April 13, 2020

Mark Ghaly, MD, MPH, Secretary
California Health & Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95814

VIA E-MAIL

Re: Request to Delay Implementation of Medi-Cal Rx

Dear Dr. Ghaly:

Together, the Local Health Plans of California ("LHPC"), California Association of Health Plans ("CAHP"), California Association of Public Hospitals and Health Systems ("CAPH"), California Primary Care Association ("CPCA"), Private Essential Access Community Hospitals ("PEACH"), and California Children's Hospital Association ("CCHA") collectively serve the vast majority of the approximately 13 million Californians enrolled in Medi-Cal. We are writing you today to request that, given the strain and uncertainty created by the COVID-19 pandemic, the Health and Human Services Agency's Department of Health Care Services ("Department") pause ongoing planning activities and re-evaluate feasibility of implementing Medi-Cal Rx on January 1, 2021.

The COVID-19 pandemic is straining our entire delivery system and demanding most of plans' and providers' clinical, administrative, operational, human and financial resources. Moreover, the latest modeling predicts we may continue to battle COVID-19 for the next several months and potentially face a resurgence in the Fall. Even in the best-case scenarios, our system will be recovering for the rest of 2020. The pandemic leaves little extra capacity to plan, implement, and absorb a system transformation of the magnitude contemplated under Medi-Cal Rx.

We commend the Administration for addressing the rising cost of prescription drugs through several initiatives, including Medi-Cal Rx. We acknowledge that our request comes after the Department and health plans have dedicated countless hours over the past several months preparing for implementation of Medi-Cal Rx. In recognition of this and our commitment to transparent dialogue, below we provide additional details explaining why our organizations believe ongoing planning should be paused and implementation of Medi-Cal Rx should be delayed.

Significant Clinical Issues Are Unresolved. Based on the recent formulary–contract drug list (CDL) analyses, twenty percent (20%) of existing managed care prescriptions will still experience processing and access challenges. This formulary–CDL gap is significant. However, it may be further exacerbated should Medi-Cal enrollment grow by 2 million Californians in the coming months, as has been suggested by the latest projections.

Additionally, there are unresolved concerns for opioid quantity limitation, immunosuppressive TAR requirements, insulin and diabetes medications, access to many non-CDL generics, just to name just a few. The 120-day transition period plan has significantly benefited from collaboration between the Department and plans but concerns still exist for the medications listed and with plans that cannot produce prior authorization (PA) files in Magellan's required format.

Specialty medication compliance, currently at over 90% with plan specialty management strategies, has not yet been addressed in the transition planning. Further, we are still in early discussions with the Department on enhancing the Medi-Cal Drug Advisory Committee (MCDAC) to ensure decisions are clinically based, transparent and follow a process that better aligns with industry standards for formulary management. A clinically sound CDL is critical to the pharmacy-based quality measures including HEDIS and consistently applied treatment authorization request (TAR) criteria are critical protections for member and treating clinicians. Technical discussions are progressing but are also identifying significant differences between the various claim and PA systems that will make a seamless transition of claim history more challenging and may possibly require individualized approach for some plans.

We might be able to address these clinical issues (including those specific to the California Children's Services program, noted below) in time for January implementation if were able to continue dedicating substantial time and resources to the stakeholder process. However, in the current environment and for reasons detailed below, we do not believe there is capacity to do so.

Health Centers are Critical to the COVID-19 response. Community Health Centers (CHCs) are the backbone of the care delivery system in California, serving 7.2 million patients in 1,370 locations while ensuring access to medical, behavioral, oral health, and social services for California's most vulnerable populations, including 1 out of every 3 Medi-Cal beneficiaries.

During this public health emergency, health centers have been working hard to triage, treat, refer and coordinate with local health departments to support the primary care needs of their patients, while also trying to manage massive financial revenue declines due to significant drops in visits. CHCs have been granted the flexibility to deliver and be paid for virtual care, however completely changing their delivery model is a substantial lift – requiring all organizational personnel and resources to accomplish. CHCs are experiencing 50% less visits, which translates to $360M in lost revenue every month. If shelter-in-place continues for three more months and CHCs are not provided additional financial relief, within just 90 days 77 health centers may not be able to make payroll. Given all the demands imposed and the financial impacts on CHCs during the COVID-19 pandemic, CHCs ask the Administration consider delaying Medi-Cal Rx and allow California's Medi-Cal delivery system to recover from the negative impact of COVID-19.

Health centers support the Governor's vision to reform the health care delivery system that would lower pharmaceutical drug costs and standardize California's drug benefit, however we question whether now is the right time to pursue such a large overhaul of our pharmacy system given the focus on COVID-19. As mentioned above, health centers are operating at capacity, and many at a deficit, making it very challenging to allocate time and resources towards making the changes required to implement Medi-Cal Rx. Additionally, Medi-Cal Rx is complicated and will require significant training of CHC staff to operationalize new processes such as changes to prior authorization for drugs not included in the CDL, handling new data formats and systems, and how to work with Magellan and their managed care plans. We worry that managing all of this now during COVID and its aftermath will not lead to a successful transition for the State or CHCs.

Lastly, the financial impact of the pharmacy transition was already predicted to be massive and destabilizing on CHCs. While the Governor proposed a supplemental payment fund to support CHCs in the transition away from 340B, we know the January budget is being reconsidered and the necessary resources may not be there. To ensure no further financial destabilization to an already very fragile community health center network, with strongly advise a delay in implementation.

More Time Needed to Address Concerns Related to the CCS Population. Another area of concern with implementing the pharmacy carve-out involves the California Children's Services program (CCS program). In late February, shortly before COVID-19 brought a halt to normal activities in the state, the Department surveyed stakeholders about potential concerns related to shifting responsibility for handling CCS outpatient drug claims from counties and managed care plans to Magellan. Although the Department has not publicly provided the results of this survey, children's hospitals and special care center leaders have raised significant concerns about the potential for this transition to disrupt access to medications for medically fragile children. For example, we are generally concerned about how well a national PBM with little experience working with a medically complex pediatric population will handle the unique authorizations this population requires. The resulting fragmentation and unfamiliarity could create substantial delays for critical medications, resulting in these children staying in the hospital longer, and potentially could also drive increases in re-admissions and ER visits if their refills get tied up. Children often need non-standard dosing, and thus require compounded prescriptions more often than adults. In addition, many medications are prescribed for off-label use in children, and common antibiotics, asthma medications and seizure meds for kids with intractable epilepsy are not standard on formularies. Standardized prior authorization criteria, established with adult needs in mind, will likely cause delays in access to these important medications.

Moreover, the impact of Medi-Cal Rx on children in the CCS Program has not been the topic of any comprehensive discussion at the Medi-Cal Rx Advisory Workgroup meetings, and there has been no follow-up with families, providers or other CCS stakeholders about the myriad of concerns raised since the Department initiated its survey. These concerns are significant and will require adequate time to work through in order to avoid significant delays in access to critical medications for the State's most vulnerable children.

Diverts Attention and Resources from COVID-19 Response. Continuing the intensive planning process for January 2021 implementation presents both near- and long-term challenges. Our system is in the middle of a transformation in response to COVID-19. Plans and providers alike are focused on doing things differently: adapting to working remotely, redeploying staff, securing revenue to maintain staffing and operations, operationalizing telehealth and telephonic visits, struggling to secure needed personal protective equipment for direct patient care, deferring routine and elective care, testing and treating patients with COVID-19, preparing hospital infrastructure and staffing for the anticipated surge in the coming weeks, conducting outreach campaigns, ensuring vulnerable patients have access to resources, and reinforcing public health messaging regarding COVID-19. Amidst all of this, all parties are constantly tracking and adapting operations in response to steady stream of regulatory, legislative and executive branch guidance.

At the same time, Medi-Cal Rx requires plans to dedicate substantial resources to prepare for the transition as well as to support the Department and Magellan through the planning process. All operational areas of a health plan – not just pharmacy departments – are involved in planning for Medi-Cal Rx. Clinical teams must understand and help their providers prepare for changes in the CDL, coordinate with the Department and Magellan to transfer PAs, amend or terminate pharmacy contracts, and train staff on functions and role of Magellan clinical liaisons. Plan IT teams must configure file layouts and conduct system testing. Member services must update and send updated EOCs and member ID cards, revise call scripts, update provider manuals, help educate network providers, and conduct the member call campaign. Compliance teams must develop and file provider contract amendments/terminations, revised policies and procedures, revised networks, contracts and benefit changes. And finance teams must understand and plan for the revenue impacts.

Looking ahead, robust provider training and education will be critical to Medi-Cal Rx's success. Providers will need modify prescriptions due to changes in coverage under the contract drug list (CDL), understand new process and policies for submitting TARs, billing and claiming through Magellan, how to utilize the provider portal, and the process for resolving any pharmacy-related issues. Currently, Medi-Cal Rx provider training is scheduled to start in the Fall 2020. However, we do not believe Medi-Cal providers can be expected to absorb training and make necessary adaptations when recovering from the operational and financial impacts of COVID-19 as well as enduring a potential resurgence. If providers don't adapt to Medi-Cal Rx and submit the necessary TARs, beneficiaries will be at risk of treatment discontinuation. Even if we don't experience COVID-19 resurgence in the Fall we anticipate significant pent-up demand for services deferred during the pandemic. We do not want to discourage patients from seeking care by noticing them that benefits are changing. We also do not want to distract providers who will be dedicated to meeting pent-up demand.

Patients Likely to Experience Confusion, Disruption. Like provider training and education, our patients and members will be notified about pharmacy benefit changes in Fall 2020. We believe this timing will cause confusion, frustration and stress for Medi-Cal patients in either in the midst of COVID-19 resurgence or pent-up demand scenario. Californians newly enrolled in Medi-Cal due to the economic downturn will be adapting to the program and, for many, transitioning care to new providers.

There are also unresolved technical details for Medi-Cal Rx that impact patients. These include pharmacy appeals and grievances processes newly managed by the Department and Magellan; statutory changes needed to lift prescription limits and modify the CDL; staffing, call scripting, and warm handoffs from Magellan's customer call center; and oversight and metrics to ensure that Medi-Cal Rx is serving beneficiaries to expected standards. Moreover, our foregoing concerns about system capacity to continue tracking to a January 1, 2021 implementation ultimately lead to patient impact. If all partners are not able to dedicate the necessary attention, time and resources to Medi-Cal Rx, our beneficiaries will suffer the consequences.

Every medical and pharmacological treatment decision involves the potential for harm. This extends to policy decisions. We believe that all stakeholders to the Medi-Cal program would be best served by decisions that promote stability and continuity of care during this unprecedented time. We therefore urge the Department to consider delaying Medi-Cal Rx in this environment of unprecedented threat to our health, healthcare system, and economy.

Sincerely,

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cc:
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