Overview of Presentation

• New NCSL Health project – a fresh look at state options for containing costs

• Review of seven state strategies

• Observations
Project on Containing Health Costs, Realizing Efficiencies

- Series of briefs on strategies to:
  - Reduce expenditures
  - Slow expenditure growth
  - Get better value
  - Eliminate waste, excessive payments
- Focus on state examples, laws
- Emphasis on documented savings, efficiencies

20+ State Strategies

- Briefs include:
  - Strategy description and target
  - Federal reform provisions
  - State, private sector examples
  - Evidence of savings, effectiveness
  - Challenges

- Areas of focus:
  - Health system financing, organization, administration
  - Efficient, effective practice of medicine
  - Benefit design, healthy choices
Today:

Highlights from 7 Briefs*

1. Episode-of-care payments
2. Global payments
3. Medical homes
4. Administrative simplification
5. Strengthen fraud and abuse control efforts
6. Increase use of generic drugs
7. Expand negotiated prescription drug purchasing

* 13 completed or in process as of July 27, 2010.

1. Strategy: Episode-of-Care Payments

Main elements:

• Single payment for all providers treating a specific illness, condition or medical event
• One payment per episode instead of multiple payments for each service
• Episode examples: heart attack, knee and hip replacements, pregnancy and delivery
Episode-Based Pay: Examples

- MN—Developing “baskets of care” (2008 legislation)
- MD—Hospital rate setting commission case rates bundle hospital, ambulatory surgery, clinic, ER care
- Medicaid—Prenatal care and delivery single payment
- Private sector—UnitedHealth testing with oncologists for cancer care; Prometheus Payment demonstrations
- CMS pilot—Bundled payments for all inpatient care for orthopedic, cardiovascular procedures
- Federal reform—Authorizes Medicaid demos in 8 states

Episode-Based Pay: Savings Evidence

- Limited evidence: savings for some conditions
  - Medicare bypass surgery demo—10% lower mean costs; 14% to 32% shorter hospital lengths-of-stay
  - Arthroscopic knee, shoulder surgeries—$125,000 savings over 2 years in small HMO pilot
  - Hospital per diagnosis (DRG) Medicare, Medicaid payments—reduced rate of growth in hospital expenditures
2. Strategy: Global Payments

- **Elements:**
  - Single pre-payment to a provider group/system for **most/all** patient care for a specified time period
  - Incentives for access and quality

- **Hottest “new” payment strategy—similar to capitated managed care**

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**Special Commission’s Recommendation**

**Current Fee-for-Service Payment System**

- **The Problem**
  - Care is fragmented instead of coordinated. Each provider is paid for doing work in isolation, and no one is responsible for coordinating care.
  - Quality can suffer, costs rise and there is little accountability for either.

- **Sums:**
  - Hospital
  - Specialist
  - Primary Care
  - Home Health

**Patient-Centered Global Payment System**

- **The Solution**
  - Global payments made to a group of providers for all care. Providers are not rewarded for delivering more care, but for delivering the right care to meet patient’s needs.

- **Sums:**
  - Primary Care
  - Hospital
  - Specialist
  - Home Health

Government, payers and providers will share responsibility for providing infrastructure, legal and technical
Global Payments: Examples

- **MA**—Special commission recommended all payers use global payments by 2014
- **MN**—Private sector Patient Choice program—provider groups bid to care for a patient population
- **Medicaid**—Program for All-Inclusive Care for the Elderly
- **Long history** of public, private payments to integrated care systems (e.g., Kaiser, Mayo Clinic)
- **Federal reform**—Authorizes Medicaid Global Payment Demos to pay safety net hospital systems in up to five states

Global Payments: Savings Evidence

- **Research mainly** from capitation experience:
  - can lead to lower costs without affecting quality
  - State Medicaid managed care savings = 2% to 19%
  - Works best with mature integrated delivery systems (e.g., Geisinger Health System in PA; Denver Health)
  - Savings mainly from fewer hospitalizations, lower prescription drug expenditures

  - **Caveat**: Most newly-formed, risk-bearing provider groups of the 1990s failed
3. Strategy: Medical Homes

Elements:

• Health practice delivers efficient, coordinated, personalized care
• Additional pay for care coordination, quality, efficiency
• Main goals: improved primary care access, quality

Medical Homes: Examples

• 29+ states have medical home laws
• Topics: certification, coordination fees, pilots, anti-trust exemption, etc.
• Some multi-payer pilots in some states (e.g., CO, IA, ME, MN, WV)
• NC program covers 950,000 Medicaid enrollees
• Federal reform defines medical homes, authorizes Medicaid grants
Medical Homes: Savings Evidence

- Some studies show savings in some instances; others indicate minimal or no savings
  - NC—Estimated $135 M - $149M SFY 2007 savings over what would have been spent otherwise
  - Group Health Cooperative investment return = 1.5
  - Studies tend to report savings from reduced ER use, hospitalizations, BUT other cost increases, (e.g., more primary, specialist care expenditures)
  - Benefits: better quality & primary care access, fewer medical errors

4. Strategy: Administrative Simplification*

Main elements:
- Common forms for billing, coding
- More efficient claims, prior-approval processes
- Single provider credentialing process
- Swipe cards with patient benefit info
- Streamlined government processes

* In current system
Administrative Costs Eat Up a Significant Portion of the Health Care Dollar

Although some costs are necessary, add value (e.g., quality, fraud monitoring)...

- Administration = 25% or more of premiums
- Physician practice cost = 14% total collections (avg = $68,274/practice)

Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans is Estimated at $31 Billion

Mean Dollar Value of Hours Spent per Physician per Year on All Interactions with Health Plans

- MDs: $15,767
- Clerical Staff: $25,040
- Lawyer/Accountant: $2,149
- Senior administrative: $3,522
- Nursing Staff: $21,796

Total Annual per Practice Cost per Physician: $68,274

1 Based on an estimated 459,000 office-based physicians.

Administrative Simplification: State Examples

- **Standard application to verify provider credentials** — LA, NJ, TN, WV and at least 9 other states
- **Standard health insurance swipe cards** — UT, CO
- **Uniform electronic claims submissions** — ME
- **Comprehensive administrative streamlining laws**, series of laws — ME, MN, WA Health Care Efficiency Act
- **Federal reform** — comprehensive administrative simplification requirements

Administrative Simplification: Savings Evidence

- **Limited evidence: results in some efficiencies**
  - Evidence comes from private sector reports
  - IBM electronic benefit verification system — saved them $2.10 per verification
  - SC BCBS immediate resolution of patient eligibility, pre-certification requests — saved them $1.4 M (2007)
  - No evidence of cost, premium savings for purchasers; capturing savings is major challenge
5. Strategy: Expand Anti-Fraud, Abuse Efforts

Main components:

- Enact State False Claims Act law
- Support sophisticated electronic fraud, abuse detection systems
- Create Medicaid Inspector General Office
- Fund additional staff
  - Enhance prosecutorial authority
  - Establish prescription drug monitoring program
  - Pass anti-kickback, self-referral, whistleblower laws

Room for Improvement in Recovery Rates

- Fraud and abuse account for 3% - 10% Medicaid payments nationwide, but...
- Average state recovery is just 0.09%; range among states = 0.01% to 1%.
Expanded Anti-Fraud Efforts: Cost Evidence

Evidence suggests efforts can save $ millions

- CMS estimates for each $1 spent on health care fraud prosecutions, recovery = $2 - $7
- OH—Addition of 10 staff to Medicaid Fraud Unit helped increase recoveries by $23 million in 1 year
- NY—Data mining project saved $132 million in 1 year
- TX—$12.3 million increase in Medicaid fraud enforcement helped increase recoveries by $176.5 million

Overview: Prescription Drugs (Rx)

- Pharmaceuticals are integral part of medicine—keep patients healthier, save lives
- More than half of Americans take prescription drugs regularly
- Proper pharmaceutical use saves $—less hospital, ER, nursing home use
- U.S. Rx total purchases = $244 billion annually
6. Strategy: Generic Drugs

Main elements:

• Purchase more generic drugs instead of their brand-name equivalents
• Purchase needed brand-name drugs with increased discounts
• Require licensed pharmacists to dispense FDA-approved generic equivalent unless doctor says no (13 states)

*Note: FDA certifies the “safety and suitability of generic drugs and encourages their use.”*

Generics: Cost Evidence

- **Documented evidence of state savings**
  - **NY Medicaid**—50% reduction in switched-to-generic drugs payments. Saved $22.9 M in FY 2009 (est.)
  - **MA Medicaid**—Mandatory generic substitution grew from 47% in 2002 to 70% in 2007. Each 1% increase generated $7.4 M state savings.
  - **CMS/HHS actuary report**—Increased use of generics and related cost containment policies slowed annual Rx increase from 10.6% in 2005 to 3.2% in 2008.
Generic Drug Cost Challenges

- No generic equivalents for 48% brand-name drugs; cannot safely be substituted unless physician identifies a different treatment.

- Drugs are not typical commodities, every patient is different. Role of orphan drugs, rare conditions.

- Status of individual unique brand drugs may eventually shift to generic or even over-the-counter, but states cannot change process—only the FDA (or courts) can.

- Legislators may be asked to mandate particular product, category of coverage. Issues: Medical expertise to decide? Role of state Medicaid Pharmaceutical & Therapeutics Cmtes (usually created by statute)?

7. Strategy: Expand Negotiated RX Purchasing

Main components:

- Expand use of preferred drug lists (PDLs)—generic and designated drugs covered automatically

- Expand use of manufacturer price “supplemental rebates”—Medicaid negotiates rebates beyond federal price arrangements

- Multi-state purchasing and negotiations
Examples: Expand Negotiated RX Purchasing

• Preferred drug lists—45 states + DC
• Medicaid Supplemental rebates—46 states + DC
• Multi-state purchasing—3 multi-state buying groups cover 24 states; 5 other recent members
  o Each pool uses common PDL and gets supplemental rebates
  o Buying pools cover 32% Medicaid enrollees and 38% of the spending

Expand Negotiated RX Purchasing: Cost Evidence*
(Multi-state plans, Medicaid programs)

Multi-state buying pool savings:
• NV—$4.3 million in 2005 (3.2% of $134 million)
• MD—$19 million in 2006 (4% of $490 million)

PDL savings:
• NY—$82.5 million (2%) in 2007
• IN—$29.8 million, 2003-2007

Supplemental rebates:
• KY—$19.8 million in 2006

Multi-state + Preferred Drug List + extra rebate savings:
• VT—$5.3 million (4.7%) in 2008.

* All savings are in addition to federal maximum price and rebate formulas.
Iowa Medicaid Savings from PDL and 7-state buying pool

2008 savings = $63 million of total Rx expenditure of $191 million

Cost Containment Lessons

- Go for proven strategies first
- Look at actual vs. projected savings
- Consider multi-payer strategies
- Pursue new federal opportunities
- Many strategies seem to work best in integrated systems
- Upfront investment often required
- Capturing savings can be challenge
- Program size matters
- Multi-pronged strategies likely hold the most promise

Note: NCSL takes no position for or against particular state laws or policies