Testimony

on

Pennsylvania Medicaid MCO Pharmacy Services Management

Submitted to

Pennsylvania Senate

Public Health & Welfare Committee

Presented by

Michael Blackwood

President and Chief Executive Officer

Gateway Health Plan®

April 29, 2008

GATEWAY HEALTH PLAN® COMMENTS ON THE PA 2008-2009 BUDGET – POTENTIAL IMPACT ON GATEWAY HEALTH PLAN® AND OTHER MEDICAID MANAGED CARE ORGANIZATIONS (MCOs)

Thank you for allowing me to speak, Mr. Chairman. My name is Michael Blackwood and I am the President and CEO of Gateway Health Plan®, headquartered in Pittsburgh, PA. On behalf of Gateway Health Plan® and its nearly 500 employees, I wish to thank the Committee for providing us this forum to articulate our positions regarding specific proposals in the Governor's 2008-2009 budget for the Department of Public Welfare (the Department).

Gateway Health Plan® is a Managed Care Organization serving the Medicaid population in PA for the past 15 years. Gateway Health Plan® is a major participant in the HealthChoices program in both Western and Central PA, as well as in the Voluntary Managed Care program. We currently serve 243,505 members in 39 counties throughout the State. We are the 2nd largest Medicaid Plan in PA, and the 9th largest Medicaid Plan in the nation. Gateway Health Plan® is ranked as the #1 Plan in PA using both industry standard preventive health (HEDIS) measures, as well as Department-specific measures of quality. Gateway Health Plan® has held an "Excellent" designation from the National Committee for Quality Assurance (NCQA) longer than any other Medicaid Plan in the nation. Our Gateway Health Plan PCM® (Prospective Care Management) model of health care delivery mobilizes the necessary resources to deploy a proactive, holistic, state-of-the-art approach to patient management. We emphasize ongoing collaborative efforts with the medical provider community, developing medical management protocols

which optimize health outcomes, enhance the quality of life, lower the overall costs of medical care and the rate of annual medical cost increases. Gateway Health Plan® is heavily engaged with its members to assure their compliance with prescribed medical and pharmaceutical medical treatment plans and, together with the other six Managed Care Organizations in the State, serves a total of 1.1 million Pennsylvanians, constituting 63% of the Commonwealth's Medicaid population. Needless to say, we are a critical component of Pennsylvania's overall Medicaid physical health strategy. Any destabilization of this medical delivery system would be catastrophic for physical health Managed Care Organization Plan members, medical providers and PA taxpayers.

The State proposes to "carve out" Pharmacy from the auspices of the Managed Care Organizations and place it under the Fee For Service component of Medicaid. This is the third attempt in as many years to carve out Pharmacy and extract it from the overall Medical Management capability of the Managed Care Organizations. The PA legislature has twice rejected this approach to the management of pharmaceuticals, but the Department persists. The Managed Care Organizations in this State, including Gateway Health Plan®, have done an excellent job of both managing pharmaceutical costs and integrating Pharmacy into the overall medical approach in which our members' care is managed. Gateway Health Plan®, together with the other Medicaid Managed Care Organizations in the State, has kept the rate of increase in Pharmacy below 2% per year for the last two years and continues to intensively manage this benefit both clinically and financially to the benefit of the State -- including all the new biological specialty drugs. Together, the Managed Care Organizations accept the pharmaceutical insurance risk for over $1 billion of combined state and federal funding, such that the State itself does not

have to worry about paying for any overages. We all know that the price of pharmaceuticals has gone up very rapidly in the last five years, but the State is proposing to take over that insurance risk for price increases and for overall cost increases which they currently do not bear. The State is presently insulated from those costs because the Managed Care Organizations accept the insurance risk, totaling $1 billion a year, instead of the State. Everyone here today sees the drug ads every night around the dinner hour, which drive pharmacy demand for the entire population, including the Medicaid population. Price increases for pharmacy come on a frequent basis. Does the State really want to go at risk for the pharmacy demand driven by these commercials for branded drugs which we are bombarded with daily? When the prices go up, under the State's plan for the '08-'09 budget, the State would bear that risk and have to pay for it. Over the past five years, the Department has had to request over a $100 million in supplemental funds to pay for the medical care which exceeded the State's budget. None of those funds apply to the Managed Care Organizations, because we bear the risk and if the prices and the volume go up, we must absorb the costs under our capitation arrangement. This will not be the case if the Department's fee-for-service program takes over Medicaid pharmacy.

Having Pharmacy integrated into the overall Medical Management capabilities of the Plans is central to our Medical Management philosophy and methods. When people are in the hospital and are about to be discharged, while they live in the community and take multiple drugs from multiple sources, and when we are trying to balance both the demand and clinical efficacy of the drugs themselves, we need real-time data to look at the pharmaceutical implications, not simply the medical/surgical impact for each member.

By fragmenting Pharmacy away from the medical/surgical component, the MCOs would be less capable of doing our job with respect to Disease Management programs, High Risk Member Management, Case Management and a number of other factors, including Preventive Health for Children. We take approximately 26,000 phone calls per month at Gateway Health Plan® in our Pharmacy department. Together with the other Plans in the State, that adds up to over 1.5 million phone calls per year from members, physicians and ancillary providers throughout the Commonwealth. I am concerned that the State has greatly underestimated the amount of staff work, time, expertise and telephone answering capability that it would take to manage an additional 900,000 lives, with all the fair hearings, appeals and direct member services which it entails. The administrative costs to the State would have to go up dramatically in order to properly take on this additional work load currently managed by the MCOs. Managing the Pharmacy benefit in-house empowers an MCO to tailor coverage decisions, member outreach and provider education relevant to the MCOs particular member population. Instead of managing the whole person, we would be asked to manage part of the person, but managing the whole person is central to our ability to manage care. The member and provider would have to call DPW for Pharmacy questions, and then have to call the HMO for physical health coverage decisions. The preauthorization process would be further fragmented and a mother with two children would have to carry a minimum of 9 coverage cards in her wallet. What are the chances of that working? 70% of the drugs we dispense are generic drugs, which are the lowest cost by far, but the State believes that it can receive much higher rebates than the Plans' can and that will drive a cost reduction. The Plans have a higher generic fill rate than DPW and no amount of rebates can make up for the savings achieved with generic utilization. Generic drugs cost under $20 per script and the

average formulary brand drug costs about $160. A 30% rebate on $160 does not get you to under $20. But there is more to total cost than simply the unit price. The ability to manage volume, the types of drugs dispensed while minimizing overlap, drug interactions and duplications are also part of the solution. This is something the Managed Care Plans have been working on for over a decade and we have become quite good at it. By simply chasing rebates, the State will lose control of a system which is well-controlled now, and where the cost trends are really quite minimal. The bottom line is, why would the State want to take on this risk? Why would it want to complicate the delivery system for the members by further fragmentation? The Plans use a very complex array of techniques to keep the cost trend down, including a Pharmacy & Therapeutics Committee, a formulary which is built around both clinical and financial outcomes that are best for the member population, preauthorization processes, "soft" and "hard" edits at the Pharmacy level, management of specialty Pharmacy (which is a very high cost element for the Commonwealth), a staff of trained pharmacists and physicians who oversee the program every day. There is also a Member and Provider Services capability which is very skilled at handling calls from members and physicians. Gateway Health Plan®, as do other MCOs, presently provides immediate and direct communication between physicians, pharmacists and nurses employed within Gateway Health Plan®, serving as a resource for each other, as well as a combined resource for its provider networks with regard to pharmacy claim/medical condition collaboration.

This is not just about costs – it is also about quality. Everything the Plans have done pharmaceutically is built around providing the highest quality service to our members and to maximize the clinical outcomes. After all, we are at risk, frankly, for those financial

outcomes. If the 1.5 million calls from providers and members start flowing in to DPW as they currently flow in to the Plans and the ability of the State to handle such a workload is exceeded, could the phone calls end up on the desks of PA House and Senate? If the members and providers cannot get their questions answered in a timely fashion and the needed medications are delayed, what will have to be done?

Under the proposed State budget for ’08-‘09, we are facing “the law of unintended consequences”. If one tries to “squeeze this health care balloon” by extricating Pharmacy from the Managed Care Organizations purview, costs will likely spurt out the other side, as often happens in health care. The MCOs need the entire compendium of Managed Care techniques to do our job. Pulling out one of the central support beams from Managed Care is not the way to go. It further fragments the system and makes our job that much more difficult, with no real payoff. We all want the best for our members and for all the eligible recipients. I urge the legislature to recommend that the pharmaceutical services provided by the Medicaid Managed Care Organizations stay where they are, knowing that the quality of care will remain at a very high level and that the costs to the State will be both predictable and within budget.

Thank you very much for your time and attention.

Michael Blackwood
President & CEO
Gateway Health Plan®