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Statement of
Margaret A. Murray, Chief Executive Officer
Association for Community Affiliated Plans (ACAP)
to the
Pennsylvania Senate Public Health and Welfare Committee

On Medicaid Managed Care Carve-Outs of Prescription Drugs
April 29, 2008

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Introduction

Chairman Erickson, Vice Chairwoman Vance, Minority Chairman Hughes, members of the Committee, thank you for the opportunity to testify today before the Senate Public Health and Welfare Committee. My name is Meg Murray and I am the Chief Executive Officer for the Association for Community Affiliated Plans (ACAP). Before I begin, I want to thank you for holding this hearing. The Medicaid program is a vital source of care for more than 40 million Americans and it is important that state legislatures do everything they can to properly understand its complexities and nuances as state governments look to change the program. Hearings like this go a long way in fostering a greater understanding of Medicaid.

About ACAP and Safety Net Health Plans

ACAP is a national trade association representing “safety net health plans” that are Medicaid-focused (75% of the plans’ enrollees have Medicaid or SCHIP coverage) and are non-profit or owned by non-profit entities like public hospitals or community health centers, including AmeriHealth Mercy and UPMC *for You*. ACAP’s mission is to improve the health of vulnerable populations through the support of Medicaid-focused community affiliated health plans committed to these populations and the providers who serve them.

As of April 2008, ACAP represents 37 plans serving over 4.5 million Medicaid beneficiaries in 21 states. ACAP plans serve one of every four Medicaid managed care pre-paid enrollees. I have included a list of ACAP’s member health plans at the end of my written statement for your review.

Carving Prescription Drugs Away from Medicaid Health Plans Threatens Quality of Care and the Ability to Plans to Effectively Coordinate Services

Several state Medicaid programs are evaluating whether to take management of pharmacy benefits away from private Medicaid health plans in order to take advantage of a federal law requiring drug manufacturers to offer the lowest drug prices to state Medicaid programs. This federal law does not allow private health plans to get these same low prices, although ACAP is working to change that. Even though state Medicaid agencies have the advantage of lower drug prices from drug manufacturers, managed care plans typically do a better job than Medicaid fee-for-service programs at encouraging Medicaid consumers to use less costly generic drugs and at reducing unnecessary use of prescription drugs, offsetting the lower price paid for each drug by Medicaid fee-for-service. A report for the Center for Health Care Strategies (CHCS) found that MCOs are able to reduce their average per member per month (PMPM) drug

costs for families in Medicaid managed care to $17.36 compared to $20.46 in the state fee-for-service programs – a savings of 15 percent[1].

Most states with Medicaid managed care continue to include most drugs in their capitation. According to a survey by NASMD of 32 states, in 2007 13 states included all drugs in managed care and nine included most drugs but carved out some drugs. Only 11 carved all drugs out of managed care.

As most state Medicaid agencies have decided, maintaining management of pharmacy benefits with the managed care plans is important not only for fiscal reasons, but also for programmatic and quality reasons.

Last year ACAP contracted with The Lewin Group to analyze the pros and cons of using a "carve-in" versus a "carve-out" approach for pharmacy benefits within Medicaid managed care programs. In short, Lewin concluded that the "programmatic advantages of a carve-in approach, without question, substantially outweigh[ed] the programmatic advantages of a carve-out model." Specifically, Lewin found that:

- Carve-in arrangements allow for improved care coordination as pharmaceutical and other medical benefits are managed under one entity versus relying upon communication and data exchange between multiple entities to coordinate an individual's care. Carve-ins also align incentives to effectively address the "total person" from both a clinical and cost perspective.
    - For example, ACAP health plans like AmeriHealth Mercy and UPMC *for You* routinely generate internal pharmacy reports that identify members with late refills or no refills of medication for chronic disease such as asthma or diabetes. This information is matched with internal case management information for individual members. The health plans' nurse case managers then contact members to offer education about how to take their medication. At the same time, they make sure members get their medication refills on time and they develop a plan for ongoing monitoring and support. They also coordinate with the prescribing physician if they identify a member who is not using their medication as directed, or if the prescribed medication is not working.
- MCOs managing pharmacy benefits have the capability to access in-house pharmacy and medical claims data in real time, which is valuable for tailoring specific health interventions to promote improved health outcomes, for identifying and addressing instances in which a member is taking several different medications for the same condition, and for positively influencing physician prescribing patterns to identify quality and cost issues.

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[1] Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting, Beronja et. all., January 2003. Study is available at no cost at following website: www.chcs.org

  - For example, Health Plans like UPMC *for You* include on their formulary expensive drugs that improve compliance or reduce side effects because they save money in ER, hospital or physician office costs.

- Pharmacy carve-in arrangements allow MCOs a unique opportunity to monitor closely in real time all prescription drugs that members may be currently taking, which assists with immediately identifying members who would benefit from case and disease management, and in addressing overuse and misuse of prescription drugs. The Plans can also use their own information systems to identify quickly any previous communications with the member or provider about care coordination, as well as any decisions that have been made.

  - For example, real time internal pharmacy data can identify members with multiple physicians prescribing oxycontin and other drugs with abuse potential without the other's knowledge.

- Pharmacy carve-outs also create a range of operational challenges as Medicaid consumers, providers, MCOs, and state Medicaid agencies must continually sort through how the various parts of the benefit package are administered. MCO enrollees in a carve-out model, for example, typically need to carry multiple health insurance cards and are often ill-positioned to keep track of which card is needed for a given type of service.

- In addition, Lewin found that maintaining the pharmacy benefit with the MCOs can create savings through greater reliance on low-cost prescription drugs and overall lower use of prescription drugs. This study documents that on average, 75 percent of the prescription drugs paid for by the MCOs are lower-cost generics, whereas only 55-63 percent are low-cost generics when there is a pharmacy carve out. This study also quantifies that the total number of prescriptions paid for by the MCOs is 8 percent lower in the carve-in setting than the carve-out environment, after adjusting to match up the demographic mix of the populations in each setting. In addition, plans assert they pay dispensing fees that are significantly lower than those paid by states. UPMC *for You* pays approximately three times less than the fee-for-service program for dispending fees.

- Lewin also performed analyses of the number and type (generic vs, brand) of prescription drugs used by MA consumers enrolled in the same health plan under both a carve-in and carve-out environment. This comparison is possible because of the way New York structures their pharmacy benefits for children in their Child Health Plus (carved-in) and TANF Medicaid (carved-out) programs. Lewin reviewed the pharmacy program experience for children ages 1-5 and ages 6-17 in both programs and found that children the Child Health Plus (pharmacy carve-in) program used 4 percent more generic medications. Even more striking, Lewin found that children in the TANF Medicaid Program (pharmacy carve out) had

considerably higher prescription drug use, often more than 20 percent higher than their counterparts in the Child Health Program. This is a strong comparison in that Lewin was analyzing the same MCO in the same state, and the only difference is SCHIP vs. Medicaid (and their associated pharmacy benefits design).

Lewin concluded that the "programmatic advantages of a carve-in approach, without question, substantially outweigh[ed] the programmatic advantages of a carve-out model."

Other Studies Found Savings From Keeping Drugs Carved into Managed Care

A previous Lewin report for the Center for Health Care Strategies on Arizona's consideration of a drug carve out found that*:* "Pharmacy costs in the AHCCCS program are the lowest that have been achieved in the Medicaid setting. Arizona's PMPM costs for aged, blind, and disabled eligibles were found to be the lowest in the nation, 38 percent below the national Medicaid average (after taking into consideration the large rebates other states receive)…Based on our qualitative and quantitative research, **we attribute this performance to the AHCCCS health plans**."

At the time of the report, Arizona had been considering carving prescription drugs out of the control of the Medicaid health plans in an effort to generate savings from the Medicaid drug rebate. Lewin addresses this in their report…

> *"In modeling the impacts of a carve-out, we estimated the incremental value of the federal rebates under a carve-out to be approximately $40 million annually. (This incremental value is the amount by which the federal rebate revenue would exceed the rebate revenues obtained by the health plans in FFY 2002.)…Our best estimate is that offsetting costs (including administrative costs and costs associated with a changing drug mix and volume) will exceed the $40 million in rebate savings,* ***resulting in net annual costs of a carve-out of approximately $3.7 million in state funds****. At a projected $7 million, net administrative costs are significant but not the driving cost factor associated with a carve-out. The key costs projected are those associated with a more expensive volume and mix of drugs that are likely to result under a carve-out."*

In short, Lewin found that Arizona would actually have lost money if it had carved prescription drugs out of the managed care plans because the State would have removed MA consumers from the health plans' drug management programs and exposed them to less coordinated and managed systems of care.

Last year the State of Rhode Island was considering a Medicaid pharmacy carve-out for a to-be-implemented managed care program for SSI adults. The Lewin Group did a study comparing the overall pharmacy costs under Medicaid fee-for-service for the SSI adult population to the projected costs if pharmacy was managed by a safety-net health plan. Based on historical FFS patterns and the safety-net provider's strong track record of effective and efficient pharmacy management for the TANF population, the Lewin study found that keeping the management of pharmacy services with the health plan would cost 7 percent less than a pharmacy carve out.. The State ultimately decided not to carve the drugs out of the SSI managed care program.

Conclusion

Given the findings above, we strongly oppose Pennsylvania's efforts to carve prescription drugs away from the health plans and instead urge the Commonwealth to maintain the integrity of coordinated care by ensuring that prescription drugs remain part of a holistic strategy of care management.

At this time when state governments are forced to make tough decisions to identify savings in their budgets, ACAP believes the proposal to carve prescription drugs away from the care coordination system of Medicaid health plans is a short-sighted solution that will certainly undermine care for MA consumers and cost additional taxpayer resources over the long term. We strongly urge you to oppose the effort to carve prescription drugs away from the health plans and maintain the integrity of the care coordination systems available to Medicaid beneficiaries through health plans.

One commonsense solution to the Commonwealth and federal governments' need for Medicaid savings while maintaining the quality of the managed care program would be to address the disparity between the rebates that states get through the federal drug rebate program and what plans can negotiate on their own.

We urge you to encourage your Representatives and Senators in Washington to cosponsor the Medicaid Prescription Drug Rebate Equalization Act (S. 1589) that would allow Medicaid health plans to access the federal drug rebate program. This bill has been cosponsored by a bipartisan group of Pennsylvania Congressmen, including Representatives Robert Brady, Mike Doyle, Chaka Fattah and Todd Platts. This legislation would provide significant federal and state savings while ensuring that health plan enrollees' can continue to access prescription drugs as part of a coordinated care management system.

This concludes my statement and I would be happy to answer any questions the Committee may have. Thank you.

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Short Biography for Meg Murray, Chief Executive Officer
Association for Community Affiliated Plans (ACAP)

As the founding CEO of the Association for Community Affiliated Plans (ACAP), Ms. Murray has led the organization since its inception in 2001, steering it through tremendous growth from its origins as an Association of 14 community health center-owned plans to 37 safety net plans, covering over 4 million people on Medicaid and Medicare. ACAP's mission is to represent and strengthen not-for-profit, safety net health plans as they work in their communities to improve the health and well being of vulnerable populations.

Ms. Murray is a national expert on health care policy for low income people and is a frequent speaker on these issues at national conferences and in the media. She has also published several articles on the German health care system as a result of an Alexander von Humboldt fellowship in Berlin.

Ms. Murray received her MPA from the Woodrow Wilson School of Princeton University and her B.A., cum laude, in Economics and Classical Civilization, from Wellesley College.

Prior to leading ACAP, Ms. Murray was the Medicaid Director for the State of New Jersey and oversaw the expansion of the FamilyCare program to cover all children under 350 percent of poverty. She was also a senior budget analyst for the U. S. Office of Management and Budget, with responsibility for negotiating the budget neutrality agreements for Medicaid managed care waivers. She was recently appointed to the Maryland Community Health Resources Commission and has served on the board a Community Health Center in Southern Maryland.