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PROVIDENCE
Health Plans

February 3, 2012

The Honorable Laurie Monnes Anderson
Chair, Senate Health Care, Human Services and Rural Health Committee
State Capitol
Salem, Oregon 97301

Dear Senator Monnes Anderson:

RE: Senate Bill (SB) 1577

On behalf of Providence Health Plan, we want to thank you for the opportunity to provide our input regarding the above referenced bill.

Providence Health Plan manages pharmacy benefits for over 350,000 individuals through the various populations we serve, which include programs for various governmental entities. The goal of our pharmacy benefit program is to provide safe, effective, affordable and accessible medications and medication management. We are concerned that SB 1577 will dismantle currently successful pharmacy programs and leave the state in a challenged position to manage the pharmacy benefits of its covered populations.

Providence has a long history of managing pharmacy benefits well. We have strong contracts that have historically been comparable to the best medication unit costs of other Prescription Benefit Programs (PBPs), including OPDP. Our ability to balance clinical need and unit cost affordability is a key reason why we were chosen to administer the Project Access Now program (Pharmacy Bridge) which allows us to provide pharmacy benefits to the uninsured through a very successful four county area in and around Portland metropolitan area.

Key components to our success include information management and physician engagement. Physician engagement tactics such as risk management and performance quality management are in force today. These are important initiatives in our current role. Information management is key to clinical management, especially in the medical home model. Currently, Providence and other MCOs and IPAs have been able to leverage our very reliable access to medical information at point of service and through paid claims data to help us make decisions about clinical quality programs as well as case and disease management. With this information we are able to support compliance with medication regimens, identify patients needing care coordination, and identify patients that need additional training and education. This data would no longer be easily, immediately, and reliably accessible if the movement was made to a statewide PBP. A statewide PBP process cannot augment these care coordination initiatives. A statewide PBP cannot engage physicians through risk management and performance quality management.

Moreover, we are concerned that a statewide PBP will create duplicative administrative expenses, one of which is creating yet another system that the member must be enrolled in, and will further fragment

the delivery of health services to Oregonians. We currently administer medical benefits for a few plans that have historically had stand alone or carved out pharmacy benefits. This has led to a high volume calls from members, doctors and pharmacies. A closer review of some of these programs has demonstrated lower generic utilization rates and reduced use of medications deemed necessary to prevent and treat acute and chronic conditions. These consequence that has also been noted by CMS when it compares "stand-alone" pharmacy benefit providers with Medicare Advantage plans that combine their pharmacy & medical benefits. Finally, there is often confusion among members, doctors and pharmacies about what is covered, where prescriptions can be purchased, and who the pharmacy benefit providers are for certain pharmacy services.

Opportunities to decrease the total cost of prescription care through various strategies involving the use of AAC (Average Acquisition Cost), and other "own use purchasing" strategies are currently being piloted at Providence and deployed in various settings. This work will result in an optimal total cost of pharmaceuticals when it is deployed in conjunction with principals and programs that encourage access and involve the use of the medical home model and/or ACO models currently under development. Separating medication procurement from the other aspects of care management, as would be done under SB1577 will not achieve the results the state is looking for.

Ultimately a move to a statewide run PBP does not support the state's vision of integrated, coordinated care. In the push to move towards all services being offered and coordinated at one point of service, it is contradictory to take one of our most important tools, medication management, out of our medical homes and fledgling Accountable Care Organizations. Doing so will likely have the unintended consequence of increasing rather than decreasing health care costs. We encourage the State to utilize the successful pharmacy programs that have been built by Oregon's MCOs, HMOs and Health Care Service Contractors, rather than attempt to take on that responsibility without a proven track record of success.

We thank you for the opportunity to provide these comments. If you would like to discuss these comments further, please contact either of us at 503-574-6485.

Sincerely,

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Chief Medical Officer

Helen Noonan-Harnsberger, Pharm.D., R.Ph.
Pharmacy Director

CC:
Senate Health Care Committee members
Jack Friedman, CEO, Providence Health Plan
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Mike Becker, Director of Regional Advocacy, Providence Health & Services
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