



NCSL's 2010 Project: Health Cost Containment & Efficiencies (A Medicaid Perspective)

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Association
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Overview

- New NCSL Health project – a fresh look at state options for containing costs
- Review of seven state strategies
- Observations

— BUSINESS —

Health care may gobble 20% of economy by 2015

By Ervin Freeling
The Associated Press

Washington — Within a decade, an aging America will be spending one of every five dollars on health care, according to government analysts.

The nation's total health-care bill by 2015 more than 14 trillion. Consumers will foot about half the bill, the government says.

Hospital costs will rise more quickly than previously anticipated, reflecting a construction boom for urban hospitals.

Meanwhile, drug costs are expected to be somewhat restrained, in part because of the new Medicare prescription drug program.

The projections, published in the Journal Health Affairs, come as President Bush focuses on the rising cost of health

care. In his State of the Union address last month, the president pushed health savings accounts and the high-deductible insurance plans that go with them. The administration predicts Americans would become more thrifty if they had to pay more of the up-front costs, which occurs with health savings accounts.

The report, written by analysts with the Centers for Medicare and Medicaid Services, attributes rising costs to the aging of the baby-boom population and the changing nature of health insurance. They forecast a 7.2 percent annual increase in health-care costs over the coming decade. That's in line with the 7.4 percent increase in 2009.

Still, the overall economy is projected to grow at a rate of 2.5 percent over the coming decade, which means health care will play an ever-growing role.



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

** 13 briefs completed or in process as of September, 2010.*



Today: Highlights from 7 Medicaid-Related Briefs

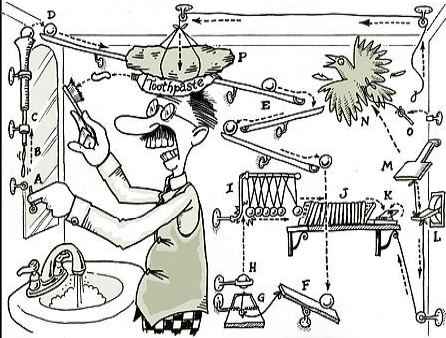
1. Administrative simplification
2. Global payments to health providers
3. Medical Homes *
4. Accountable Care Organizations
5. Strengthen fraud and abuse control *
6. Use of generic drugs
7. Expand negotiated prescription drug purchasing

* Advance copies, not yet released



1. 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 health 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 (average = \$68,274/ practice)



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
 - Single rules for eligibility verification and claims status (1/1/2013)
 - electronic funds transfer and health care payment & remittances (1/1/2014)
 - health claims processing, enrollment, premium payments, and referral certification and authorization (1/1/2016)

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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
 - S.C. 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

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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

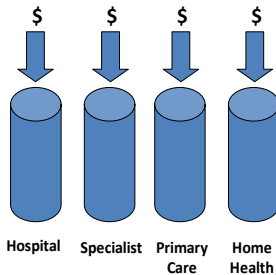


Special Commission's Recommendation

Current Fee-for-Service Payment System

The Problem

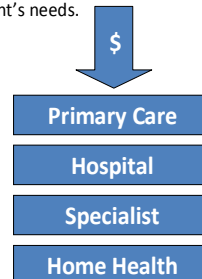
Care is fragmented instead of coordinated. Each provider is paid for doing work in isolation, and no one is responsible for coordinating care. Quality can suffer, costs rise and there is little accountability for either.



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.





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

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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*

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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

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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

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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



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4. Strategy: Accountable Care Organizations (ACOs)

A local health entity comprised of a wide range of collaborating providers that is accountable to health care payers for the overall cost and quality of care for a defined population.

Vermont enacted legislation in 2009 that included ACO provisions. 1st project planned for July 2010.

Massachusetts commission report calls for a structure to be responsible for defining and establishing risk parameters for ACOs, which will receive and distribute global payments. ACOs will assume risk for clinical and cost performance.

Colorado and North Carolina —use networks of Medicaid providers that responsible for improving care, quality and efficiency for the patients



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 state laws



Room for Improvement in Recovery Rates

- *Fraud and abuse account for up to 3% - 10% of Medicaid payments nationwide, but...*
- *Average state recovery is 0.09%; range among 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

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6. Strategy: Use of 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 encourage 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.



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
 - Each pool uses common PDL and gets supplemental rebates
 - 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.



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A final note on Provider Fees or Taxes

These state revenue mechanisms, used in 45 states allow Medicaid programs to take advantage of Federal Medicaid Percentage matching funds to bring in \$100s of millions in federal funds.

This is a cost shift more than cost containment BUT it is viewed as win-win in many states. [See NCSL report September 2010.](#)



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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