over the MCOs in purchasing drugs for Medicaid consumers.
 - In SFY 06–07, the Department collected \$144 million in rebates – equating to over 39 percent savings. The MCOs reported collecting \$41 million in rebates that equates to about 4 percent savings.

- On a per drug claim basis, the Department collected nearly 7 times the amount of savings than the MCOs.

- We also wanted to highlight the many achievements and improvements the Department has made to its own internal operations to effectively manage the drug benefit; many such improvements mirror those found in the managed care industry. The Department:
 - Implemented a preferred drug list to ensure appropriate utilization of drugs and related quality and patient safety controls
 - Created, staffed and expanded a new Pharmacy Division with dedicated clinical staff and a call center
 - Negotiated supplemental rebate savings with drug makers, in addition to the existing federally-required rebates
 - Established a Pharmacy and Therapeutics Committee that is open to the public with consumer participation
 - Increased the Department’s prescription drug generic dispensing rate to over 60 percent

- Our supplement also documents the data-sharing processes the Department already has in place or is implementing to directly support the MCOs’ ongoing care management responsibilities for their enrolled members.
 - Instead of the MCOs outsourcing the drug benefit to their PBM and/or using an external pharmacy claims processor, the Department will act as a uniform pharmacy

manager; providing data directly to the MCOs similar to how managed care plans and PBMs/claims processors work together now.

- The Department's proposal simplifies the policies and procedures for providers to follow because providers will not have to work with several different MCO drug formularies, differing MCO prior authorization guidelines or multiple MCO call centers. The Department represents a single point-of-contact.

- Our supplement also highlights that several other State Medicaid Agencies have also chosen to retain responsibility for the Medicaid drug benefit in their respective programs.
 - 10 states plus the District of Columbia do not have drugs included in MCO capitation rates
 - 9 additional states have only limited pharmacy drug classes included in MCO rates

Wisconsin recently transitioned responsibility for the Medicaid drug benefit from the capitated MCOs to the State in February 2008. According to State officials, this process has gone smoothly. Additionally, Connecticut is reprocurring its Medicaid MCO program and the State will retain management of its drug benefit.

As a direct result of the Department's operational and financial achievements, the Department's pharmacy management program is more comparable to the managed care sector than to old-fashioned, unmanaged fee-for-service. Therefore, any other study on the virtues of carving-out drugs from an MCO program that does not take into consideration the

specific and current operational and financial qualities found in the Department's program is unfair and misrepresents the Commonwealth.

For example, opponents of a drug carve-out say that it will move a program back towards unmanaged fee-for-service settings, and that the savings from a state's rebate advantage may be off-set by overall cost and utilization increases. I would agree that if a state opted to carve-out drugs from an MCO program before improving, modernizing and re-engineering the state's operational and financial oversight of the Medicaid drug benefit, the result could lead to overall cost increases. However, the Department has clearly demonstrated the significant improvements to its oversight and accountability of the Medicaid drug program.

Additionally, even these opponents note that carve-out arrangements in capitated Medicaid managed care programs are fairly common for behavioral health, dental, transportation and pharmacy benefits. Pennsylvania is no different; Medicaid consumers today are required to obtain behavioral health services, non-emergency medical transportation, home- and community-based services and other services through entities other than their PH-MCO. The Department will need to communicate with and educate consumers regarding this initiative, but the Commonwealth has proven processes to perform this function.

And finally, those who oppose a drug carve-out note that implementing such a drug carve-out can motivate MCOs to push as much drug usage as possible because drugs become "free" to the MCOs. This statement seems to contradict other comments made by these same groups regarding the MCOs' goal of managing the whole person and engaging the

consumer in disease and case management programs. The quality of a Medicaid consumer's medical care should not be determined by the services the contracted MCOs have to actually pay for.

For Pennsylvania Medicaid consumers enrolled in the HealthChoices MCOs, the Commonwealth pays for drugs through the HealthChoices program today, but with this proposal the Commonwealth will become a direct purchaser, and thus an adjustment to the HealthChoices capitation rates is necessary. This adjustment ensures the Commonwealth does not double pay for the Medicaid drug benefit. Regardless of whether pharmacy is in or out of a state's Medicaid MCO program, Mercer's actuaries will develop and certify rates that are appropriate for the populations and services covered by the respective managed care program as we always have.

Health care is ever-changing, and the Department is faced with the challenge of sustaining a MA program that is vital to the needs of many Pennsylvanians. Through the Department's proposal, there is a clear and compelling opportunity for the Commonwealth to save money, simplify the administration of the MA drug benefit and minimize any change that directly impacts the consumer.

In conclusion, because the Department has modernized, enhanced and improved its management of the Medicaid drug benefit, in Mercer's opinion, the Department is well-positioned to take on this responsibility, maximize the Commonwealth's purchasing power to save money and partner with the MCOs to maintain quality of care for the consumer.

I hope my testimony today has been helpful and informative to you for purposes of evaluating the merits of the Department's proposal.

Thank you.