State Health Watch

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In This Issue

■ **Too much of a good thing?** For the first time in history, state spending on Medicaid is likely to pass education and a turnaround isn't here yet. . . . . cover

■ **Medicaid managed care saves money when done properly.** Some plans have learned what doing it properly means . . . . cover

■ **Increasing ranks of the uninsured.** The number of people without health coverage is up, and the number of people with employment-based health insurance is down 4

■ **Significant racial and ethnic health care disparities are a real problem.** Researchers see the need for more studies 9

■ **State officials often don't know where to begin to overcome health care disparities.** However, researchers have many ideas based on successful programs. 10

■ **Clip files/Local news from the states** 12

■ **Also in this issue:** 2004 index of stories

Managed care results in improvements in access and preventive care, as well as savings

A synthesis of 14 research studies by the Lewin Group for America's Health Insurance Plans (AHIP) indicates that Medicaid managed care provides significant cost savings and high-quality medical care.

"Since the early 1990s, many state Medicaid programs have turned increasingly to managed care to improve the quality of and access to care and to contain costs," noted AHIP president Karen Ignani. "This report demonstrates how our members are fulfilling these expectations. The report provides tangible evidence that Medicaid managed care is getting results for states and the beneficiaries they serve. It also shows there is a tremendous opportunity for future growth in this important public-private partnership as more states look to Medicaid managed care plans to meet more of their health care needs."

The report said the studies "present compelling evidence that Medicaid managed care programs can yield savings. The studies also suggest that certain populations or services are especially likely to generate savings in a managed care delivery system."

Specific findings presented by the Lewin Group include:

- Studies strongly suggest that Medicaid managed care typically yields cost savings ranging from 2% to 19%.
- Studies provide some evidence that Medicaid managed care savings could be significant for the Supplemental Security Income (SSI) and SSI-related population.
- Studies demonstrate that states' Medicaid managed care cost savings largely are attributable to cuts in inpatient utilization.
- Studies indicate pharmacy is an area where Medicaid managed care programs yield noteworthy savings.

According to Lewin Group analysts, there still is substantial opportunity for states to expand Medicaid enrollment in managed care plans. They note that according to the Centers for Medicare & Medicaid Services, 59% of the Medicaid population is enrolled in managed care. Of the Medicaid managed care population, 66% are in comprehensive, prepaid managed care plans. Thus, the report said, approximately 39% of all Medicaid enrollees are in prepaid managed care plans.

"A number of states, though, have carved out some of the highest-cost services from their managed care programs," the report explained, "and most states have

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excluded some entire eligibility categories — generally the high-cost disabled populations — from their managed care initiatives. As a result, while prepaid managed care plans provide health care services to almost half of Medicaid beneficiaries nationwide, 88% of national Medicaid spending remains in the fee-for-service system where coordination of care is the exception rather than the rule."

With states continuing to face budget pressures, the analysts said, there is interest in assessing whether Medicaid managed care expansion might ease the fiscal pressures less painfully than alternatives such as cutting eligibility, eliminating benefits, or reducing already low provider payments.

Structural means to save money

According to the Lewin Group study, savings opportunities in Medicaid managed care largely are created by the inherent structural challenges of coordinating care and containing costs in the fee-for-service setting. "The fee-for-service model is an unstructured system of care that creates incentives to provide as many services as possible, while doing little to encourage providers to manage the mix and volume of services effectively," the report noted. "Managed care organizations, on the other hand, combine within one entity the responsibility for both the financing and delivery of health care and thus have strong incentives and means to coordinate care and, in turn, reduce the costs of inpatient and other expensive categories of health care services, where Medicaid spending is concentrated."

While states often have turned to provider payment cuts for savings in fee for service, the Lewin Group explained such a strategy risks driving mainstream physicians out of the Medicaid program, impeding Medicaid beneficiaries' access to primary and preventive care services, and funneling Medicaid care toward more expensive institutional-based services.

In contrast, Medicaid managed care can achieve savings through a number of mechanisms including improving access to preventive and primary health care by requiring participating doctors and hospitals to meet standards for hours of operation, availability of services, and acceptance of new patients; investing in enrollee outreach and education incentives to promote utilization of preventive services and healthy behaviors; providing a medical home for individuals and using a physician's expertise to refer patients to the appropriate place in the system rather than relying on patients' ability to self-refer; providing individualized case management services and disease management services; channeling care to providers who practice cost-effectively; using lower-cost services and products where available and clinically appropriate; and conducting provider profiling and enhancing provider accountability for quality and cost-effectiveness.

But the Lewin Group compilation also identified some factors that work against the ability to achieve Medicaid savings, including:

- **Transitory enrollment.** The Lewin Group said there is volatile eligibility in the Transitional Assistance to Needy Families (TANF) population. Most Medicaid managed care enrollees are TANF recipients and, by definition, have short-term enrollment duration. The Lewin Group said this poses a substantial administrative burden in continually processing a large volume of enrollments and disenrollments.
- **Poverty-related enrollee characteristics.** Barriers to health care related to Medicaid recipients'

impoverished status include low educational attainment, language and literacy barriers, homelessness, lack of reliable transportation, and inadequate child-care options. Such barriers can challenge the efforts of managed care organizations to manage and coordinate enrollee care and often require them to make additional investments to accomplish their goals.

- **Prescription drug rebates.** Drug manufacturers participating in the Medicaid Drug Rebate Program provide quarterly rebates to states for drugs dispensed to Medicaid recipients. These rebates result in best price to Medicaid. But as private purchasers, Medicaid managed care plans aren't entitled to the rebates and must enter into separate negotiations with drug manufacturers either directly or through their contracting pharmacy benefits manager.
- **Rural barriers.** Rural settings can pose daunting challenges to managed care in Medicaid and other payers, the report explained. The limited number of providers can make it difficult to assemble a network, and the market may be unable to provide the economies of scale achievable in more metropolitan areas.
- **Limited price discount strategies.** While managed care organizations outside of Medicaid are able to negotiate price discounts, they generally are not available to Medicaid plans. The Lewin Group report said that given the low levels of Medicaid participation among physicians, it is not realistic or appropriate from a network development perspective to drive down Medicaid prices. Savings thus have to come from truly managing care rather than managing price.
- **Capitation rate setting.** An overarching issue that determines the level of Medicaid savings that can be achieved through a capitation model is the capitation rates themselves, the report noted. It is not an automatic process for states to pay a capitation rate that builds in savings and also is sufficient to cover managed care organizations' medical costs, administrative costs, and profit/operating margin needs. Capitation rates set unnecessarily high can result in states having greater expenditures under their managed care program than in fee-for-service, while rates set too low will make it difficult to attract or retain health plans and could violate federal requirements for actuarially sound rates.

The report said the 14 studies provided some evidence that Medicaid managed care savings could be significant for the SSI and SSI-related population because they typically are high users of services and are the most costly group to cover. In some states, most of overall Medicaid managed care savings achieved is attributable to this population.

Thus, in Arizona, 60% of the $102.8 million saved from 1983 to 1991 was from the SSI population, while in a Kentucky region, the SSI population made up 25% to 34% of total enrollment and accounted for 53% to 61% of savings from 1999 to 2003.

States also demonstrated that cost savings largely are attributable to decreases in inpatient utilization. A study of preventable hospitalizations in California found that the TANF and TANF-related population had 38% lower rates of preventable hospitalizations, saving the state an estimated $66 million between 1994 and 1999. The SSI and SSI-related population had 25% lower rates of preventable hospitalizations.

Pharmacy also was an area in which noteworthy savings were seen. A Center for Health Care Strategies comparison of fee-for-service and Medicaid managed care drug costs in 2001 found that the per-person-per-month cost of drugs in a capitated setting was 10% to 15% lower than in a fee-for-service setting, even after considering the larger rebates state agencies receive under fee for service.

Access improved generally

While access to care and quality under Medicaid managed care were not the main focal points of the Lewin Group review of research, the studies yielded some information on access and quality data. In most cases, the report said, Medicaid managed care programs have improved Medicaid beneficiaries' access to services, and both the programs and individual managed care organizations have earned high satisfaction ratings from enrollees.

In Wisconsin, for example, HMO members are more likely to have at least one primary care physician visit than those in fee for service.

Policy implications the Lewin Group gleaned from the studies include recommendations that states consider including the SSI and SSI-related population in a managed care program and states with managed care programs that have carved out prescription drugs consider revisiting that decision, since capitating the pharmacy benefit may reduce costs more than are offset by rebates available to carved out programs.

The Lewin Group report concluded that there have been instances where states have not achieved savings from their Medicaid managed care program in

a given year, and other instances where health plans have left the program. "There is obviously always going to be a point below which the state's managed care payment rates are no longer viable for managed care organizations," the authors said. "However, the preponderance of the research evidence is that prepaid managed care partnerships between state Medicaid agencies and managed care organizations can produce a substantial program cost savings without forcing the health plans to operate at a financial loss.

"The federal requirement for actuarially sound rates is a critical building block for a successful program. As states consider expanding their Medicaid managed care programs and as other states implement new Medicaid managed care programs, they may wish to include certain populations and services that have often been excluded from Medicaid managed care due to quality and access to care concerns."

Plans for difficult populations

Two plans that have succeeded in serving difficult populations are AmeriHealth Mercy Health Plan and Amerigroup. The Lewin Group cited units of both organizations as models of how plans can cover the SSI and SSI-related populations.

Medicaid managed care for AmeriHealth Mercy's Passport Health Plan SSI population made up 25% to 34% of total enrollment and accounted for 53% to 61% of savings achieved from 1999 to 2003. Other studies have shown that since its inception, Passport has demonstrated more than $10 million in cost savings for the Commonwealth of Kentucky.

"The results from the AHIP report clearly support what we have always believed — that managed care works in Medicaid," says AmeriHealth Mercy president Daniel Hilferty.

"Like the numerous success stories of the plans in the report, AmeriHealth Mercy and its family of companies have demonstrated their value for more than 20 years by giving Medicaid recipients access to the health care system, providing preventive care, offering case management and disease management programs, supporting community health initiatives, and saving taxpayer money at the same time."

Mr. Hilferty tells *State Health Watch* that his organization has been a Medicaid-only managed care plan since its founding by a group of inner-city hospitals. "We've developed expertise in managing the care of this population," he says.

What AmeriHealth Mercy has learned, according to Mr. Hilferty, is to use capitated payments to develop a structure for a modest margin financially and then at the same time improve quality and access to care.

"We're able to help states that are in a fiscal crunch with their fee-for-service program going out of control," he adds.

AmeriHealth Mercy plans in Kentucky and Pennsylvania provide managed care services to the SSI population and Mr. Hilferty says it has enabled them to put very sick individuals into a system of care with access to a primary care physician, specialists, and everything else that is needed for their care so that care is managed for the highest quality with the lowest cost.

Asked how patient advocates have responded, Mr. Hilferty says that traditionally advocates have resisted managed care models. "We've learned that in dealing with advocates, parents, and others, we need to help them realize that the system in place provides a higher quality of care and access to better care," he says.

AmeriHealth Mercy makes good use of community outreach efforts and meetings with advocacy groups and parents and guardians to listen to their concerns and explain how the plan addresses them.

"This is not the traditional Medicaid population that is largely poor and has other cultural and social issues," Mr. Hilferty explains.

"These often are children of people who have access to commercial health insurance care. They've been thrown into a system that is bureaucratic and run by the government, but they expect it to be the same as what they have," he noted. "Their comfort level with us develops over time through dialog, but there certainly are still issues. However, we don't see the large level of concern any more."

Mr. Hilferty says there continues to be an undercurrent of anti-managed care sentiment, often because people's sense is that too often care is managed by denying care.

"We've found that just doesn't work," he says. "We need to coordinate care and collaborate with providers. We have to be better promoters of our success stories so people understand that this is the right way to manage care for those in need."

In Texas, the report said, Amerigroup's Star+Plus program is targeted to the urban SSI population of Harris County. Assessments of the program reviewed by the Lewin Group indicate that the enrollment of the population into Medicaid managed care has yielded savings and that the level of savings has grown over time. Savings during the first waiver period (February 1998 to January 2000) was $6.05 million or $4.11 per member per month, while in the second waiver period (September 1999 to August 2002) it was $123 million or $91.67 per member per month.

Star+Plus president Aileen McCormick tells *State Health Watch* that care coordination for the SSI population is very different from that used with traditional Medicaid populations, and the nuances in care require different types of plan associates and not solely RN case managers.

New care model needed

"We need social workers and long-term care coordinators," Ms. McCormick notes. "We're working with psychosocial needs that go well beyond the traditional medical needs. In fact, we have to address the psychosocial issues before we can address the clinical issues. This a real psychosocial model rather than a medical model and we have to truly understand the nature of the people we are working with."

It's not always easy for the plan to find the resources it needs, Ms. McCormick says. They need to reach out to home health agencies and other sources of professionals who are used to going into homes and providing hands-on work.

But while serving the SSI population requires intensified resource utilization, she says they have found that if they can ensure that patients have the basics and comply with the other elements of the care plan, they will have more of a chance of remaining ambulatory and staying out of the hospital, meaning that overall costs will be lower.

"It takes a lot of money up front and a lot of outreach to really make a difference so that patients remain ambulatory," Ms. McCormick says.

She says Star+Plus patient satisfaction scores are high, sometimes driven by how satisfied long-term care providers are.

"We have made great strides [to bring long-term care providers in as partners], but we can still do more," she says, noting that sometimes when aides voice problems, it will affect member satisfaction. "There's been a learning curve, even for us, but we've now got it."

Medicaid managed care for the SSI population will be expanding into other Texas communities and Ms. McCormick says Star+Plus is developing networks outside of Harris County to be ready for the expansion.

"It's easier for us to deal with expansion," she says. "We've gotten over the learning curve, and we don't have to make the same mistakes again."

Pharmacy is politically sensitive

With the Lewin Group report recommending that plans consider not carving out pharmacy, Ms. McCormick says there have been preliminary discussions with Texas officials on what is a politically sensitive issue. "We have pharmacy risk in our other models, and we think it would be in the state's best interests to put that risk with us," she explains.

Mr. Hilferty says AmeriHealth Mercy's PerformRx pharmacy management program serves nearly 900,000 members in five states and has demonstrated the kinds of savings the report suggested are possible by maintaining an average pharmacy cost trend of 8%, contrasted with a national trend of 15% in the Medicaid sector.

For other plans considering moving on the Lewin Group report's recommendation to expand managed care to SSI recipients, Ms. McCormick offers the following suggestions:

1. Don't have stars in your eyes, and understand how sick SSI patients are so you realize you will spend a lot of money on medical care.
2. Staffing ratios are much higher with SSI patients than with other populations.
3. SSI patients require a different care management system rather than the typical case management on-line tool.
4. Recognize that you will feel more like a social and outreach agency than a medical management department and accept the positive aspects of that difference — that you are touching patients and improving their lives.
5. Don't underestimate the need to work with advocates, building trust so they accept that your plan is in this business for the right reasons.

[The Lewin Group report is available on-line at www.ahip.org. Contact Mr. Hilferty through www.amerihealthmercy.com. Contact Ms. McCormick at (713) 218-5101.] ■