



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

An Evaluation of Medicaid Savings from Pennsylvania's HealthChoices Program

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Sponsored by the following HealthChoices Managed Care Organizations: AmeriHealth Mercy Health Plan, Gateway Health Plan, Inc., HealthPartners of Philadelphia, Inc., Keystone Mercy Health Plan, UnitedHealthcare Community Plan, UPMC for You

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I. Executive Summary

A. Introduction and Background

HealthChoices – the Commonwealth of Pennsylvania’s mandatory capitated managed care program for Medical Assistance (MA) recipients¹ – was implemented in 1997. Eight managed care organizations (MCOs) currently provide services to HealthChoices enrollees: Aetna Better Health, AmeriHealth Mercy Health Plan, Coventry Cares from HealthAmerica, Gateway Health Plan, Inc., HealthPartners of Philadelphia, Inc., Keystone Mercy Health Plan, UnitedHealthcare Community Plan, and UPMC *for You*.²

Mandatory enrollment into the HealthChoices program is required in 25 counties. Pennsylvania has also implemented an enhanced primary care case management fee-for-service Medicaid program named ACCESS Plus. ACCESS Plus is used exclusively in 16 counties for Medicaid consumers without Medicare coverage.³ In Pennsylvania’s remaining 26 counties, the MCOs serve Medicaid consumers on a voluntary enrollment basis, with consumers who do not select an MCO option receiving coverage under ACCESS Plus.

The Pennsylvania Coalition of Medical Assistance Managed Care Organizations (the Coalition) is comprised of physical health managed care organizations that contract with the Commonwealth of Pennsylvania to provide services to recipients enrolled in the HealthChoices program. In 2005, the Coalition commissioned The Lewin Group to conduct a comparative evaluation of Pennsylvania’s HealthChoices program and fee-for-service program, focusing on four areas that contribute to a health care program’s overall value:

- Cost-effectiveness as compared to traditional fee-for-service;
- Impact on access;
- Quality of services provided; and
- Focus on and approaches to serving individuals with special needs.

The Coalition has now asked The Lewin Group to update our analysis of the cost savings of the HealthChoices program as compared to traditional fee-for-service and to ACCESS Plus.

B. Summary of Approach

To conduct this evaluation, Lewin interviewed six of the eight managed care organizations participating in HealthChoices to gain context for the medical cost comparisons. Additionally, we calculated per member per month (PMPM) costs for Pennsylvania and other comparison states using Medicaid Statistical Information System (MSIS) data to review cost trends for blind/

¹ In Pennsylvania, the HealthChoices program encompasses both physical and behavioral health managed care. This report focuses specifically on the physical health managed care organizations.

² Six of the eight HealthChoices MCOs sponsored this study and participated in its development: AmeriHealth Mercy Health Plan, Gateway Health Plan, HealthPartners of Philadelphia, Keystone Mercy Health Plan, UnitedHealthcare Community Plan, and UPMC *for You*.

³ Persons dually eligible for and enrolled in Medicaid and Medicare are not served by HealthChoices nor by ACCESS Plus.

disabled consumers who are not dually eligible for Medicare.⁴ This subgroup was the focal point of the cost trending estimates as it is particularly amenable to coordinated care impacts due to coverage continuity, prevalence of chronic conditions, and high usage of services (e.g., inpatient hospital and pharmacy) that managed care models can typically influence.

C. Summary of Findings

The HealthChoices program continues to provide Medicaid cost savings to the State through a broad and innovative array of cost containment strategies. Below we provide HealthChoices cost saving estimates compared to fee-for-service and ACCESS Plus, cost trends and cost containment efforts in the HealthChoices program, and estimates of potential savings associated with a geographic expansion of HealthChoices.

1. Savings Compared to Fee-for-Service

In the 2005 study, Lewin found that HealthChoices saved the State \$2.7 billion (\$1.4 billion in State funds) during the preceding five-year period. This update of the cost-effectiveness component of that previous study finds that the HealthChoices managed care approach continues to yield significant savings to the State. The current study finds that:

- HealthChoices is estimated to have yielded overall Medicaid savings of \$5.0 to \$5.9 billion (\$2.9 billion to \$3.3 billion in State funds) when compared to fee-for-service over the past 11 years (CY2000 – CY2010).
- Looking forward, HealthChoices is projected to yield State Fund savings of \$2.9 billion to \$3.6 billion versus fee-for-service over the next five years (CY2011 – CY2015) in the existing HealthChoices counties. These savings are projected to increase to between \$5.4 billion and \$6.6 billion for the ensuing five-year period (CY2016 – CY2020).

The original 2005 study used Medicaid fee-for-service as the baseline for comparison as ACCESS Plus was still in its early stages. Therefore, for the purpose of consistency, this update to the study also used a traditional fee-for-service baseline to demonstrate that, consistent with the 2005 study, HealthChoices continues to provide significant savings to Pennsylvania when compared to an unmanaged fee-for-service system in the HealthChoices zones.

2. Savings Compared to ACCESS Plus

Another reference point for HealthChoices' savings impacts is the State's enhanced primary care case management program ACCESS Plus. When comparing HealthChoices to ACCESS Plus, the current study found:

- HealthChoices is estimated to have yielded total savings \$1.1 to \$1.4 billion in State funds when compared to ACCESS Plus over the past five years (CY2006 – CY2010).
- Looking forward, HealthChoices is projected to yield State Fund savings of \$2.1 billion to \$2.4 billion over the next five years (CY2011 – CY2015) in the existing HealthChoices

⁴ The MSIS data are available on the CMS website at <http://msis.cms.hhs.gov>. This data set includes Medicaid cost and eligibility information for each state throughout the past decade. MSIS data can be tabulated for various Medicaid population subgroups and types of service.

counties and between \$3.8 billion and \$4.4 billion for the ensuing five-year period (CY2016 - CY2020) when compared to ACCESS Plus.

Because ACCESS Plus incorporated additional cost containment strategies that the traditional fee-for-service model does not utilize, the annual savings HealthChoices is creating, although still large, are smaller relative to the ACCESS Plus baseline in recent years than relative to the traditional fee-for-service setting from earlier years when ACCESS Plus did not exist.⁵

In the estimates of savings compared to ACCESS Plus, as well as the savings compared to fee-for-service, the State's premium tax program accounts for approximately 40 percent of the State Fund savings the HealthChoices program is yielding, with HealthChoices' care coordination model accounting for the majority (approximately 60 percent) of State Fund savings.

3. Cost Trends and Cost Containment

Cost trends were assessed across a five-year timeframe, CY2003 - CY2008, as 2008 is the most recent year for which parallel information is currently available from every state. For the non-dual blind/disabled population, Pennsylvania's PMPM Medicaid costs were lower in 2003 than in the three comparison groups of geographic peers, size peers, and the United States overall. These PMPM costs subsequently trended more slowly in Pennsylvania (an average of 3.5 percent annually between 2003 and 2008) than in the comparison groups, which all averaged an annual trend of 4.8 - 4.9 percent. Thus, Pennsylvania's PMPM costs for these subgroups as of 2008 were further below those of the comparison groups. Given Pennsylvania's high percentage of capitation, it is probable that HealthChoices was a major contributing factor to both the relatively low PMPM and cost trend in the blind/disabled population.

The structure of the HealthChoices program also features more cost containment attributes than either fee-for-service or ACCESS Plus, including: channeling patient volume towards lower cost settings and towards cost-effective providers, avoidance of unnecessary services, and assuming risk for medical costs. While all cost containment techniques used by ACCESS Plus are also deployed by HealthChoices, the HealthChoices MCOs implement a wide array of additional cost containment approaches that do not occur under ACCESS Plus.

From a service-specific perspective, HealthChoices has demonstrated cost containment techniques in prescription drugs and inpatient hospital care resulting in large-scale cost savings. For pharmacy costs, MCO dispensing fees are half of what is paid in fee-for-service and ACCESS Plus (\$2 versus \$4), resulting in an estimated \$40 million a year in savings. Further, MCOs use generics on average 10 percent more frequently than fee-for-service. HealthChoices plans have also focused on reducing inpatient hospital costs and usage throughout their tenure. Recent initiatives in this area include the use of "observation day" rates for low-acuity patients during short hospital stays rather than the higher Diagnosis Related Group (DRG) rate for inpatient care, resulting in substantial savings per case for these admissions.

⁵ Another factor that reduced the savings HealthChoices is annually able to achieve involves the removal of Medicaid/Medicare dual eligibles from the HealthChoices program as of CY2006 in conjunction with the creation of the Medicare Part D pharmacy coverage program.

4. Savings from Geographic Expansion

The Coalition also asked Lewin to estimate the potential savings that could result from converting ACCESS Plus members into HealthChoices in the 42 counties where the ACCESS Plus program currently operates. We estimate that this policy change would yield State Fund savings of approximately \$375 million between CY2012 and CY2015. State savings are projected to total approximately \$725 million across the five-year timeframe CY2016 - CY2020. Thus, State savings from replacing ACCESS Plus with HealthChoices across the nine-year period CY2012 - CY2020 are projected to be roughly \$1.1 billion.

II. Introduction

A. Coordinated Care in Pennsylvania's Medicaid Program

Pennsylvania has extensively utilized coordinated care approaches in its Medicaid program. As of 2008, 53 percent of Pennsylvania's total Medicaid expenditures were paid via capitation, versus a nationwide average of 23 percent.⁶ Pennsylvania ranks second only to Arizona (where 83 percent of Medicaid expenditures were capitated) on this statistic. Thus, an extensive base of coordinated care experience exists in Pennsylvania that can be evaluated. As Arizona's figure indicates, there is still considerable room for expansion of the capitated model in Pennsylvania should the State's policymakers desire to draw on this approach more extensively going forward.

Pennsylvania's mandatory enrollment capitated Medicaid managed care program is named HealthChoices. In 25 counties, including all of the state's largest urban areas, Pennsylvania utilizes only the HealthChoices model for all persons not dually eligible for Medicare. Eight managed care organizations (MCOs) participate in the HealthChoices program through contracts with Pennsylvania's Department of Public Welfare (DPW). These contracts are awarded through a competitive procurement process.

Pennsylvania also has an enhanced primary care cases management program named ACCESS Plus. ACCESS Plus is the only program offered in 16 counties for consumers without Medicare coverage. A private contractor is used to assist DPW in implementing ACCESS Plus. This contract is also awarded through a competitive procurement process.

In Pennsylvania's remaining 26 counties, the MCOs serve Medicaid consumers on a voluntary enrollment basis. In these counties, non-dually eligible consumers who do not select an MCO receive coverage under ACCESS Plus.

B. Findings from 2005 HealthChoices Study

In 2005, Lewin conducted a study for the Coalition of Medical Assistance Managed Care Organizations to evaluate HealthChoices as compared to the State's fee-for-service and ACCESS Plus programs. The report, "Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program," included information collected from interviews with the managed care organizations participating in HealthChoices as well as an analysis of relevant data from the HealthChoices and fee-for-service programs in the State. At the time of the report, ACCESS Plus was a relatively new program with limited data available, and therefore the evaluation of HealthChoices against ACCESS Plus was based primarily on the latter program's contractual requirements. The study reviewed the HealthChoices program in four specific areas.

1. Cost-Effectiveness

The report compared HealthChoices to ACCESS Plus and other similar managed fee-for-service models. While ACCESS Plus was found to offer some cost containment opportunities, managed

⁶ This figure includes capitation payments to Medicaid MCOs, to specialty management organizations (e.g., behavioral health care management entities who are at-risk), and monthly payments to primary care providers that occur under primary care case management (PCCM) programs.

fee-for-service models reviewed were generally not found to be as effective as potential strategies in a fully capitated setting. The report indicated that ACCESS Plus would likely provide initial savings, but noted that HealthChoices also provided initial savings at its inception and was found to continue to provide the State compounding savings in the form of lower annual cost trends.

Through an analysis of financial statements from nearly all of the HealthChoices plans as well as Medicaid MCOs in other states, HealthChoices plans were found to have maintained a relatively consistent medical loss ratio, indicating that over a nine year span (1996 - 2004) the plans were able to reduce their administrative costs (from 13.7 percent in 1996 to 9.0 percent in 2003-2004) and maintain a high investment in medical costs compared to total revenue. Further, the study found that spending on administrative activities by the plans was highly efficient, providing value to Pennsylvania's Medicaid program by creating an integrated system of care delivery, access, patient education, and cost-effectiveness.

An analysis of Medicaid Statistical Information System (MSIS) data (obtained from the CMS website⁷) suggested a correlation between greater use of capitation and lower costs per eligible, supporting the finding that HealthChoices likely contributed to Pennsylvania's relatively low per capita costs across the blind/disabled, adult, and child populations. The study also found that HealthChoices MCOs were able to control rates of medical cost escalation, leading to total Medicaid savings of an estimated \$2.7 billion across the five-year 2000 - 2004 timeframe (Federal and State shares combined). Cost-effectiveness in the HealthChoices plans was found to be primarily driven by coordination of care, including utilization management, patient outreach, and patient education.

2. Access

HealthChoices MCOs offered significantly more access-enhancing initiatives than could occur under a fee-for-service model, including improved member access through active provider participation, comprehensive assistance in locating network providers, and value-added services including member incentive programs, health education materials, and other initiatives to invest in the communities in which their members live. The plans were driven by a competitive desire to attract and retain members, a strong interest in serving their members, and by the bottom line - extra investments to keep members healthy helps the plans avoid costly health problems in the long run. Fee-for-service and managed fee-for-service models were not structured or funded in a way to allow for the same level of investment the plans were able to make in access initiatives for members.

3. Quality

At the time of the study, DPW required that HealthChoices and ACCESS Plus conduct many of the same quality standard activities. However, because of the MCOs' existing experience in the State, the MCOs already had a strong foundation of quality management and improvement expertise that they were able to build on, including experience with the population being served, experience reporting quality indicators to DPW, and existing relationships with stakeholders throughout the community. While ACCESS Plus had many of the same quality

⁷ The MSIS data are available on the CMS website at <http://msis.cms.hhs.gov>.

standards criteria built in to its program, the criteria were not as extensive as the HealthChoices requirements. Additionally, the HealthChoices plans were found to have made significant investments in developing quality improvement initiatives and monitoring performance to evaluate quality of care concerns and other potential problems in an effort to improve care. The MCO's quality procedures are also reviewed externally through the accreditation process by the National Committee for Quality Assurance and are subject to an annual review by their members through the Consumer Assessment of Health Plans consumer satisfaction survey.

4. Special Needs Assessment

While fee-for-service traditionally does not have any mechanisms for identifying individuals with special needs, ACCESS Plus is required to develop and implement an identification process as part of its disease management program. However, as of the time of the study, HealthChoices MCOs were found to employ more strategies to identify individuals with multiple and complex needs from the time of initial enrollment and on an ongoing basis through activities including initial health assessments, multiple referral sources, integrated data systems, and targeted data analyses. The MCOs' disease management programs also covered additional chronic conditions not addressed in ACCESS Plus, including sickle cell disease and hemophilia, as well as condition-specific management for high-risk pregnancies and transplant cases. Finally, the study found that while ACCESS Plus had considerable potential to improve care coordination and disease management in the fee-for-service setting, the program lacked key features present in the HealthChoices program, where the MCOs are able to offer a more highly integrated system of care and a local community presence. Further, an ongoing competition for members and a full-risk model were found to spur innovation in developing methods for identifying, monitoring, and supporting special and high needs members.

C. Methodology for Analyses Conducted in Current Report

To conduct the current study on cost containment and effectiveness of managed care as compared to fee-for-service and ACCESS Plus, Lewin staff focused on quantitative and qualitative data from two primary sources. First, we used publicly available data on each state's Medicaid program tabulated from CMS' Medicaid Statistical Information System (MSIS) to determine cost and capitated trends in Pennsylvania Medicaid as well as states that are similar in size and location. Lewin's MSIS analysis specifically focused on identifying the per member per month (PMPM) total Medicaid costs and the percent of dollars paid through capitation by basis of eligibility. (See Appendix A for additional information on the MSIS methodology.)

We also conducted interviews with six of the HealthChoices plans. These interviews provided context for the medical cost comparisons. Staff offered challenges, successes, and opportunities related to costs, quality, outreach, and coordination of care in the HealthChoices program.

III. Cost Savings Analyses

A. Cost Trends

Because the capitated component of Pennsylvania's program has been in existence for decades on a large scale, quantifying the cost savings the capitated model achieves is inherently challenging and imprecise. However, it is possible to assess the general direction and magnitude of the savings that have occurred in Pennsylvania relative to the fee-for-service setting that is still relied upon heavily in other states. This section of the report assesses the per capita cost trends that have occurred in the overall Pennsylvania Medicaid program during the past several years.

While the majority of Medicaid consumers are in the Temporary Assistance to Needy Families (TANF) and TANF-related eligibility categories, this report's cost trend analyses have focused primarily on disabled persons who are not dually eligible for Medicare. The non-dual Social Security Income (SSI) population was used as the focal point of the cost trend analyses for several reasons:⁸

- This subgroup accounts for a large proportion of spending. Excluding dual eligibles, 53 percent of Pennsylvania's 2008 Medicaid expenditures occurred in this disabled subgroup.
- Non-dual disabled consumers have, on average, stable and lasting Medicaid eligibility, creating an opportunity for the coordinated care model to influence a person's longer-range health status and medical cost trajectory. This subgroup averaged 10.8 months of Medicaid coverage per unique individual covered at any time during 2008 in Pennsylvania, out of a maximum possible figure of 12.0. Given that newly eligible persons gain SSI coverage each year and that some existing consumers lose Medicaid coverage or change eligibility category (e.g., becoming dually eligible for Medicare), this statistic is indicative of a high level of coverage stability.
- The non-dual disabled population has extremely high per capita costs, including a high prevalence of chronic conditions that are conducive to care coordination interventions. Additionally, there is very high utilization of the services that the coordinated care model has been shown to favorably impact, such as inpatient hospital care and prescription drugs.
- Pennsylvania has relied heavily upon the capitated model of coverage for the non-dual disabled subgroup for many years. The State is by far the national leader (more than double any other state) in total dollars paid in capitation for disabled non-dual consumers. Pennsylvania ranks second nationally (behind only Arizona) in the percentage of Medicaid expenditures that are capitated in this subgroup — 65 percent during 2003, increasing to 72 percent during 2008.

⁸ Conversely, while the capitation contracting model has generally been shown to yield considerable savings with the TANF population, measuring these savings is made more complex by the large eligibility fluctuations that occur, the extensive proportion of TANF costs that occur during retrospective eligibility periods (which health plans cannot influence), and demographic differences across states (e.g., CHIP is included in TANF Medicaid on many states, but is separately categorized in many others). The scope of this engagement did not permit making all the adjustments needed to produce valid cost trend analyses in the TANF and TANF-related eligibility categories.

Thus, if coordinated care in Pennsylvania is favorably impacting cost trends, this would most likely be visible in comparing Pennsylvania's non-dual disabled population's cost trends to those of other states. Three comparison groups were selected. The first involved "geographic peers" including the six states that share a border with Pennsylvania: Delaware, Maryland, New Jersey, New York, Ohio, and West Virginia. The second comparison group included "size peers." Pennsylvania has the fifth largest Medicaid program in the country. Eight size peers were selected including the four states with larger programs (New York, California, Florida and Texas) and the next four largest states (Illinois, Ohio, North Carolina and Michigan). The third comparison group was the entire United States. The comparison statistics between Pennsylvania and these state groupings are summarized in Exhibit 1.

Exhibit 1. Comparison Statistics between Pennsylvania and Other States, Disabled Consumers (excluding dual eligibles)

Geographic Region	PMPM Expenditures for Disabled Consumers (excluding dual eligibles)			Average Number of Covered Disabled Persons, 2008 (excluding dual eligibles)	Percentage of Disabled Non-Duals' Expenditures Paid Via Capitation	
	2003	2008	Total Trend, 2003-2008		2003	2008
Pennsylvania	\$932	\$1,106	18.6%	330,794	65.1%	71.5%
Six Neighboring States	\$1,648	\$2,081	26.3%	788,066	8.9%	18.4%
Eight Largest States (other than PA)	\$1,208	\$1,535	27.1%	2,255,599	9.6%	14.7%
USA Total	\$1,090	\$1,388	27.3%	5,040,315	13.8%	18.2%

The figures in Exhibit 1 suggest that highly favorable cost containment performance has occurred in Pennsylvania. Per member per month (PMPM) costs for non-dual disabled consumers were lower in Pennsylvania than in all three comparison groups in 2003, and Pennsylvania's PMPM costs trended far more slowly than occurred in each of the three comparison groups.⁹

Pennsylvania's 2008 PMPM costs of \$1,106 in this subgroup are hundreds of dollars below the other comparison groups and lower than every neighboring state except West Virginia. The overall cost trend in Pennsylvania from 2003 - 2008 of 18.6 percent for the disabled averages 3.5 percent annually. The three comparison state groups all averaged an annual trend of 4.8 - 4.9 percent during this timeframe, which compounded across five years, creates a total difference of 7.7 - 8.7 percent as of 2008. Pennsylvania's total expenditures for the disabled non-dual population in 2008 were \$4.4 billion. Had Pennsylvania's costs in this subgroup trended upward from 2003 at the average rate of the comparison states, the 2008 costs in Pennsylvania

⁹ The 2003 - 2008 trends in Pennsylvania have been exaggerated by the 5.5 percent premium tax that HealthChoices MCOs now pay for purposes of securing additional Federal funds. This tax did not exist in 2003 and has the effect of artificially inflating Medicaid capitation payments (by 5.5 percent) with these funds then returned to the State. We have not made an explicit adjustment to Pennsylvania's trends above because many other states have also implemented Federal revenue maximization initiatives during this period which also artificially exaggerate their cost trends.

would have been more than \$300 million higher for the non-dual disabled subgroup. Had Pennsylvania's 2008 PMPM costs in this subgroup been equal to the average across its neighboring states, an additional \$3.8 billion in spending would have occurred.

The neighboring state comparison is somewhat skewed by New York, which has a large consumer population as well as exceptionally high PMPM costs. However, even if Pennsylvania is compared to the *lowest* PMPM costs among the three comparison populations (the overall US average of \$1,388) for non-dual disabled consumers, actual costs in Pennsylvania during 2008 were \$1.1 billion lower based on its PMPM costs of \$1,106 and the size of its covered population in this consumer cohort.

While many factors influence PMPM cost levels and cost trends, it is probable that the HealthChoices program was a major contributing factor to both of these favorable cost outcomes. As shown in the right-hand columns of Exhibit 1, Pennsylvania relies upon the capitated model to a profoundly greater degree than any of the three comparison groups (more than 70 percent of Pennsylvania's expenditures were paid via capitation versus less than 20 percent in each comparison group).

A further comparison was made with Medicare fee-for-service costs, given that the Medicare program represents an extremely large statistical sample of persons who also have a high level of coverage continuity and large PMPM costs with a high prevalence of chronic conditions that are conducive to care coordination interventions. Exhibit 2 presents Medicare PMPM statistics in the unmanaged setting for all fee-for-service consumers. These figures include the acute care services covered by Medicare (all Part A and Part B benefits) but do not include pharmacy coverage given that the Part D program was not implemented until 2006 and data are not available in the same comprehensive public format as for the Part A and Part B services.

Exhibit 2. Medicare Fee-for-Service PMPM Costs for Part A & Part B Benefits

Jurisdiction	Medicare PMPM Cost Trend for Part A & B Services, 2003-2008	Medicare FFS Persons 2007	Medicaid PMPM Trend, 2003-2008, Disabled Non-Dual Eligibles
Pennsylvania	27.90%	1,639,195	18.6%
Six Neighboring States	26.36%	6,173,852	26.3%
Eight Largest States (excluding PA)	29.75%	183,587,127	27.1%
USA Total	30.09%	37,124,362	27.3%

The Medicare fee-for-service figures and the Medicaid trends in other states shown in Exhibit 2 demonstrate a strong degree of consistency, with PMPM costs always increasing between 26.3 and 30.1 percent from 2003 - 2008. However, the average trend for Pennsylvania's non-dual SSI Medicaid consumers is considerably lower, at 18.6 percent. As noted above, it is reasonable to attribute much of this difference to the HealthChoices coordinated care model primarily used for this population.

B. Cost Containment Capability Comparisons

This section describes the medical cost management techniques used in the HealthChoices program relative to those occurring under ACCESS Plus and in the fee-for-service setting. While it is not possible to precisely quantify the cost containment impacts of any given coordinated care model, a side-by-side comparison can be made of cost containment *approaches* that occur in each setting. Exhibit 3 visually compares the three settings across a variety of cost management characteristics.

Exhibit 3: Summary Comparison of Cost Containment Features of Various Medicaid Models

Rating Key:			
● Model strongly provides this attribute			
◐ Model partially provides this attribute			
○ Model does not have this attribute			
Cost Containment Techniques	FFS	ACCESS Plus	HealthChoices
General Attributes			
Channels Patient Volume to Low-Cost Settings and to Cost-Effective Providers	○	○	●
Avoids Unnecessary Services	○	◐	●
Creates and Uses Network of Providers	○	◐	●
Directly Pays Providers for Health Care Services	●	○	●
Requires Lower-Cost Services Where Available	○	◐	●
Vendor At Risk for Medical Costs	○	◐	●
Achieves Favorable Unit Prices for Medical Services	●	●	●
Specific Attributes			
Primary Care Physician Required	○	●	●
Prior Authorization for Costly Services	○	◐	●
Referrals Required for Outpatient Specialty Care	○	◐	●
Disease Management	○	●	●
Case Management	○	◐	●
Enrollee & Provider Outreach and Education	○	◐	●
Management of Prescription Drug Mix & Usage	○	○	●
Can Pay for Uncovered Services on Exception Basis	○	○	●
Provider Profiling/Reporting, Quality Measurement, and Monitoring	○	◐	●

C. Cost Containment Practices: Pharmacy and Inpatient Hospital Services

More extensive information has been provided regarding cost containment techniques in two areas of the benefits package where large-scale cost savings are likely occurring in the capitated HealthChoices program — prescription drugs and inpatient hospital care. Together, these two areas represent more than half of the HealthChoices MCOs' medical expenditures. Exhibit 4 provides much of this information in summary form, followed by a more detailed narrative description.

Exhibit 4: Specific Comparisons of Selected Cost Containment Techniques

Cost Containment Area	HealthChoices	ACCESS Plus	Fee-For-Service	Comments
Pharmacy Dispensing Fee	Pennsylvania's Medicaid MCOs' payment averages roughly \$2.00	Payment is \$4.00	Payment is \$4.00	HealthChoices pharmacy dispensing fee yields \$40 million annual savings; Medicaid FFS payment is excessive relative to private health plan payments in all sectors
Use of relatively low-cost prescription drugs	79% of HealthChoices prescriptions are generics; formulary adherence approaches 100%	Generics represent 70% of prescriptions	Generics represent 70% of prescriptions	Large savings accrue through MCOs' steerage towards generics (and to net lower cost products within generics and brands)
Observation days in lieu of full inpatient admission	MCOs use this at cost of approx. \$1,000 - \$1,500 per day; applies to as much as 20% of non-obstetrical admits	Technique not used; full DRG paid for similar admission	Technique not used; full DRG paid for similar admission	Average DRG cost is approximately \$8,000; assuming lower-acuity admissions are those being converted to observation days, large-scale per case savings occur due to this technique

1. Pharmacy Cost Management

The HealthChoices program is clearly creating pharmacy savings. Approximately 20 million prescriptions are paid for annually by the MCOs. Savings occur in the following ways:

Dispensing Fee: Pennsylvania's dispensing fee in the fee-for-service and ACCESS Plus settings is \$4.00, whereas the MCOs have negotiated fees that average approximately \$2.00. This differential creates an annual savings of approximately \$40 million per year under HealthChoices at the current mix and volume of enrollees.¹⁰

Drug Mix: Several studies have documented that Medicaid MCOs operating in a pharmacy carve-in setting have achieved substantially higher use of generics than occurs in the fee-for-service setting.¹¹ This occurs through aggressive use of formularies and strict adherence to the formulary rules (e.g., "step therapy" to introduce lower-cost medications and move to higher-cost approaches only if the initial medication is not working sufficiently well). According to recent available data on Pennsylvania tabulated through the CMS website, 70 percent of Pennsylvania's Medicaid fee-for-service medications were generics in 2009. Data obtained from Pennsylvania's

¹¹ The dispensing fee savings are one of the few areas where the HealthChoices MCOs negotiate prices below underlying Medicaid FFS levels. In general, the MCOs pay providers at or above Medicaid FFS levels to achieve a more "mainstream" delivery network given that the low Medicaid FFS payment rates discourage provider participation and can create access barriers.

¹¹ For example, a recent Lewin report, "Projected Impact of Adopting a Pharmacy Carve-In Approach Within Medicaid Capitation Programs," published in March 2011 (and available at www.lewin.com), showed that at least a 10 percentage point differential in the generic dispensing rate occurred in two large multi-state Medicaid MCOs. The report compared these MCOs' usage data in carve-in states with their enrollees' usage in carve-out states, after adjusting for demographics.

HealthChoices MCOs suggests an average generic dispensing rate of approximately 80 percent. We estimate that each percentage point increase in the generic dispensing rate creates a savings of approximately 1.125 percentage points in *net* Medicaid pharmacy costs. (Net costs are post-rebate and take into consideration that considerably smaller rebates occur on generics.) Somewhat conservatively estimating that the HealthChoices program's generic dispensing rate is 8 percent above the fee-for-service and ACCESS Plus environment, HealthChoices is creating an annual Medicaid savings of approximately \$150 million on the generic drug mix.¹² It is likely that additional drug mix savings are occurring, given that MCOs have demonstrated an ability to steer volume towards relatively low-net-cost generics (when generics are used) and towards relatively low-net-cost brands (when brands are used).

Prescription Volume: Based on prior Lewin studies of Medicaid MCO impacts in other states, it is likely that HealthChoices is achieving further savings through lower pharmacy utilization relative to fee-for-service based on MCOs' aggressive use of medication management and prior authorization processes.¹³ Data obtained for these prior studies have shown prescription volume to be several percentage points lower in the capitated Medicaid setting. However, no specific assessment of HealthChoices usage versus Pennsylvania fee-for-service usage was made. MCOs are adept at data analyses that identify potential abuse/overuse of the prescription drug benefit, avoiding inappropriate drug-to-drug interactions (sometimes referred to as "poli-pharmacy"), and at taking corrective action.

It is worth noting that with the passage of the Federal health reform bill, the Affordable Care Act, Federal rebates have been made equal for any given Medicaid prescription whether it is paid for in the fee-for-service setting or by a Medicaid MCO. Thus, the key factor limiting net pharmacy savings in the HealthChoices program prior to CY2010 is no longer relevant.

2. Inpatient Hospital Usage

Given the significant costs associated with inpatient hospital stays, HealthChoices MCOs have focused significant attention on controlling inpatient hospital utilization as well as the costs associated with inpatient hospital stays. During interviews with the health plans, efforts to curb costs and utilization were identified for both admissions and readmissions. One effective strategy utilized by a number of health plans was the use of a lower "observation day" rate for low acuity patients during short hospital stays (less than two days) rather than the higher DRG rate for inpatient care. One plan identified that the observation day rate was being used on inpatient stays for 15-20 percent of non-maternity adults, resulting in a savings of as much as \$3,000 per inpatient day.

¹² This figure represents net savings after rebates are taken into consideration. Typically, Medicaid rebates are much larger for brand medications than for generics. However, in the vast majority of instances, net (post-rebate) costs are still far lower for the generic alternative.

¹³ The following Lewin studies have examined managed care utilization in detail and can be found at available at www.lewin.com: "Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs" (October 2007); "Financial Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs" (October 2007); "Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System" (November 2003); and "Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting" (January 2003).

All MCOs use innovative strategies to reduce inpatient hospital usage. There are a number of strategies employed among the plans. For example, one plan identified a strategy where data mining is used to identify those members most at risk for hospital admissions and/or readmissions, allowing the plan to further focus effort on coordinated care services for individual members, resulting in a decrease in hospital admissions and readmissions by 5 percent over the last several years. Another plan put in place a shared savings program to provide incentives to members, keeping them stable at home and reducing readmissions by 25-30 percent.

D. Summary of Cost Containment Capability

As indicated in Exhibits 3 and 4, there are clear “stair steps” between fee-for-service, ACCESS Plus, and HealthChoices. While there are no cost containment approaches in the fee-for-service setting that are not used in ACCESS Plus, ACCESS Plus deploys many techniques that are not used in the fee-for-service setting. Similarly, while all cost containment approaches used in ACCESS Plus setting are also used in HealthChoices, HealthChoices deploys many additional techniques that are not used in ACCESS Plus.

There are also differentials in the rigor with which the cost containment techniques are deployed. For example, both HealthChoices and ACCESS Plus utilize a primary care physician (PCP) centered model whereby all enrollees are matched to a PCP who is expected to serve as a first point of contact for non-emergency care and to refer patients appropriately throughout the health system. Under HealthChoices, this PCP system is enforced through a referral process whereby certain specialty services must be recommended, referred, or ordered by the PCP. However, all that is required for payment to occur in ACCESS Plus is for a specialist to know who the PCP is (and to put that provider’s information on the claim form). No actual interaction with the PCP needs to occur.

Similarly, in the pharmacy arena both HealthChoices and ACCESS Plus utilize preferred drug lists (also called formularies) that steer volume to lower-cost products. However, the HealthChoices formularies are adhered to much more ardently than in the fee-for-service setting (used by ACCESS Plus). MCO pharmacy directors asserted that pharmacies and physicians are more readily able to obtain exceptions for relatively costly prescriptions under fee-for-service and ACCESS Plus.

In summary, the HealthChoices MCOs utilize the largest amount of medical cost containment techniques and use them to the greatest degree. New cost containment approaches typically occur predominantly in the MCO setting, and are utilized there for years prior to being deployed in the “managed fee-for-service” environment by programs such as ACCESS Plus. The observation days initiative in Exhibit 4 serves as an example of how new Medicaid cost containment techniques tend to be adopted first in the MCO setting. However, ACCESS Plus represents a marked improvement over pure fee-for-service in terms of medical cost containment capability. Based on the attributes comparison in Exhibits 3 and 4, we estimate that the overall cost containment capability of the capitated MCO approach is substantially superior to the fee-for-service setting. While ACCESS Plus is expected to yield savings relative to fee-for-service, the potential savings occurring under ACCESS Plus are deemed to be far below the amount available through the HealthChoices model when the care management differences and the State’s premium tax program are taken into account.

IV. HealthChoices Savings Estimate

Lewin estimated the savings that the HealthChoices program has achieved relative to ACCESS Plus across a 15 year period (2006 – 2020) and to Medicaid fee-for-service overall across a 21 year period (2000 – 2020). Exhibit 5 provides an overview of estimated Federal and State savings in five-year increments. We derived the following savings estimates, showing a range driven by “low-end” and “high-end” percentage savings factors for various population groups (TANF, SSI, and Medicaid expansion):

- HealthChoices yielded savings of \$5.0 to \$5.9 billion (\$2.9 to \$3.3 billion in State funds) when compared to traditional fee-for-service over the past 11 years (CY2000 – CY2010).
- Looking forward, HealthChoices is projected to yield State Fund savings of \$2.9 to \$3.6 billion over the next five years (CY2011 – CY2015) and between \$5.4 and \$6.6 billion for the ensuing five-year period (CY2016 – CY2020) when compared to traditional fee-for-service in the existing HealthChoices counties.
- HealthChoices is estimated to have yielded total savings \$1.1 to \$1.4 billion in State funds when compared to ACCESS Plus over the past five years (CY2006 – CY2010).
- Looking forward, HealthChoices is estimated to yield State Fund savings of \$2.1 to \$2.4 billion over the next five years (CY2011 – CY2015) and between \$3.8 and \$4.4 billion for the ensuing five-year period (CY2016 – CY2020) when compared to ACCESS Plus in the existing HealthChoices counties.

The estimated savings are large-scale and compound favorably. Due to the introduction of the expansion population beginning in 2014, savings in the ensuing periods will become much higher, based on the addition of an estimated 750,000 individuals into the Medicaid program.

Exhibit 5: Estimated Savings of HealthChoices (in billions of dollars)¹⁴¹⁵

Timeframe	Total Medicaid Savings Relative to ACCESS Plus Setting	State Savings Relative to ACCESS Plus Setting	Total Medicaid Savings Relative to Traditional FFS Setting	State Savings Relative to Traditional FFS Setting
CY2000 - CY2005 ¹⁶	NA	NA	\$2.9 - \$3.0	\$1.4
CY2006 - CY2010	\$1.0 - \$1.4 ¹⁷	\$1.1 - \$1.3	\$2.1 - \$2.9	\$1.5 - \$1.9
CY2011 - CY2015	\$2.0 - \$2.8	\$2.1 - \$2.4	\$4.2 - \$5.8	\$2.9 - \$3.6
CY2016 - CY2020	\$3.9 - \$5.4	\$3.8 - \$4.4	\$8.1 - \$11.0	\$5.4 - \$6.6

¹⁴ Savings projections assume only current HealthChoices counties are served (and in the same manner with regard to mandatory/voluntary enrollment).

¹⁵ Savings figures do not include the General Assistance population. Medicaid savings estimates have also been prepared for CY2005 – these range from \$238 - \$312 million in total and from \$201 - \$235 million in State funds. Savings projections assume only current HealthChoices counties are served (and in the same manner with regard to mandatory/voluntary enrollment).

¹⁶ Savings for the 2000 - 2004 timeframe are taken from the initial Lewin Group report from May 2005, with estimated savings from the updated analyses herein added for 2005.

¹⁷ In some years and scenarios we estimate that the Federal Government experienced a net *loss* from the HealthChoices program due to the impacts of the gross receipts tax.

These estimates were prepared through the following process.

- **Baseline Capitation Expenditures:** Pennsylvania's actual capitated costs by major eligibility category were obtained for 2003 and 2008 using MSIS data. Costs were projected for "regular" Medicaid through CY2020 using observed annual expenditure trends from 2003 – 2008 (capturing population size and mix changes as well as medical cost inflation).
- **Introduce Medicaid Expansion Population in 2014:** Costs for the Medicaid expansion population from 2014 – 2020 were projected based on The Lewin Group estimates of a monthly per capita cost of \$268 in 2008 (trended upwards at 5 percent per year), and of a population size of approximately 750,000 persons at full phase-in (assuming a phase-in of this population during CY2014 and CY2015).¹⁸
- **Estimate Impacts of Percentage Savings:** "Low-end" and "high-end" savings percentages were prepared to acknowledge the inherent challenges in developing precise savings estimates. HealthChoices savings as of CY2003 for the non-dual disabled population are estimated at 6 percent at the low-end and 7 percent at the high-end. Savings percentages for other enrollees are assumed to be half those achieved for the non-dual disabled subgroup, due to the advantageous characteristics (e.g., coverage continuity, very high inpatient and pharmacy baseline costs, prevalence of chronic conditions) of the SSI population relative to the TANF population from a care coordination perspective. The disabled population's 2003 savings were estimated to increase annually by 0.5 percentage points from 2003 – 2008 at the low-end, and by one full percentage point at the high-end, based on the trend analyses presented earlier herein (showing a lower trend in Pennsylvania of more than one percentage point in this subgroup). Savings were increased by 0.25 percentage points annually in both the low-end and high-end assumptions for the non-dual disabled population from 2009 – 2020. These savings percentages are consistent with Lewin's prior work in Pennsylvania (although more conservative than those used in the prior study)¹⁹ and in several other states. The largest percentage savings assumed in this study relative to the fee-for-service setting is 15 percent for disabled persons in CY2020 at the high end estimate. CY2011 percentage savings estimates range from 9.25 – 12.75 percent for disabled persons and from 4.63 - 6.38 percent for TANF persons.
- **Factor in Gross Receipts Tax Impacts:** Savings were initially derived without the premium tax and gross receipts tax amounts. The State savings were then derived by adding the amounts of Federal match contributed to these taxes to the "regular" State savings created by the efficiencies of the HealthChoices program. Note that the vast majority of savings for the expansion population accrue to the Federal Government (because it pays 90 – 100 percent of costs from 2014 – 2020), although the expansion population yields considerable gross receipts tax savings to the State.

¹⁸ The Lewin Group's estimates of the size of the Medicaid expansion population were used throughout this report. Alternative estimates of this population have been prepared by other organizations.

¹⁹ Potential HealthChoices savings from 2006 forward became smaller, all other factors being equal, versus prior years due to the creation of the Medicare Part D program. This benefits change led DPW to "carve-out" Medicaid/Medicare dual eligibles from the HealthChoices program beginning in 2006.

- **Identify Savings Compared Specifically to ACCESS Plus:** We estimate that HealthChoices saves the State roughly double the savings of ACCESS Plus without including the impact of the gross receipts tax. Once the tax savings are factored in, HealthChoices is projected to achieve roughly triple the savings that can be achieved in the ACCESS Plus setting.

Throughout the projections, the majority of the State Fund savings (approximately 60 percent of the total) are derived from the non-dual SSI population.

V. Summary

The key finding of this report is that the HealthChoices program continues to yield massive savings to Pennsylvania's Medicaid program relative to the fee-for-service and ACCESS Plus settings. From 2006 – 2010, the program yielded an estimated Medicaid savings of \$2.1 – \$2.9 billion relative to the fee-for-service setting, of which \$1.5 – \$1.9 billion represented State savings (i.e., savings to Pennsylvania taxpayers). With the expansion of the Medicaid population and with the existing program's savings compounding over time, the savings during the upcoming ten year period will compound in a highly favorable manner. State Fund savings across the 2011 – 2020 timeframe are estimated at \$8.4 – \$10.2 billion. We estimate that HealthChoices saves the State roughly double the savings of ACCESS Plus without including the impact of the gross receipts tax. Once the tax savings are factored in, HealthChoices is projected to achieve roughly triple the savings that can be achieved in the ACCESS Plus setting.

While this study has not focused on the access and quality aspects of HealthChoices, it is important to note that the financial savings are occurring within a “whole person focused” coordinated care program structure. Prior studies of HealthChoices have demonstrated that the program is achieving significant success in fostering access to needed care and in measuring and improving the quality of care rendered to Pennsylvania's lowest-income population sector.

With regard to public policy implications, there are two potential opportunities to expand the role of the HealthChoices program.

1. Geographic Expansion

Approximately three-fourths of Pennsylvania's Medicaid consumer population resides in the 25 counties where HealthChoices is exclusively used. However, approximately 330,000 additional consumers are currently enrolled in ACCESS Plus. These persons reside in the 42 counties where HealthChoices is either not used at all or is used on a voluntary enrollment basis in conjunction with ACCESS Plus. When the Medicaid expansion population is fully enrolled, more than 100,000 additional consumers will receive coverage through ACCESS Plus. Lewin has estimated the savings of converting the ACCESS Plus membership into HealthChoices beginning in CY2012. Due to the medical cost savings of HealthChoices relative to ACCESS Plus and the State premium tax advantages associated with HealthChoices, Lewin estimates that this policy change would yield State savings of approximately \$375 million across 2012 – 2015. State savings are projected to total approximately \$725 million across the five-year timeframe 2016 – 2020. Total State savings across the nine-year period 2012 – 2020 are projected at roughly \$1.1 billion.

Many states (including Arizona, Delaware, Ohio, New Mexico, Rhode Island, and Tennessee) have been successful in utilizing the mandatory enrollment MCO model in their most rural areas. This may be an opportune time, given the pressing need to maximize fiscal savings in Medicaid, to increase the role of HealthChoices in Pennsylvania. States currently in the process of extending their existing Medicaid managed care programs to their most rural counties include Kentucky, Texas and West Virginia.

2. Health Insurance Exchange Interaction

The Lewin Group estimates that approximately 1.4 million Pennsylvanians will enroll in the Exchange once this component of the health reform bill is fully implemented and the enrollment

transitions are fully phased in. The Exchanges will provide coverage to persons with incomes above the Medicaid eligibility thresholds and who cannot otherwise obtain coverage through traditional employer-sponsored coverage.

There is expected to be considerable eligibility flux between the Medicaid program (particularly with its expansion population at higher income levels) and the Exchange. It is likely that most – if not all – of the HealthChoices MCOs will participate in the Exchange once it is implemented. Thus, under HealthChoices, individuals whose income circumstances change such that their health coverage fluctuates between Medicaid and the Exchange will not experience disruption in their health plan and provider network (unless they wish to switch).

Conversely, under ACCESS Plus and Medicaid fee-for-service, there will be “forced fluctuation” in persons’ health coverage when they move between Medicaid and the Exchange. While this is not a large-scale financial issue, this dynamic adds a programmatic advantage to Pennsylvania’s partnership with the HealthChoices MCOs. The greater the degree to which HealthChoices is used in Medicaid, the greater the coverage continuity will be for the considerable number of persons whose health coverage “toggles” between Medicaid and the Exchange.

Over the past 11 years included in this analysis, the HealthChoices program is estimated to have saved the State over \$5 billion compared to traditional fee-for-service and continues to provide Medicaid cost savings to the State through a broad and innovative array of cost containment strategies. Our future estimates indicate that HealthChoices will continue to provide significant savings to the State as well as offer coverage stability to the Medicaid population once the Exchange is put into place. A geographic expansion of HealthChoices also offers the State an opportunity to maximize fiscal savings in Pennsylvania’s Medicaid program.

Appendix A: Medicaid Statistical Information System (MSIS) Methodology

To determine cost trends in Pennsylvania Medicaid as well as states that are similar in size and location, Lewin conducted an analysis using MSIS data specifically focused on identifying the per member per month (PMPM) total Medicaid costs and the percent of dollars paid through capitation by basis of eligibility. Below we provide an overview of the MSIS data system, an explanation of our data pull, and a description of the analysis conducted.

MSIS Data Overview

Based on requirements in the Balanced Budget Act of 1997, states submit five files to CMS quarterly through MSIS: one file which contains eligibility and demographic characteristics for each person enrolled in Medicaid at any time during the quarter, and four separate files of claims broken out by long-term care services, drugs, inpatient hospital stays, and all other types of services.

The data is organized in two ways: a monthly cube and a quarterly cube. The monthly data cube contains eligibility information and provides counts of consumers for each month of the fiscal year. The quarterly cube contains information on eligibility and utilization. MSIS data can be found on the following website: <http://msis.cms.hhs.gov/>.

MSIS Data Methodology and Analysis

Lewin utilized both the monthly and quarterly data cubes for FFY 2000 through FFY 2008.²⁰ All data used excluded Medicaid/Medicare dual eligibles.²¹ From the monthly data cube, Lewin selected 'Total Months Eligible' which provides the number of enrolled consumers in each month aggregated by fiscal year. From the quarterly data cube, Lewin selected total Medicaid dollars and total capitated dollars for each fiscal year. All three data elements were broken out by basis of eligibility with our analysis focusing on the blind/disabled population.

In order to calculate the PMPM for each consumer we divided total Medicaid dollars by total months eligible for each state. Once PMPMs were calculated for all states, we focused our analysis on comparing Pennsylvania against two comparison groups:

- 1) The nine states with the highest Medicaid expenditures (California, Florida, Illinois, Massachusetts²², Michigan, New York, North Carolina, Ohio, and Texas)
- 2) The six states that geographically touch Pennsylvania (Maryland, Ohio, West Virginia, New York, and New Jersey)

Once the PMPMs were calculated for total Medicaid dollars and total capitated dollars, we then calculated the cost trends for each state for several time periods. Additionally, we calculated the percent of total dollars that were capitated in each state and the changes in the percentage of capitated dollars over time.

²⁰ As of the time of the study, FFY 2009 data was incomplete.

²¹ The FFY 2000 - FFY 2003 monthly cube did not allow for isolating the non-dual population.

²² The comparison against states by expenditure did not include Massachusetts for the blind/disabled population