
MANAGED MEDICARE & MEDICAID

AmeriHealth Mercy Uses Series of Initiatives To Slash Annual Pharmacy Cost Increases

Through a series of initiatives including identification of high utilizers of prescription drugs and intensive case management, a Medicaid MCO based in Philadelphia has cut annual pharmacy cost increases of 20% to 22% to below 9% over the past several years.

Officials report that the MCO now “comes in below budget” on pharmacy every month, and recently began marketing its pharmacy care management program to Medicaid plans beyond its own affiliates in Pennsylvania, New Jersey, Kentucky, and South Carolina.

“On a monthly basis, since the beginning of the year [2003] we are 3% to 5% below [pharmacy] budget,” says Mesfin Tegenu, vice president of pharmacy services for AmeriHealth Mercy Health Plan in Philadelphia. He would not disclose the size of the pharmacy budget. “Since Medicaid plans don’t have the luxury of cost shifting [to members], we are in a situation where if we don’t properly manage utilization and our unit costs, [then] we haven’t fulfilled our responsibilities...and our mission of providing care for this population will be in jeopardy,” he says.

Using a commercial pharmacy benefit manager (PBM) “when costs were \$5 PMPM [per member per month] was OK,” Tegenu says, “but now pharmacy is 25% of total costs.” He says escalating costs compelled AmeriHealth Mercy to develop a detailed pharmacy management program, called PerformRx, that focuses on the Medicaid population.

Tegenu discussed AmeriHealth Mercy’s approach to pharmacy cost management March 11 at the National Managed Health Care Congress in Washington, D.C. He and Tom Lyman, AmeriHealth Mercy’s senior vice president for market expansion, offered further details to *MMM* in a March 18 telephone interview.

Lyman explains that AmeriHealth Mercy’s senior management faced “a real struggle” in the late 1990s after the Medicaid MCO got a major influx of Supplemental Security Income (SSI) recipients with complex chronic illnesses and pharmacy costs of perhaps \$200 PMPM. The SSI members joined AmeriHealth Mercy’s mainly Temporary Assistance for Needy Families (TANF) population that had pharmacy costs of perhaps \$12 to \$15 PMPM. Unsatisfied with a string of PBMs, the MCO decided to develop its own clinical expertise and to outsource claims processing and decision support, which

have been handled by Argus Health Systems, Inc., of Kansas City, Mo., since 1999.

“We had three [PBMs] in four years. We just couldn’t get the data out of them. We couldn’t get a feel for what the costs were,” Lyman says. Adds Tegenu: “When we managed the TANF population, PBM was OK — unit cost management, and that’s it. But with a sicker population, this approach wasn’t working. We decided if we were serious about the managed Medicaid business, we had to manage [pharmacy] costs.”

Prior to the new approach, Lyman says that AmeriHealth Mercy’s management worried about the unpredictability of monthly pharmacy costs. “Now, we control it,” he says. “We come in below budget every month...We know the issues, who the high utilizers are.”

For example, AmeriHealth Mercy officials cite a pharmacy case management program for hemophiliacs. When the program began three years ago, the plan had about 45 hemophiliacs on intensive treatment at an annual cost of nearly \$10 million. The population rose to 55 in the second year but, Tegenu says, “because of unit cost control strategy and a dedicated nurse case manager and close [patient] monitoring, we got a \$2 million savings.”

Thus far in 2003, Tegenu says, the program — which now treats 62 hemophiliacs — has continued to maintain savings and is under budget by close to \$400,000. AmeriHealth Mercy projects the annual cost will fall by another \$1 million to \$1.5 million by the end of 2003.

(Although data were unavailable, AmeriHealth Mercy officials also report that corresponding hospitalization and emergency room utilization among members with hemophilia has declined because of the pharmacy case management program.)

In fourth-quarter 2002, AmeriHealth Mercy also began focusing on hepatitis C patients who use costly injectable medications, Tegenu says. By employing “a unit-cost strategy — both rebates and judicious purchasing — and intensive case management, our program in three months has helped us to cost-avoid over \$200,000” for 1,075 patients, he says.

AmeriHealth Mercy officials assert that Medicaid MCOs must take control of their pharmacy programs by developing the clinical programs and administrative processes to manage drug utilization and product costs.

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In addition to creating specialty drug management programs and providing case management to high drug utilizers, they recommend:

Three More Ways to Control Drug Costs

◆ **Focusing on formulary management.** “Formulary management is the critical tool,” Tegenu says. “We call it a Medicaid-specific formulary, which means we take into consideration what our population needs.” He explains that the MCO designed its formulary — comprised of 960 drugs, including 715 generic medications — for clinical appropriateness without considering rebates. For products on the list, he says the MCO tries to maximize unit-cost savings through aggressive pricing negotiations.

◆ **Maximizing program staffing.** AmeriHealth Mercy, which uses call centers to handle member, provider, and pharmacy queries, felt compelled to increase its clinical pharmacist and support staff, Tegenu says, because of the pharmacy management program’s intensive techniques, including the need to communicate regularly 120-odd protocols to providers and pharmacies and to support providers on preauthorization telephone calls. AmeriHealth Mercy uses approximately one clinical pharmacist for every 30,000 members, he says, compared with a typical ratio of about 1:200,000 commercial members for PBMs, “which means higher quality care and getting protocols implemented properly.”

◆ **Concentrating on Medicaid-focused utilization management.** The MCO’s officials say that a wide range of strategies, including prior authorization, step-therapy protocols, and point-of-sale edits use evidence-based medicine in an effort to eliminate inappropriate utilization and ensure that the correct drug is being administered for a particular diagnosis. If a member tries to fill a

costly drug, a pharmacist may get a message to call the member’s physician and seek a cheaper generic equivalent. In case of disagreement with physicians over prescriptions, medical directors make the final call. Tegenu says AmeriHealth Mercy’s TANF population, consisting mainly of young and healthy members, is being managed with protocols for appropriate therapy and medical compliance. For example, he says, the MCO found widespread abuse of Oxycontin, a narcotic painkiller, so it put in a protocol to monitor the drug and allow only oncologists, physicians treating HIV/AIDS patients, and pain-care specialists to prescribe it. Once that protocol was implemented, he says, the number of Oxycontin prescriptions written per month dropped from 3,000 to 600.

Lyman says AmeriHealth Mercy’s pharmacy program, which began at 250,000-member Keystone Mercy Health Plan in Philadelphia, was rolled out to its affiliated 68,000-member AmeriHealth Mercy Health Plan in Harrisburg, Pa., and 55,000-member Select Health in South Carolina. AmeriHealth Mercy is “also responding to RFPs [i.e., requests for proposals] for PBMs with other [managed Medicaid] plans,” and focusing on Medicaid MCOs with 30,000 to 40,000 lives where prescription is part of the benefit, he notes.

As of last week, AmeriHealth Mercy had not yet signed up any unaffiliated plans for the program. While AmeriHealth Mercy is targeting TANF-based plans, Lyman says its pharmacy program could be “especially attractive” in states such as Pennsylvania and Kentucky that are drawing clinically complex/high-drug-utilizing SSI populations into Medicaid managed care.

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