Medicaid Managed Care Testimony

Presented to:
Pennsylvania Human Services Commission

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Overview of The Lewin Group

- Leading health care consulting firm since 1970
- Key strengths:
  - extensive knowledge of all models of Medicaid managed care
  - analytical rigor & objectivity
- We've conducted a vast range of Medicaid work
  - Helped design, implement, operate, evaluate and/or strengthen Medicaid managed care programs in more than 20 states
  - Recent project focus for our state clients has been on achieving fiscal savings in the most constructive manner

Our Presentation Has Three Components

1) Summarize Lewin's 2005 study of HealthChoices

2) Discuss retention of MCO voluntary enrollment program alongside ACCESS Plus

3) Describe pros & cons of carving pharmacy out of HealthChoices MCO capitation

Purpose and Scope Of HealthChoices Study

- Purpose:
  - Conduct an independent assessment of the value of the HealthChoices Physical Health Program to help inform the continuing debate about the future direction of the Commonwealth's Medical Assistance program
- Focus on four areas that contribute to a health care program's overall value:
  - cost-effectiveness
  - access
  - quality
  - serving individuals with special needs

HealthChoices Cost-Effectiveness Assessment

- HealthChoices has delivered massive savings, and the level of savings continues to compound upwards
  - savings of more than $2.7 billion from 2001-2005
  - average annual medical cost escalation of 7.4 percent, vs. 10.4 percent in fee-for-service program
- Financial status of the program in exceptional balance year after year
  - approximately 88% MLR, 9% admin, 3% operating margin
- The cost savings are predominantly attributable to true coordination of care (as opposed to price discounting)
  - program has been a vehicle for preserving and even propping up provider prices

Medicaid MCO Financial Performance Summaries By State And Year

State	Year	Mandatory Enrollment Population	# Of Health Plans	Medical Loss Ratio	Admin Cost Ratio	Operating Gain (Loss)
District of Columbia	2001	TANF	2	82.2%	14.4%	3.4%
District of Columbia	2002	TANF	3	78.2%	19.6%	2.2%
District of Columbia	2003	TANF	3	74.9%	15.6%	9.6%
District of Columbia	2004	TANF	3	75.5%	13.4%	11.1%
Maryland	2002	TANF & SSI	7	87.8%	12.1%	0.1%
Maryland	2003	TANF & SSI	7	86.3%	11.3%	2.4%
Maryland	2004	TANF & SSI	7	91.5%	9.9%	-1.4%
Pennsylvania	1996	TANF & SSI	2	88.6%	13.7%	-2.3%
Pennsylvania	1997	TANF & SSI	3	89.6%	13.1%	-2.7%
Pennsylvania	1998	TANF & SSI	3	88.7%	11.7%	-0.3%
Pennsylvania	1999	TANF & SSI	4	87.9%	8.9%	3.1%
Pennsylvania	2000	TANF & SSI	4	88.7%	8.8%	2.5%
Pennsylvania	2001	TANF & SSI	5	87.9%	9.8%	2.2%
Pennsylvania	2002	TANF & SSI	6	88.3%	9.1%	2.6%
Pennsylvania	2003	TANF & SSI	6	88.5%	8.4%	3.1%
Pennsylvania	2004	TANF & SSI	6	88.4%	8.6%	3.0%
West Virginia	2000	TANF	2	88.2%	9.8%	2.0%
West Virginia	2001	TANF	2	87.2%	9.9%	2.9%
West Virginia	2002	TANF	2	89.5%	8.4%	2.1%
West Virginia	2003	TANF	2	88.1%	8.9%	3.0%
Texas	2001	mostly voluntary	10	84.8%	14.2%	1.0%
Texas	2002	mostly voluntary	12	82.6%	14.0%	3.3%
Texas	2003	mostly voluntary	8	82.6%	14.0%	3.3%
New York	2002	TANF	18	73.7%	19.2%	7.1%
New York	2003	TANF	18	76.7%	16.2%	7.1%
Washington State	1999	TANF	6	88.5%	11.0%	0.5%
Washington State	2000	TANF	6	86.7%	12.0%	1.3%
Washington State	2001	TANF	6	85.3%	13.5%	1.2%
Washington State	2002	TANF	6	85.3%	13.3%	1.4%
Arizona (long term care)	2003	SSI	8	90.9%	7.8%	1.3%
Arizona (acute care)	2003	TANF & SSI	10	92.0%	7.6%	0.4%
Illinois	2002	all voluntary	2	65.8%	26.2%	8.0%
Illinois	2003	all voluntary	4	74.0%	21.7%	4.4%

Access Assessment

- We assessed the various ways access can be influenced and promoted
  - What assistance with access occurs at the point of obtaining coverage?
  - At the point of seeking care?
  - What outreach and education occurs to *assist* members in following treatment protocols?
  - In obtaining preventive services and engaging in healthy lifestyles?
- Along all of these dimensions, the HealthChoices program is engaging in both significantly more and far superior access-enhancing initiatives than can occur under any type of fee-for-service model. For instance, the MCOs...
  - enhance active provider participation via numerous approaches
  - help recipients locate network providers
  - engage in vast array of value-added initiatives designed to enhance access

Quality Assessment

- Quality measurement in FFS environment is exceedingly difficult
- General focus on quality and quality monitoring are far less integral components of PCCM model compared to capitated health plan model
- All HealthChoices health plans have received high ratings from National Committee on Quality Assurance
- Zest for continual and intensive self-evaluation was a common theme across the seven managed care organizations

Serving Individuals With Special Needs

- The HealthChoices MCOs employ a number of mechanisms to identify members' special needs (medical and non-medical) that must be addressed in order to effectively serve them
  - All health plans operate a special needs unit (SNU) as required by DPW that coordinate care between primary and specialty services, health education, other human service systems needed by the member
  - In addition, HealthChoices health plans have made substantial investments in separate care coordination and disease management units
- The MCOs' care coordination programs are multifaceted, serving members with a wide range of needs and coordinating services and care across multiple providers
- The MCOs' DM programs do not *replace* their individualized case management approaches, but rather serve as one component of that approach

Concluding Remarks Regarding Lewin's Study of HealthChoices

- Many aspects of the HealthChoices model simply cannot be replicated under any FFS model
  - full risk
  - integration
  - competition
  - local focus
  - innovation
  - accountability
- On all fronts, HealthChoices is as effective a program as we have seen anywhere across the nation in the Medicaid arena

Pennsylvania's Voluntary MCO Enrollment Program Seems Well Worth Preserving

- ♦ A policy option under consideration would remove MCO option where the MCOs operate alongside ACCESS Plus
  - this currently occurs in 25 counties
- ♦ We do not view this change to be in Commonwealth's interest
  - ♦ ACCESS Plus is a new approach without demonstrated success in Pennsylvania; its design is less comprehensive than MCO model
    - – ACCESS Plus doesn't match up to MCOs' "horsepower" in outreach & other access enhancement, cost containment, or quality monitoring
  - MCO model has a proven, stellar track record in Pennsylvania
    - – each of the seven MCOs have participated throughout the past __ years,
  - DPW's design avoids all potential drawbacks of voluntary MCO model
    - – MCO marketing not permitted: DPW dollars used for service (not sales)
    - – All MCOs have scale economies: *smallest* MCO has xxx,000 enrollees
    - – Rate-setting adjusts to MCO enrollment selection and mix

Lewin Has Conducted Several Analyses Relevant to Medicaid Pharmacy Carve-Outs

Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting

- we found net PMPM costs in Medicaid MCOs to be well below net State FFS costs: lower volume of medications, less costly drug mix handily offset FFS large rebate advantage

Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System

- we found moving to a carve-out in Arizona would be slightly more costly than continuing carve-in (AZ's net Medicaid Rx costs are nation's lowest)
- the comparison wasn't close programmatically: a carve-in is far more consistent with an integrated coverage system
- prescription drugs have become central to health care treatment
- medical and pharmacy management are deeply interwoven - putting pharmacy into its own "silo" shouldn't occur without compelling advantages

Our Most Recent Disabled Adult Rx Analysis In Rhode Island Had Similar Findings

- Carve-Out Cost Estimates:
  - Baseline state claims costs were reduced 25% to account for rebates
  - Another 5% reduction was applied for a recently implemented pharmacy price discount
  - State capitation savings of 5% built into estimates
- Total Carve-Out reduction from "amount paid" baseline: 35%

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- Carve-In Cost Estimates:
  - > MCO simulation of same claims showed a 16% reduction versus baseline due to drug mix, fill fee, base price discounts
  - > MCO rebates were estimated at 4% of baseline costs
  - Prescription volume reduction of 17.5% assumed under carve-in
- Total Carve-In reduction from "amount paid" baseline: 37.5 %

Assessments Of Net PMPM Pharmacy Costs in Carve-Out States Supports Our Findings

- Using MSIS data, TANF PMPM pharmacy costs in New York and Delaware (two pharmacy carve-out states) averaged above net PMPM costs of MCOs in northeastern states where carve-in is used

  - Despite mandatory enrollment into MCOs, Delaware's SSI Rx costs are among highest in the nation on a PMPM basis under its carve-out program.
  - New York and Delaware are both among nation's five highest-cost states with regard to Medicaid PMPM pharmacy costs for the blind/disabled population.

- We conclude from this data that a large prescription volume differential exists between the carve-out and carve-in settings; large-scale Medicaid Rx price differences do not exist between states

Mercer's Assumptions And Lewin's Differ Widely In Several Key Areas

- Mercer estimates less than a 1 % savings under a carve-in from "MCO Efficiency Improvement'; we assume a 15-20% volume differential exists between a setting where prescriptions are ""free" to the MCO versus a setting where MCO is at full risk
- Mercer modeling didn't estimate a large difference in brand/ generic mix under a carve-out; we consistently see a much higher mix of low-cost generic medications when MCOs are accepting full risk
- Mercer assessment assumes 8.4% "extra" cost reduction under carve-out from supplemental rebates
  - we are very skeptical about achievability and sustainability of this level of additional rebates) concerned about the "strings" attached to the rebates)
  - we don't see States getting & maintaining large extra rebates on net drug spending *and* a favorable brand/ generic mix simultaneously

Pharmacy Carve-Outs Have Many Inherent Disadvantages

- Rx carve-outs significantly undermine an integrated system of care/coverage. Pharmacy is not a peripheral benefit that can be "pulled out" and moved into its own silo without large ramifications

- Incentives no longer involve managing a person's overall costs: carve-outs create "buckets" of services, some of which the MCO is at dollar for dollar risk, some of which are free to MCOs.

  *"Let's face it. When **I'm** driving a rental car I don't take care of it as well as my own car. I don't abuse it, but I don't take care of it as well. These same dynamics seem to exist with the pharmacy cost situation. It's not going to be taken care of as well if it's all someone else's money. "   —Arizona physician*

- Moving drug benefit into FFS setting politicizes the content of formularies and the way the benefit is managed. The pharmaceutical industry is exceptionally well-equipped to favorably navigate this kind of situation.

- Carve-outs focus on a rebate-driven strategy, but you can "go broke on all the money you think you're saving."

"Rebates are accepted or offered by a drug manufacturer for only one reason — they are getting something of greater value in return for the rebate. -- Arizona stakeholder

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- **Most studies referenced in this presentation can be downloaded at no charge from our website:**
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