

Testimony of The Legal Aid Society

On

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TOPIC:

**PUBLIC HEARINGS ON THE MEDICAID MANAGED CARE
PRESCRIPTION DRUG CARVE-IN IMPLEMENTATION**

Presented before:

THE NEW YORK STATE

ASSEMBLY COMMITTEE ON HEALTH

Presented by:

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MAKING THE CASE FOR HUMANITY

The Legal Aid Society's Health Law Unit operates a Statewide Helpline that assists hundreds of New Yorkers in need of health care services or health insurance coverage, and those mired in medical debt. In addition to providing direct client assistance, our unit provides technical assistance and training to advocates and consumers throughout the State. We are active members of coalitions raising consumer concerns including Medicaid Matters New York, Office of the Medicaid Inspector Workgroup and the Statewide Consumer Coalition on Medicare Part D. We also participate in workgroups on Medicaid Redesign Team Managed Long-term Care.

The Health Law Unit of The Legal Aid Society appreciates the opportunity to testify today and would like to thank the Committee for holding this hearing to consider the impact of this Medicaid Redesign Team change to prescription benefits for Medicaid recipients.

Today, we present this testimony as members of Medicaid Matters New York, the Statewide HIICAP network, and as a specialist agency along side Empire Justice Center and Medicare Rights Center for the Community Health Advocates network.

Preparing For Change

The change to Managed Care from Fee-For-Service coverage for prescription drugs for Medicaid recipients is not a new phenomenon to advocates for low-income New Yorkers. In 2006, we at The Legal Aid Society, along with many others experienced the upheaval that went along with of the creation and implementation of Medicare Part D. In 2006, we saw a lot of fear and concern about the change. Our clients were worried about being able to access their brand medications, they were worried that their access to prescriptions would get lost in the transition period, and they were worried about the introduction of utilization controls and a new appeals process. With the introduction of Medicaid Prescription drug regulation this year, we predicted that we would soon be working through these same fears and concerns with our Medicaid clients, and we were correct. We have indeed observed the resurgence of all of these issues, and we anticipate that when the 90-day transition period ends on January 1st, even more cases will present and with higher urgency.

We are very lucky to have with us here today a client of The Legal Aid Society's Health Law Unit, Lorraine Sepulveda. Lorraine has been kind and brave enough to share her experience of advocating to secure medication for her son. Her experience highlights many of our concerns.

My name is Lorraine Sepulveda. I am the mother of Obrin Pichardo. Obrin is 10 years old and he has been diagnosed with ODD, ADHD, a learning disability, and dyslexia. Obrin is currently on medication: Concerta 18 mg., Intuniv 2 mg, and. Intuniv 1 mg. On September 20, 2011, I received a letter in the mail which stated that my son's Intuniv medication was a non-formulary drug and it needed a pre-approval from a doctor. I decided to call my plan to find out more information and how do I get this pre-approval.

The lady I spoke to on the phone told me she didn't know what I was talking about. She spoke to her supervisor and then returned to the phone to tell me the medication is not covered and my son would have to get a generic medication. I informed her there is no generic brand for Intuniv and she told me there is nothing she can do.

Then I spoke to my son's lawyer at The Legal Aid Society who is helping him his Board of Ed case. She referred me to the Health Law Unit. Legal Aid called my plan to tell them about the problem. The Plan called me to help me get Obrin's medication. I was able to get his medication for October and I was told there would be no problem in the future..

As October 1st passed, everything went through fine. Little did I know that November would be my worst month ever. The evening of November 8th, I got a phone call from the pharmacist, telling me Obrin's medication was not covered. I thought it was just the Intuniv 1 mg. and the Intuniv 2 mg. because that was the only medication on the letter, but it was the Concerta too. My son was running out of medication and having my son on no medication is not a good thing. I called my plan and I left pleading messages on answering machines. When I did reach someone I pleaded to them, in tears crying, explaining to them that I've had my son without medication before and that Obrin will literally be climbing the wall. Obrin will hurt himself. I have had complaints from many people about Obrin when he is not on medication. The man on the phone said nicely, "I'm sorry ma'am there's nothing I can do to help you, I wish there was." Still in tears, I asked if I can speak to his supervisor. But to no avail. It wasn't until my Legal Aid lawyer called someone at the plan that I was able to fill Obrin's prescription a full week later. Obrin got the Intuniv and a generic form of Concerta. A month after my son had run out of my medication, I got return calls from my crying messages to my plan. The representative asked me if my problem had been fixed. Obrin has his medication now, but even today, it is not clear to me if I will run into this problem next month. This was a terrible experience for me and my son. I don't feel that children and people with disability should be restricted from receiving the medication they desperately need.

Ms. Sepulveda's experience in accessing information from her plan, and her attempts to navigate the plan's unique utilization controls and, if a proper decision is ever communicated, an exception to policy or Fair Hearing are illustrative of what we have been hearing from other clients, peers in the legal services community, in the health advocacy community, and in the medical communities. We contacted medical providers that work with the HIV+/AIDS population – a group that is particularly vulnerable when it comes to access to medications. These peers reported spending hours every week working on prior authorizations for medications that their patients have been using successfully for extended periods of time. Each plan has its own forms and procedures. Several plans have subcontracted to prescription management companies with their own procedures and forms, further adding to the administrative burden and related delay for the individual seeking critical medication. The single largest complaint that was shared with us was related to the confusion created by the quality of information available to patients and their advocates.

Access to Information Survey

Recently, The Legal Aid Society's Health Law Unit conducted a State-wide survey to assess the Medicaid enrollees' ability to access information about their health insurance through their

Managed Care Plans.¹ Specifically, this survey was designed to assess the information provided to enrollees about the prescription drug change, the new formularies, and their appeal rights.

The staff members conducting the survey always identified themselves as members of The Legal Aid Society's Health Law Unit, and explained that they were looking for information on the pharmacy benefit changes. The telephone portion of the survey was scripted to eliminate discrepancies in phrasing. The following questions were asked: (1) how can I get a copy of your plan's drug formulary? (2) What is the process for requesting prior authorization for a drug that is not on the formulary or that requires prior authorization? And (3) how do I request an evidence packet for a Fair Hearing?

The portion of the survey conducted on the internet focused on six points of information that were thought to be most relevant to consumer needs. The questions we sought answers to were as follows: (1) is the Drug Formulary accessible online? (2) Does the website provide information about drug limitations (e.g., prior authorization requirements, step therapy)? (3) Does the website provide information about transition processes (e.g., what is the transition process for those individuals currently taking prescription drugs that are not covered under the Plan's drug formulary or covered with limitations)? (4) Does the website provide information about exception processes (e.g., internal and/or external complaint and appeals processes, the State's Fair Hearing system)? (5) Does the website provide misinformation about pharmacy benefits coverage (e.g., an absence of information about the change in coverage or incorrect information that fee-for-service Medicaid still provides coverage)? And (6) Does the website provide any information about the pharmacy change? If so, is it correct (e.g., does the website describe the October 1, 2011 change)?

The results of the survey were varied, with the plans scoring well on having educated their staff on how help a consumer to locate the formulary and about the change. Where their preparation was insufficient was in their failure to provide adequate information on drug utilization controls, exception to policy procedures and forms and how to secure Fair Hearing evidence packets.

Specifically, 81% of the representatives surveyed were able to tell us where we could find the formulary online, and all were willing to mail a copy of the plan's formulary. Unfortunately, just under 25% of the managed care plans representatives were able to explain the procedure for requesting prior authorization for a medication not covered in the formulary. The remaining 76% provided a range of inadequate responses including instructions to look on their website or formulary. Many plans simply transferred the call to a department unrelated to prescription drugs.

The resources available to consumers seeking resolution through due process are also troublesome. When asked about the procedures for requesting an evidence packet for a Fair Hearing, 76% of representatives surveyed immediately said that they did not know what an evidence packet was. After putting us on hold, 76% returned with a range of inadequate or incorrect responses that included instructions to contact SDOH, offers to send an Explanation of

¹ The study involved 23 Medicaid Managed Care and Family Health Plus health plans in New York State. The phone survey was conducted September 23-26, 2011 with one call made on October 5, 2011. The internet survey was conducted during September 28 to October 14, 2011.

Benefits in the mail, or worse, leaving the consumer without any information with statements as simple as “I am sorry, I just do not know.”

Based on this survey, there are a few things that are very clear. First of all, it is clear that the SDOH departments responsible for the implementation of the MRT and upcoming changes have the capability to ensure that a large number of member services staff are properly trained on complex issues. This is evidenced by the overwhelmingly helpful responses to questions about accessing the formulary. Furthermore, the results for the online portion of our survey were extremely positive. For example, 90% of the websites surveyed had a copy of the drug formulary on their respective websites. And 86% of those drug formularies provided which drugs had which limitations. However, knowledge of which drugs are on a certain plans’ formulary does little good to the consumer who does not have access to the internet and/or is unable to obtain information on how to request prior approval for a drug not on the formulary, or how to properly appeal a decision to deny a drug not on the formulary. The inability to access this, and other crucial information, deprives Medicaid beneficiaries of their most basic consumer protections, and prejudices those seeking to advocate for themselves and their family members as was evidenced by Lorraine’s struggle.

Recommendations

Going forward, we have three specific recommendations applicable to both prescription drugs and the other MRT changes that are being implemented, including (1) standardize forms and procedures (2) vigorous monitoring and (3) protection of due process rights of consumers.

Standardize Forms and Procedures

Require the plans and the enrollment broker to accept an SDOH form to initiate appeals and a release will reduce the administrative burden for individuals, their doctors and advocates. What purpose is served by allowing over 20 different forms and procedures for consumers to appeal a denial or limitation. Furthermore, the releases utilized by the City Human Resources Administration or the Unified Court System should be accepted by the private vendors doing business as agents of the State Department of Health. It is a pointless dilatory practice to require a consumer and their medical provider or advocate to wait for the company’s release to be mailed to the client.

Vigorous Monitoring and oversight

The prescription drug transition demonstrated how a well-staffed SDOH could both train and monitor the plans effectively. The SDOH Pharmacy Bureau did a good job of making sure that the plans provided adequate access to their formularies. Over one decade of experience working with the NYS DOH Division of Managed Care has shown us the depth of their commitment to ensuring coverage and access to services for Medicaid recipients via the managed care model. The Model Contract for Medicaid and Family Health Plus Managed Care Organizations requires the plans to report on 17 different data sets - some monthly, quarterly, annual or on a rolling basis. Based on the experiences of our clients’ and reports from peer advocates, we question the adequacy of staffing for the SDOH Division of Managed Care to monitor and to provide

oversight of these private vendors to which we are handing millions of dollars² a year to provide medical care for our Medicaid recipients. It is essential that the Division of Managed Care be adequately staffed to monitor these contracts.

Consumer Protections

The individual complaint is critical to informing the State in its monitoring of these large contracts. Overall, the SDOH needs to improve its monitoring of the plans in their provision of notice of fair hearing rights, evidence packets and aid to continue. Individual consumers are protected by stopping the further erosion of Fair Hearing rights by asking the SDOH to strike the language limiting Aid To Continue rights for reductions proposed at the end of a period of authorization in the pending Medicaid Managed Care Regulations in Proposed 18 NYCRR §360-10.8(e)(2)(iii). The Federal Regulation which allows this interpretation uses discretionary not directive language thus delegating the choice to rely or follow the regulation to a state's Medicaid Program. It is already having a deleterious affect on the most vulnerable Medicaid recipients, the elderly and the disabled. The difficult fiscal times and the need to reduce Medicaid spending in New York State should not become a dangerous "Race to the Bottom" which endangers the most vulnerable New Yorkers for whom Medicaid is their only option to remain safely in their communities. Finally, it is important to continue to protect civil legal services funding and funding for the two health navigators programs, CHA and HIICAP, so that we can stand by Ms. Sepulveda and our other clients as they navigate these changes.

Conclusion

We are extremely grateful to the members of the Assembly for your leadership and ongoing commitment to protect Medicaid recipient's health in accessing health care services.

² The State does not share the specific capitation rate paid on behalf of an individual MA recipient. We know that the rate is adjusted to consider high needs such as maternity/newborn care and, new after MRT, Personal Care Services. The Office of Medicaid Inspector General charges \$300 per month for an individual when they are pursuing collections against a recipient alleged to have a period of ineligibility for coverage. Using that figure, we estimate that for an individual recipient approximately \$3,600 is paid to a managed care organization for a year of coverage.