

Testimony:  
Health and Human Services Subcommittee of the  
PA House Appropriations Committee

*Tuesday, March 27, 2007*

Presented by:  
Peter J. Keim, M.D.  
Chief Medical Officer  
Gateway Health Plan



**Question** – Do I want the Department of Public Welfare to manage the health care of the poor and needy of the state? That’s what this is all about!

15 years ago, after participating in the FFS (Fee For Service) Program as a Family Physician for 25 years, my answer was –

“No!”

I was one of only a few practitioners in the community who participated in the Medicaid FFS program. Actually, I ran the OB Clinic at the hospital because none of the Obstetricians participated.

Thus, I signed on with the “new” Managed Care Plans “voluntarily.” And, it was called a voluntary plan also for the recipients of Medicaid. Recipients had a CHOICE – FFS or Managed Care. As those of us, old enough to remember, recall, they signed on for managed care.

Managed care essentially was given an opportunity to “knock their socks off,” because Pennsylvanians on Medicaid had been shortchanged access to quality health care for a long time!

The practitioners, including myself, early on, agreed managed care was better for recipients and practitioners than FFS. More services, a “medical home” other than the ER, access to more specialists, attention to quality of care, case management support, prompt payment, and better reimbursement.

Not sure? **Ask your doctor.**

In the mid 90’s after I transitioned from active clinical practice to medical management, and later became Chief Medical Officer of Gateway Health Plan, I began to take part in designing and implementing programs to further improve the services to the poor and needy. We have delivered!

Over the past five years, Managed Care Plans have saved -- \$2.7 Billion dollars – for the state. And it is proven by an independent audit (Lewin Group).

Let’s talk independent audit and accreditation.

The recent Mercer audit compared the success of *ACCESS Plus* over its first six months (Jan – June, ’06) to the ’04 managed care data (not the same period – many changes in pharmacy occurred in ’05 and ’06 that have reduced Plans’ pharmacy expenses). Why did they not use Plans’ ’06 data to compare to their ’06 data? And it only compared financials, not quality. Health care is more than the numbers.

The health plans, at their own expense, undergo intense accreditation regularly by NCQA, a nationally recognized independent agency.

The FFS program and ACCESS *Plus* has never been accredited by NCQA.

I don't think Walter Reed was either.

Have you inspected these programs?

All six Plans in PA are rated in the top 25 Medicaid plans in the nation based on quality.

Back to my initial question. Do you want to see the Department of Welfare managing the care of our most needy?

Is 12 months of questionable financial data (ACCESS *Plus*'s first year) reason to answer – “Yes”? I say “NO”.

Let's review for a minute the plan to take members away from the managed care plans (which the recipient voluntarily signed up for) in “voluntary” counties. This will greatly compromise quality of care. The Plans have much larger networks, especially specialists. Without the specialists, you are handcuffing the primary care physicians. Why are our networks of specialists better than ACCESS *Plus*? First, we pay them better, easier and faster.

In addition, the Plans also have provides intense “one on one” case management, disease management programs, outreach and holistic attention to the members' needs. All of the above support the practitioners. As you know, Medicaid recipients have many psychosocial issues to deal with every day. They necessarily prioritize those issues before getting health care. The Plans have staff, whose sole job is to help the members with these psychosocial issues, and thus open the door to better health. The Plans also have Outreach staff that hunt for “lost” members, and get them engaged in care.

Are you allowing your constituents, our most needy, to be forced into a program with barely one year of questioned success rather than stay in programs that are proven over the past 10-15 years? Let the recipients choose! Let the doctors choose! What is the saying? “Let the voters decide.”

We need your help.

Let's spend a minute talking about the planned “carve out” of Pharmacy from the plans. One of the basic problems with health care delivery in the United States, Pennsylvania no exception, is fragmentation of care and management with poor communication, monitoring and attention to getting people to seek care.

It simply does not make sense to further fragment it.

It is a perception of DPW that significant dollars can be saved by getting larger rebates than the plans through federal programs.

Remember this – **Rebate dollars do not drive pharmacy spending.**

Unit cost and integration of pharmacy with all of a plan's programs drive costs. It doesn't make sense clinically or operationally to carve out pharmacy.

One cannot separate pharmacy spend from other parts of the health care spend. Rebates are primarily captured on the use of **brand** medications. Yes, there are small rebates on **generics**, but it is pennies compared to **brand** drugs. In order to get rebates, you **must use brand drugs**. They are much more expensive than generic drugs. And, the manufacturer raises the price of the brand drugs 2-3 times a year. The price of generic drugs goes down each year.

For the past three years, the health plans have survived despite rate increases less than the national rise in health care costs. They have accomplished it by developing innovative programs to provide quality care while not wasting money on unnecessary services and expensive drugs. They have developed formularies based on the membership's needs, not rebate potential. They integrate pharmacy data with other department's data to better manage the health care services.

Take away pharmacy, and you are taking away a vital part.

Managed Care Plans continue to have the opportunity to further “knock their socks off.” **Don't take away this benefit from our most needy!**

Don't jeopardize the quality of their health care for a few dollars this year. The Plans will continue to save money for the state. But, our focus will be on efficiently providing quality care and making the membership healthier, not simply saving money.

Don't allow further fragmentation of healthcare.

Back to the original question.

Do I want the Department of Public Welfare managing the health care of the poor and needy in the state? My answer is still “No!”

I expect your constituency would answer “No.” As well as, your doctor.

We **all** need your help.