COMMUNITY CATALYST

February 25, 2011

Secretary Kathleen Sebelius
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC
20201

Re: Medicaid Cost-Savings Opportunities

Dear Secretary Sebelius:

We are writing in response to your February 3rd letter to the nation's Governors about opportunities to save money in state Medicaid programs. Thank you for your commitment to helping states sustain this critical safety-net program through difficult economic times.

We are very pleased that you highlighted so many opportunities to reduce state Medicaid expenditures while also strengthening the quality of care for high-risk beneficiaries. Since you indicated you are open to further ideas, we wanted to bring a few additional policy options to your attention. Below, we outline eight options currently at states' disposal for improving care and efficiency in Medicaid. We also suggest three actions CMS could take to reduce state Medicaid costs, given current statutory authority.

These approaches are particularly important given the alternatives for reducing Medicaid expenditures outlined in your February 3rd letter: imposing higher cost-sharing and eliminating or restricting benefits like prescription drugs. Those alternatives only shift costs from states onto struggling families and safety-net providers, and they would harm the health of chronically-ill Medicaid enrollees. And they may be less effective at reining in state spending than estimates suggest; studies show that when patients delay or forgo certain services because of cost-sharing, their illnesses can worsen and eventually require more expensive care, canceling out some of the state's savings.[1] We urge you to discourage states from resorting to those options until they have exhausted the lengthy list of opportunities – those you already highlighted in your letter and those we outline below – for reducing Medicaid costs while strengthening the program.

Opportunities at States' Disposal for Saving Money in Medicaid

Our recommendations focus on aligning payment to reward clinical appropriateness and better outcomes, improving care for dual eligibles and people needing long-term care, and increasing the clinical integrity and cost-effectiveness of prescription drug spending.

[1] Center on Budget and Policy Priorities, "The Effect of Increased Cost-Sharing in Medicaid", July 5 2005. http://www.cbpp.org/cms/?fa=view&id=321

Aligning payment to reward clinical appropriateness and better outcomes

- ***Recalibrate inpatient and outpatient payment rates:*** While states can and should implement a variety of methods aimed at improving the delivery of care for its most vulnerable — and therefore expensive — Medicaid beneficiaries, a critical starting place for states to realize savings is to reexamine their inpatient and outpatient payment rates. In many states, the inpatient rates are higher, thereby incentivizing unnecessarily high hospital admissions. New York's Medicaid, for example, found that it was drastically overpaying for inpatient care while underpaying for outpatient care. Through a series of payment changes over a three year period, the state shifted $600 million in inpatient rates to outpatient rates for care in community clinics and through physicians. These actions positioned the state to take on other payment reforms that can save the state money, such as medical homes or the expansion of certain outpatient services, like smoking cessation.[2]

- ***Reduce preventable hospital readmissions and complications*:** One promising option for states to achieve cost savings is to change payment incentives to reduce potentially preventable hospital readmissions and complications. While many states have followed Medicare's lead and are no longer paying for "never events," a small number of states are beginning to adjust Medicaid payments for other types of hospital acquired complications and are considering doing the same for 30-day hospital readmissions. The savings potential from reducing these types of events is substantial — as much as 20 percent of all health care spending. [3] By adjusting payments for preventable readmissions, it is estimated that states could achieve savings of two to five percent of inpatient hospital expenditures. And, for preventable complications, savings are estimated to be one to two percent of inpatient hospital expenditures.[4] While it will take some years to fully realize these savings, some savings should be readily achievable for most states. For instance, in the second year of an initiative tying payments to rates of hospital-acquired complications, Maryland experienced an 11.9 percent drop in the frequency of hospital acquired complications, which translated to savings of approximately $62.5 million. Similarly, infection-related complication rates declined by 19.06 percent resulting in $34.3 million savings.[5] In New York state, a program that made risk adjusted modifications to hospital inpatient rates based on potentially preventable readmissions generated $47 million in total savings in the first year.[6]

Improving care for dual eligibles and people needing long-term care

- ***Rebalance long-term care dollars*:** While your letter notes the availability of the Community First Choice option, it does not remind Governors of the availability of other ACA reforms aimed at rebalancing state spending on long-term care toward more home and community

[2] Deborah Bachrach, "Medicaid Payment Policy: From Vision to Reality – Lessons from NYS." PowerPoint Presentation. November 11, 2010.
[3] Journey to Accountable Care: Aligning the Incentives, Treo Solutions Webinar, October 21 2010.
[4] Norbert Goldfield, "Can We Improve Outcomes and Payment for Pediatricians (and Save Medicaid)" PowerPoint Presentation. January 2011.
[5] Memo from Sule Calikoglu to the Maryland Health Services Cost Review Commissioners. January 26, 2011.
[6] New York State Proposal to Design Medicaid, Proposal Number 87. "Reduce Unnecessary Hospitalizations - Community Based Pay for Performance."

based services. In particular, we recommend that states consider participating in the upcoming Balancing Incentives Payment Program (BIPP), which would provide qualifying states with either a two or a five percentage point increase in their federal match for Medicaid Home- and Community-Based Services (HCBS) costs. This would not only bring new money into states, but would begin to guide states toward higher quality, more efficient care.[7]

- ***Better integrate care for the dually-eligible*:** We applaud your encouragement to state Governors to address the poor care generally provided to people dually eligible for Medicare and Medicaid. The Federal Coordinated Health Care Office will undoubtedly provide much-needed leadership in aligning the two programs and reducing the confusion dual eligibles currently face in today's health care system. The Office, working with the Innovation Center, will also test new models of care that could vastly improve health outcomes for dual eligibles, while also lowering the costs associated with their care. We note, however, that missing from the list is the expansion of existing programs serving dual eligibles, most notably the Program for All-Inclusive Care for the Elderly (PACE) and Special Needs Plans (SNPs).[8]

  Evidence shows that people enrolled in PACE — which receives a combined, capitated payment from Medicare and Medicaid to provide a range of integrated preventative, acute care, and long-term care services to the frail elderly — have higher rates of preventive care, lower rates of difficulties with pain and activities of daily living, higher rates of life satisfaction, and lower rates of hospitalization.[9] Currently, there are only 75 programs in 29 states. Thus, there is a key opportunity for states to request a state plan amendment to opt into a program that can improve care while providing greater predictability in the costs associated with that care.

  Fully-integrated SNPs that provide a comprehensive and patient-centered model of care for dual eligibles offer yet another opportunity for states. Under the 2008 Medicare Improvements for Patients and Providers Act, SNPs serving dual eligibles must have a contract with states by January 1, 2013 to provide for Medicaid benefits. This requirement provides states with the prospect of benefiting more directly from reduced hospitalizations and nursing home admissions. For example, in Massachusetts, where there is a contract with the state in place, the dual SNPs — which are part of the state-based, Senior Care Options program — have demonstrated a reduction in nursing home admissions.[10]

Increasing the clinical integrity and cost-effectiveness of prescription drug spending

- ***Increase the use of generic drugs:*** Generic prescribing rates have risen from an average

[7] "Taking the Long View: Investing in Home and Community-Based Services is Cost-Effective." AARP Public Policy Institute. March 2009. http://www.aucd.org/docs/policy/AARP%20Cost-Effectiveness%20of%20HCBS.pdf

[8] Medicare Payment Advisory Commission, Report to the Congress, Chapter 5 "Coordinating the care of dual-eligible beneficiaries." June 2010 http://www.medpac.gov/chapters/Jun10_Ch05.pdf

[9] National Pace Association website, accessed February 24 2011. http://www.npaonline.org/website/article.asp?id=203#PACE_Provides_High_Clinical_Outcomes_and_Beneficiary_Satisfaction

[10] "MassHealth Senior Care Options Program Evaluation." JEN Associates. June 2008. http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/SCO%20Program%20Evaluation%209jun08%20(2).pdf

of 57 percent in 2004 to 75 percent in 2009, which has saved billions of dollars. However, many states can improve their rates further by strengthening generic substitution laws, which allow pharmacists to substitute generics for brand name drugs if a physician does not indicate "brand" only. While all states have these laws, only fourteen include mandatory substitution. In addition, all but three states allow pharmacists to override generic substitution if requested by the patient.[11] A recent study found that in states requiring patient consent to substitute for the generic drug, there was a 25 percent reduction in substitution. The authors estimate that if states adopted regulations allowing pharmacists to substitute generics without mandatory patient consent, $100 million in Medicaid could be saved on just three drugs scheduled to come off of patent in the next eighteen months (Lipitor, Plavix and Zyprexa).[12]

- ***Implement evidence-based drug selection and purchasing***. Well-designed programs include a preferred drug list (PDL) based on the best evidence, along with management tools, such as prior approval, quality measurement and provider supports, to encourage provider adherence to the drugs on the PDL. The goal of these programs is to increase the use of preferred drugs, either generics or equivalent but lower-cost brand name drugs. While 45 states currently utilize PDLs, many have carved out classes of drugs or medical conditions, such as mental health, HIV/AIDS and cancer. Expanding PDLs can reduce costs, although access and quality must be protected, given the vulnerability of these patient populations and the potential for increasing the costs of other health services.[13] New York estimates it will save $34 million a year by 2012 by adding four currently exempted drugs to its PDL. These drugs currently account for 50 percent of the cost of the top 25 drugs.[14]

  To protect quality of care states should base selection of preferred drugs on an evidence-based evaluation of available therapies. A study of the Massachusetts pharmacy program, which has achieved substantial savings and a generic use rate of 80 percent, found that it "relies overwhelmingly on a clinical approach, avoiding the pitfalls or restrictions based on negotiated pricing or arbitrary coverage limits." Similarly, Washington State's Chapter 121, passed in 2005, requires all state agencies to participate in a prescription drug purchasing consortium based on evidence-based medicine. [15] In a 2011 report, the Medicaid Medical Directors Learning Network addressed the burgeoning use of psychiatric drugs in children, and reported on practices that can improve quality and reduce overuse.[16]

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[11] ASPE Issue Brief. *Expanding the Use of Generic Drugs.* December 1, 2010. www.aspe.hhs.gov

[12] Shrank, W.H., et al. *State Generic Substitution Laws Can Lower Drug Outlays Under Medicaid.* July, 2010. Health Affairs, 29:7.

[13] C.Y. Lu et al. *Association Between Prior Authorization for Medications and Health Service Use by Medicaid Patients With BiPolar Disorder.* Psychiatric Services. 62:186-193; February 2011.

[14] New York HHS: Redesigning the Medicaid Program. http://www.health.ny.gov/health_care/medicaid/redesign/ Accessed February 18, 2011.

[15] Lewis, Jeffrey R. *The Oregon Blueprint: Coordinated Contracting of Prescription Drugs.* July, 2006. Heinz Family Philanthropies.

[16] Medicaid Medical Directors Learning Network. *Antipsychotic Medication Use in Medicaid Children and Adolescents. Report and Resource Guide from a 16-State Study.* June, 2010. http://rci.rutgers.edu/~cseap/MMDLNAPKIDS/Antipsychotic_Use_in_Medicaid_Children_Report_and_Resource_Guide_Final.pdf Accessed February 18, 2011.

Many states can enhance their capacity to design these programs by utilizing the resources of the Agency for Healthcare Research and Quality (AHRQ), entering into collaborations with local medical schools or universities, or joining The Drug Effectiveness Review Project (DERP), a self-governing collaboration that now includes eleven states and the Canadian Agency for Drugs and Technologies in Health. DERP synthesizes global evidence on the relative effectiveness, safety and effect on subpopulations of drugs within therapeutic classes.[17]

- ***Improve prescriber education:*** Doctors and other prescribers need up-to-date information about the effectiveness of different medications and alternative approaches (e.g. talk therapy, exercise, etc.). "Academic detailing" programs in nine states provide effective evidence-based, face-to-face consults and materials, serving as an unbiased alternative to pharmaceutical industry promotion which tends to promote higher-cost drugs that are not necessarily more effective and new drugs without the established safety record of older drugs.[18] These types of programs have been proven to be a highly effective method to transmit the best evidence on clinical therapies to prescribers, improve outcomes and reduce overall costs.[19] [20,21] A Medicaid initiative in six states provides consults to reduce inappropriate prescribing of psychotropic drugs to children. The Pennsylvania Academic Detailing Program, operated by the Department of Aging in its senior prescription drug program, estimates its savings as $2 for every dollar of investment.

- ***Combat off-label drug promotion and inappropriate prescribing:*** Prescribing of drugs for off-label use — uses other than those approved by U.S. Food and Drug Administration — may have cost Medicaid federal and state programs as much as $3.58 billion in 2010. Since 2004, six of the nation's largest drug manufacturers have pled guilty to illegally promoting drugs for off-label uses. While some off-label uses are critical to patients, a 2006 study concluded that 73 percent of overall off-label uses, and 90 percent of all psychiatric off-label uses, lack a finding that the drug is an effective treatment.[22]

  A significant barrier to reducing inappropriate off-label prescribing is the lack of data on which practitioners are prescribing medications off label and for what reasons. States could require physicians to report their off-label prescribing, which could be used by Medicaid to improve drug utilization review and design corrective action. In order to enhance the protection of patients and encourage appropriate prescribing, states could also require that physicians inform their Medicaid beneficiary patients whenever the physician prescribes a

[17] Center for Evidence Based Health Policy, O., Systematic Reviews of Drugs Within Classes: Searching for Health Care Value. 2005.
[18] Pew Prescription Project. Academic Detailing: Evidence-Based Prescribing Information. 2010. Available at: http://www.prescriptionproject.org/tools/initiatives_factsheets/files/Academic-Detailing-Fact-Sheet_CB.pdf
[19] O'Brien MA, Rogers S, Jamtvedt G, et al. Educational outreach visits: effects on professional practice and health care outcomes. Cochrane Database Syst Rev. 2007;(4)
[20] Soumerai S, Avorn J. Economic and policy analysis of university-based drug "detailing". Med Care 1986;24(4):313-31
[21] Mason, Freemantle, Nazareth, et al. When is it cost-effective to change the behavior of health professionals? JAMA 2001;286(23):2988-92
[22] Center for Health & Pharmaceutical Law & Policy, Seton Hall, supra note **Error! Bookmark not defined.**, at footnote 67 (citing D.C. Radley et al., "Off-label Prescribing Among Office-Based Physicians," *Archives of Internal Med.*, 166 (2006): 1021-1026.)

drug for an unapproved use, and the patient must consent to the treatment. Such "informed consent" is currently required by law in the District of Columbia.[23]

Opportunities HHS Could Create for Cost-Savings in Medicaid

These three opportunities would help increase the clinical integrity and cost-effectiveness of prescription drug spending in state Medicaid programs.

- ***End pay-for-delay settlements:*** Federal Trade Commission reports[24] document that the drug industry has increasingly delayed access to generic drugs by paying-off competing generic manufacturers, forcing CMS and state health programs to pay billions more for brand-name drugs. We support the Administration efforts to enact reforms banning these pay-for-delay settlements. In the interim, we recommend that CMS share relevant information on Medicaid spending on brand-name drugs so as to allow the FTC to evaluate and report on the effect of pay-for-delay settlements upon spending by Medicaid and upon States.

- ***Accelerate the pathway for generic biologic drugs:*** Biologic drugs can cost hundreds of thousands of dollars a year for a single patient. Some classes of biologic drugs to treat Multiple Sclerosis or other disorders have seen alarming price increases of 20 percent or more in the last two years.[25] We urge HHS to advocate for regulations that will accelerate the pathway for generic biologic drugs (biosimilars) as enacted under ACA. HHS could also study trends in spending on biologics, project impact on costs upon federal health programs, and identify key clinical areas of concern (e.g. drugs to treat MS, cancer).

- ***Protect against conflicts of interest and industry influence on prescribing.*** Industry promotion to physicians and other prescribers, as well as consumers, is a serious impediment to evidence based prescribing and utilization of medications throughout the health care system. IMS estimates that $29.8 billion was spent by the drug and device industry on marketing in 2005, the majority on direct marketing to physicians.[26] Medicaid program costs and quality of treatment are potentially affected in numerous ways by conflicts of interest produced by industry promotions.

  We recommend CMS require that no member of a state Medicaid Pharmacy and Therapeutics committees, either in Fee For Service or Managed Care plans, be allowed to have industry relationships. To avoid inappropriate industry assistance and influence, we recommend that CMS expand support for state Medicaid staff development, especially for states with limited infrastructure and expertise. We also recommend that CMS assist states in analyzing public data on industry payments to physicians. Required by the Affordable

[23] See The Off-Label Informed Consent Act of 2008; D.C. Code Ann. § 48-841.03 (2011).
[24] Federal Trade Commission, *Pay-for-delay: How Drug Company Pay-offs Cost Consumers Billions*, An FTC Staff Study, January 2010, at 2,4, available at http://www.ftc.gov/os/2010/01/100112payfordelayrpt.pdf (last visited Sept. 27, 2010).
[25] See AARP Public Policy Institute, Rx Watchdog Report: Brand Name Drug Prices Continue to Climb Despite Low General Inflation Rate, Nov. 2009, at 10, available at http://assets.aarp.org/rgcenter/ppi/health-care/i36-watchdog.pdf, last checked Feb. 14, 2011; See also AARP Public Policy Institute, Rx Watchdog Report: Brand Name Drug Prices Continue to Climb Despite Low General Inflation Rate, May 2010, at 10, available at http://assets.aarp.org/rgcenter/ppi/health-care/i43-watchdog.pdf, last checked Feb. 14, 2011.
[26] Donohue, J.M et al. *A Decade of direct-to-consumer advertising of prescription drugs.* N Eng J Med. 2007; 357: 673-681.

Care Act to be available in September 2013, this data can be used to audit potential industry influence on Medicaid prescribers.[27]

As always, Community Catalyst remains committed to sustaining Medicaid and improving the quality of care for its beneficiaries. We thank the Department of Health and Human Services for your consideration and seek to be a resource as you continue tackling this issue. If you have any questions or concerns please contact Katherine Howitt at 617-275-2849 or khowitt@communitycatalyst.org.

Sincerely,

Robert Restuccia
Executive Director
Community Catalyst

cc: Donald Berwick, M.D., Administrator of the Centers for Medicare & Medicaid Services (CMS)
Cindy Mann, Director of the Center for Medicaid and State Operations at CMS
Vikki Wachino, Director of Family and Children's Health Programs at CMS
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Richard Gilfillan, M.D., Acting Director of Center for Medicare and Medicaid Innovation at CMS

[27] 1128G of the Social Security Act (42 U.S.C. §§ 1320a–7h).