Saving Money by Improving Medicaid

January 2009

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About Community Catalyst

Community Catalyst is a national nonprofit advocacy organization dedicated to making quality, affordable health care accessible to everyone. Since 1997, Community Catalyst has worked to build consumer and community leadership to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

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Executive Summary

Medicaid is a prime target for state budget savings

- Forty-four states face budget shortfalls this fiscal year or next and must balance their budgets
- Medicaid accounts for a large portion - 17 percent - of the average state budget
- Twenty-six states have cut Medicaid this fiscal year by reducing provider payments, benefits, or eligibility or by increasing co-payments

But Medicaid should be *strengthened*, not weakened, during difficult economic times

- Medicaid is an important source of federal revenue for states and helps to stimulate the economy. Cutting Medicaid during a downturn can actually deepen an economic crisis
- Medicaid is a safety net that keeps many families insured as employment falters and, with it, employment-based health insurance. Enrollment, now at nearly 60 million, is growing
- Cutting Medicaid – whether by cutting provider rates, reducing benefits or restricting eligibility – diminishes quality by reducing access to care

So what are the alternatives?

- In the short run, federal aid to maintain state Medicaid programs is the best hope for avoiding deeper cuts in eligibility, benefits, and provider payments
- Other quick options to preserve Medicaid include raising revenue through tobacco taxes, imposing assessments on hospitals or nursing homes, and tapping "rainy day" funds
- The current crisis also provides an opportunity to strengthen Medicaid by improving quality while containing costs. Some of these changes could yield Medicaid savings in the next few years, while others lay the foundation for long-term improvements that could help avert Medicaid cuts in the next economic downturn

  For example:

  - Chronically ill patients account for the largest portion of Medicaid spending, and care management programs that efficiently deliver treatment can save money and greatly benefit patients. North Carolina’s Medicaid program has an effective model.
  - Tying treatment decisions more closely to evidence of effectiveness can save money and improve care. Many Medicaid programs already employ “preferred drug lists” that can be strengthened quickly. Washington state provides a good example.
  - Longer-term cost containment strategies – enhancing primary care to reduce emergency room use, eliminating payment for preventable hospital readmissions, and developing alternatives to institutional long-term care – also have great potential for improving quality.

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What can consumers do?

Keeping Medicaid strong this year will almost certainly require additional aid from the federal government, as well as new state-generated revenue. Consumers can:

- *Advocate for additional federal funds.* Urge state leaders and members of Congress to push for immediate federal relief. Organize consumers to talk with legislators and the media about the importance of Medicaid, especially during tough economic times
- *Advocate for increasing state assessments on hospitals or nursing homes to help fund Medicaid.* This money can help states draw down additional federal matching funds
- *Propose other revenue increases, such as tobacco taxes.* Earmarking these funds for heath care can bolster state spending on Medicaid

To improve quality and contain costs in the longer run, consumers can press leaders to think beyond crisis management. They can:

- *Research strategies used in other states.* Learn the potential and track records of specific cost containment strategies and advocate for these alternatives to Medicaid cuts
- *Generate stories from adults and children* who have chronic health needs to make the case for coordinated care. In addition, stories about poor-quality outcomes can support the need for evidence-based medicine. Share these stories in state budget hearings, meetings with state and local leaders, and the media.
- *Get involved in state Medicaid decisions.* Ensure that there is consumer representation on your state Medical Care Advisory Committee. Use this venue to share the consumer perspective on the importance of a strong Medicaid program. Many states have additional commissions on health reform initiatives.
- *Develop coalitions to advance initiatives such as evidence-based prescribing of drugs and integrated care for patients with chronic illnesses.* Make common cause with other stakeholders, including non-traditional allies such as businesses and hospitals, to develop quality and cost agendas.

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Medicaid Under Fire

State budgets are in crisis. Forty-four states face budget shortfalls this fiscal year or next according to the Center on Budget and Policy Priorities. Most states must balance their budgets annually, and are now trying to do so by cutting program spending, tapping into reserve funds, or raising revenues.[1]

Because of Medicaid's prominence in state budgets– accounting for 17 percent of spending – the program is often a target for budget cuts.[2,3] Twenty-six states and the District of Columbia have cut Medicaid this fiscal year by reducing eligibility, benefits or provider payments and increasing patient co-payments. The outlook is equally grim for next year.[4] [See Figure 1]

These cuts are counterproductive because they hurt the very people Medicaid is designed to serve, limiting access to health care for some and reducing quality of care for others.[5] The cuts are especially harmful in a recession when more people need coverage because they lose their jobs or their employers reduce health care benefits.[6]

In fact, more than one million people will likely lose health insurance due to Medicaid cuts already in place.[7] The uninsured are less likely to seek necessary primary and preventive care and typically have poorer health outcomes and lower life expectancy than those who are insured, according to the Institute of Medicine.[8,9] Cutting or freezing provider rates makes primary and preventive care less available to people who remain on Medicaid.

Cutting Medicaid during a downturn can also worsen the economic crisis.[10] Because the federal government matches at least half of all state Medicaid spending, states need to cut at least $2 to save $1. Many states receive higher federal matching rates, and would need to cut even more to see savings. These cuts reduce health care jobs and other economic activity generated by hospitals, physicians, and other health services. The effect filters through the broader economy as health care workers and facilities have less money to spend.[11] Decreased business activity and fewer jobs also means the state collects less taxes, which deepens the budget gap.

Cuts in Medicaid will also likely reduce the amount of new money states will receive if Congress approves an increase in federal matching funds that national leaders are discussing as part of a plan to stimulate the economy. House leaders have proposed tying the funding to preservation of current Medicaid eligibility.

Alternatives to cuts

In the short run, federal help to maintain state Medicaid programs is the best hope for avoiding deeper cuts in eligibility, benefits, and provider payments. Other quick options include raising revenue through assessments on hospitals or nursing homes, tobacco taxes, and tapping "rainy day" funds. All of these choices preserve the economic and health benefits of Medicaid.

The current crisis can also provide an opportunity to strengthen Medicaid by improving quality in ways that contain costs. Some of these changes could yield Medicaid savings in the next few years, while others will lay the foundation for long-term improvements that could help avert Medicaid cuts in the next economic downturn.

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Short-term cost containment ideas

The quickest savings that also improve quality in Medicaid can come from expanding programs already in place in most states to manage care of people with chronic conditions and encourage use of the most effective treatments.

Expand existing care management programs: The majority of Medicaid costs are concentrated in a small proportion of people with chronic health needs, such as asthma, diabetes and behavioral health issues. In 2004, the highest cost five percent of enrollees accounted for more than half of Medicaid spending.[12] Much of the care for these patients is complex and may not be coordinated or appropriate. Managing this care more effectively could save $194 billion nationally over 10 years, according to the Commonwealth Fund.[13]

More than half of states have created care management programs for people on Medicaid with chronic health conditions.[14] These programs typically involve provider teams coordinating care and delivering proven treatments using best practices.[15] States have also taken steps to improve primary care for people with chronic conditions.[16] Strengthening these programs could yield significant savings quickly.[17] North Carolina's Medicaid program, for example, saved upwards of $154 million in 2006 and improved quality for thousands of people by creating medical homes to help manage care. It is described in detail below.

Strengthen evidence-based medicine review for Medicaid services: Providers may not have the most unbiased, up-to-date information on which drugs, medical procedures, and equipment are most effective. As a result, they may prescribe treatments that are more expensive or do not produce the most desired results. Clinical effectiveness studies evaluate the health outcomes, safety and cost of two or more medical services used to treat the same condition.[18] These studies can inform Medicaid policy. For example, nearly all states have a "preferred drug list" for Medicaid to suggest which prescriptions are most effective for patients and should be prescribed. However, many PDLs are ineffective. PDL committees may be biased by inaccurate information, or prescribing rules may not be properly enforced. A Washington state case study below discusses a strong PDL that uses independent review, and provides ideas for strengthening other state Medicaid PDLs.

Longer-term cost containment ideas

To achieve bigger savings in the longer term, states must lay the foundation now by investing in better quality care.

Stop Paying for Poor-Quality Care: State Medicaid programs could save millions of dollars and improve quality by limiting or eliminating payments for care that is harmful to patients—preventable errors, hospital-acquired infections, and preventable readmissions to hospitals. Massachusetts recently enacted a law that prohibits reimbursement to health care facilities for these types of harmful care.[19] New York's Medicaid program stopped payment for 14 serious problems caused by health providers beginning October 2008.[20]

One out of every five hospital patients in a 1999 study of four states was readmitted to the hospital for conditions such as asthma, diabetes, and hypertension, which could have been treated at an earlier stage in doctors' offices.[21] The cost amounted to $7,400 per readmission.[22] Medicare

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recently began eliminating payment for preventable hospital-acquired infections and injuries, at a potential savings of $21 billion of Medicare's $110 billion hospital budget.[23]

Further resources:

The Commonwealth Fund Quality Matters: Hospital Readmissions, March 2008 Newsletter
[http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=673140#note3]

Community Catalyst. More for Our Health Care Dollar: Improving Quality to Cut Costs, October 2008
[http://communitycatalyst.org/doc_store/publications/Cost_Containment_Overview_Oct2008.pdf]

Reduce Emergency Room Use through Enhanced Primary Care: Medicaid enrollees use emergency departments (ED) more frequently than the general population.[24] Improving access to primary care providers can significantly decrease ED use by providing care when patients need it and before they become seriously ill.[25,26] Medicaid programs that reward doctors and nurses for providing care in the evening and on weekends are likely to reduce emergency department use. In addition, greater care management, around-the-clock care information lines, and consumer education programs help Medicaid enrollees to get the right care when they need it.[27]

Further resources:

Center for Health Care Strategies, Emergency Department Use and Its Relationship to Ambulatory Care: Translating Study Findings into Policy and Practice, August 2005.
[http://www.chcs.org/publications3960/publications_show.htm?doc_id=289109]

Center for Health Care Strategies, Addressing the Realities of Emergency Department Use in Medicaid Managed Care, February 2005.
[http://www.chcs.org/publications3960/publications_show.htm?doc_id=261617]

Home- and Community-Based Long-Term Care: Medicaid pays for the bulk of nursing home care nationally, spending billions of dollars to institutionalize people who may prefer to receive care at home.[28] While federal rules require Medicaid to pay for needed nursing home care for all low-income people, states may obtain special federal permission to offer home- and community-based options. Oregon has restructured financing for long-term care and, at 70 percent, has the highest proportion of long-term care funds spent on community-based care.[29] While cost savings vary, states report being able to care for about two people in the community for the cost of one in a nursing home.[30]

Further resources:

Laura Summer, Georgetown University Health Policy Institute for the Kaiser Commission on Medicaid and the Uninsured. Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities
[http://www.kff.org/medicaid/7402.cfm]

Integrated Care Models: Coordinating care for people who are elderly and disabled could save considerable money—more than $7 trillion nationally over 15 years in the Medicaid and Medicare

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programs, according to the Lewin Group.[31] Coordinated care can prevent or delay the declines in health and functional status that often result in hospitalization or nursing home placement.

One way that states are implementing this is through Special Needs Plans (SNPs), health plans that coordinate care primarily for Medicaid enrollees who are also eligible for Medicare (dual eligibles).[32] SNPs provide an opportunity to integrate care *between* the Medicaid and Medicare programs, which has the potential to increase financial stability in the Medicare program and state Medicaid budgets, while maintaining enrollees' benefits and services. When Medicaid and Medicare are not integrated, there are incentives for providers to shift costs between the two programs. However, there are few standards for SNPs, and advocates have identified problems with the way some SNPs serve members.

Some SNPs are providing high-quality coordinated care to their members and have demonstrated the potential for improving care through integration. Estimates suggest that SNPs can generate significant savings. While Medicare would see savings immediately, projections show that it would take about five years before SNPs would produce Medicaid savings for states.[33] National policymakers have discussed changes at the federal level that would allow states integrating care between Medicaid and Medicare to share savings earlier.

Further resources:

Community Catalyst. Medicare Special Needs Plans: A Consumer Advocate's Guide to Opportunities, Risks, and Promising Practices, February 2008
[http://communitycatalyst.org/doc_store/publications/medicare_special_needs_plans_guide_february_2008.pdf]

SNP Alliance. The Basics about Special Needs Plans
[http://www.nhpg.org/about-snps.aspx]

For additional information on these and other cost and quality ideas, visit:

- Center for Health Care Strategies, *Medicaid Best Buys Initiative* examines a number of smart ways to manage Medicaid funds [chcs.org]
- Kaiser Family Foundation releases an annual survey of state Medicaid directors with further information on cost containment ideas [www.kff.org/medicaid/7815.cfm]

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What can consumers do to promote these ideas in states?

Keeping Medicaid strong this year will almost certainly require additional aid from the federal government, as well as new state-generated revenue. Consumers can:

- *Advocate for additional federal funds.* Urge state leaders and members of Congress to push for immediate federal relief. Assemble stories describing the importance of Medicaid as a safety net during difficult economic times, and share them with legislators and the media. Target media outlets where there are high levels of Medicaid participation, but also where employment may be sagging and working families may soon have to turn to public programs – perhaps for the first time – for health insurance. Make common cause with other stakeholders, such as safety net hospitals and community health centers that also benefit from a strong Medicaid program.

- *Advocate for increasing state assessments on hospitals and nursing homes to help fund Medicaid.* This money can help states draw down additional federal matching funds.

- *Propose other revenue increases, such as tobacco taxes.* Earmarking these funds for heath care can bolster state spending on Medicaid.

To improve quality and contain costs in the longer run, consumers can press leaders to think beyond crisis management. They can:

- *Research strategies used in other states.* Learn the potential and track records of specific cost containment strategies and advocate for these alternatives to Medicaid cuts. The case studies described in this paper can be models. While many changes to Medicaid occur through administrative changes and may require federal approval, improvements can also be achieved through state legislation.

- *Generate stories from adults and children* who have chronic health needs to make the case for coordinated care. In addition, stories about poor-quality outcomes can support the need for evidence-based medicine. Share these stories with leaders who can make changes to the Medicaid program—in state budget hearings, meetings with state and local leaders, and the media.

- *Get involved in state Medicaid decisions.* Become involved with your state Medical Care Advisory Committee.[34] By law, these committees must include consumers. Use this venue to bring the consumer perspective to state Medicaid administrators. Many states have other commissions on initiatives to reform health care. Ensure consumers are represented on these committees.

- *Develop coalitions to advance initiatives such as evidence-based prescribing of drugs and coordinated care for patients with chronic illnesses.* Quality and cost coalitions may include non-traditional allies, such as businesses and providers.

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Case Studies

North Carolina's Medical Homes in Medicaid

North Carolina's state Medicaid agency began a pilot program in 1991 to create local nonprofit care networks organized and run by community providers, public health agencies, and health centers. The state directed the networks to provide a full range of care for members, from preventive visits through hospitalization, with treatment centered in one facility – a "medical home" to coordinate care.[35]

Community Care of North Carolina (CCNC) has since become a model for improving quality and saving money in Medicaid.[36] This program, mandatory for Medicaid enrollees, is now statewide and covers about 874,766 people through 1,300 networks of about 3,800 primary care physicians.[37] CCNC currently manages care for nearly all children and parents enrolled in Medicaid. In addition, the initiative has specialized programs to coordinate care for people with asthma, diabetes, congestive heart failure, and other high-risk conditions.[38]

Unlike a typical Medicaid managed care program, CCNC contracts with local nonprofits directly to provide access to coordinated care around the clock though the networks.[39] The program emphasizes local control and local leadership. Networks choose a physician who is a community champion to become clinical director, and that person works directly with the state to develop quality measures and patient outcome goals for their care delivery network. The program works closely with health advocacy groups such as agencies on aging, and consumers have shown their support by advocating for the program in times of threatened budget cuts.[40]

CCNC is saving North Carolina's Medicaid program millions of dollars each year. Mercer Government Human Services Consulting has determined program cost savings since 2001, and found that in comparison to a benchmark of the basic managed care program that existed in the base years (2000-02) of the program, CCNC saved the state between $154 and $170 million in 2006.[41] [See Figure 2]

The quality of care also improved significantly for enrollees. In pilot projects for children and adults with asthma, hospital admissions dropped by 50 percent between 2000 and 2006, emergency room use declined, and the need for asthma medicine was also reduced significantly.[42] Between 2000 and 2002, these programs alone, which were operating in about 10 percent of North Carolina, saved $5.4 million.[43,44] The state expects these savings will grow as the program expands statewide.

To encourage participation, CCNC networks receive an extra $3 per member per month from Medicaid to manage enrollees' care. Case managers oversee health care education and coordination of needed services for all enrollees. Primary care providers participating in CCNC networks also receive an additional $3 per member per month to participate in medical homes, and must comply with recommended clinical guidelines, provide around-the-clock coverage and use health information technology.[45]

Many states already deliver care for Medicaid enrollees through managed care organizations (MCOs). North Carolina currently has no MCOs participating in Medicaid, mainly because the

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success of the CCNC program has meant that no private health organization can compete in savings or outcomes. However, CCNC program administrators express optimism that states with MCOs could create similar programs. Medicaid agencies could require their existing MCOs to build collaborations with local communities, health centers, and public health managers in a clinical partnership very similar to CCNC.[46]

For further information:

Community Care of North Carolina
http://www.communitycarenc.com
Telephone: 919-715-1453
Email: ccnc.program@ncmail.net

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Washington State's Preferred Drug List

Prescription drug costs are among the most significant and fastest-growing components of state Medicaid budgets.[47] Many states already use a preferred drug list (PDL) to reduce prescription costs in Medicaid.[48] The goal of a PDL is to encourage doctors to prescribe drugs that are the most clinically effective and least costly. Typically, Medicaid covers drugs on the list without question, but requires doctors to get approval for other medications.

However, PDLs in state Medicaid programs have had mixed results in reducing costs and improving quality.[49] Two requirements for a PDL that accomplishes its goals are a drug list based on evidence of clinical effectiveness, and a mechanism to ensure that physicians prescribe mostly what is on the list. Washington State has both.

In response to rising prescription drug costs, the Washington Legislature created the Prescription Drug Program in 2003. Coordinated by the state Health Care Authority, the program oversees a process to create one PDL for Medicaid, the public employee health plan, and the workers' compensation program. The PDL applies to about 750,000 to 800,000 people, including the Medicaid fee-for-service population.[50] The program's strong focus on determining the evidence-based *quality* of prescription drugs was critical in garnering support for Legislative passage.[51]

There are four main steps to the PDL in Washington:

- A committee oversees PDL decisions. A Pharmacy and Therapeutics (P&T) committee, made up of qualified, informed physicians and other providers, makes decisions about what drugs to include using a transparent, public process and evaluation based only on clinical evidence. Without considering cost, the committee makes recommendations on drugs that are safe and effective.[52]

- The P&T committee uses comprehensive clinical effectiveness studies from the Drug Effectiveness Review Project (DERP) to make decisions. DERP, at Oregon Health and Science University, is an independent collaboration of organizations that support comparative research on health outcomes for drugs. Fourteen states can use these studies as members of DERP.[53]

- Only after considering quality and clinical effectiveness does the state examine the cost of the preferred drugs. The state then endorses drugs for the PDL that are *both* cost-effective and high in quality.

- State rules enforce the PDL. "Endorsing practitioners" agree to allow pharmacists to exchange preferred, equivalent drugs for medicines prescribed that are not on the PDL. These approved prescribers can also request to dispense a drug as written if they strongly recommend a drug not on the PDL. Medicaid providers who do not agree to be endorsing practitioners must seek written prior authorization process to dispense drugs as written.[54]

Washington state saw savings within the first two years of the PDL program. According to the Prescription Drug Program, the state has saved between $20 million and $24 million annually in fiscal years 2005 through 2007.[55] These results represent savings of about five percent of prescription drugs costs for the Medicaid, workers' compensation and state employee health plan

programs. The Medicaid fee-for-service program specifically saved $16.8 million in 2005 and $13.7 million in 2006. (Prescription costs for people enrolled in both Medicaid and Medicare transitioned to Medicare Part D in 2006, which accounts for the decrease in savings.)[56]

Basing prescribing practices on clinical effectiveness has also improved quality for Medicaid enrollees in Washington. The state removed Vioxx from the PDL in 2002 based on concerns of effectiveness and safety, two years before the drug was removed from the market due to serious cardiac side effects.[57] In addition, there has been a marked increase in the use of preferred drugs by enrollees, with about an 80 percent compliance rate with the PDL. After adding drugs to treat hypertension to the PDL in 2004, claims for non-preferred drugs decreased by about 60 percent.[58]

While many states have PDLs in Medicaid, Washington has an advanced drug review process—one that involves a thorough analysis of quality, effectiveness and cost before approval. States can apply the tenets of Washington's program by revamping their Pharmacy & Therapeutics committees to ensure unbiased decisions, using clinical effectiveness data as members of DERP, and enforcing compliance in prescribing. States can see savings quickly, in only a few years, as Washington did.

For further information:

Washington's Prescription Drug Program
Health Care Authority
http://www.rx.wa.gov/

Drug Effectiveness Review Project
Oregon Health and Science University
http://www.ohsu.edu/drugeffectiveness/

The Prescription Project
http://www.prescriptionproject.org/
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Recommendations for policymakers from The Prescription Project:
http://www.prescriptionproject.org/tools/solutions_resources/files/0004.pdf

Resources on generics from Generics Are Powerful Medicine:
http://www.genericsarepowerful.org/

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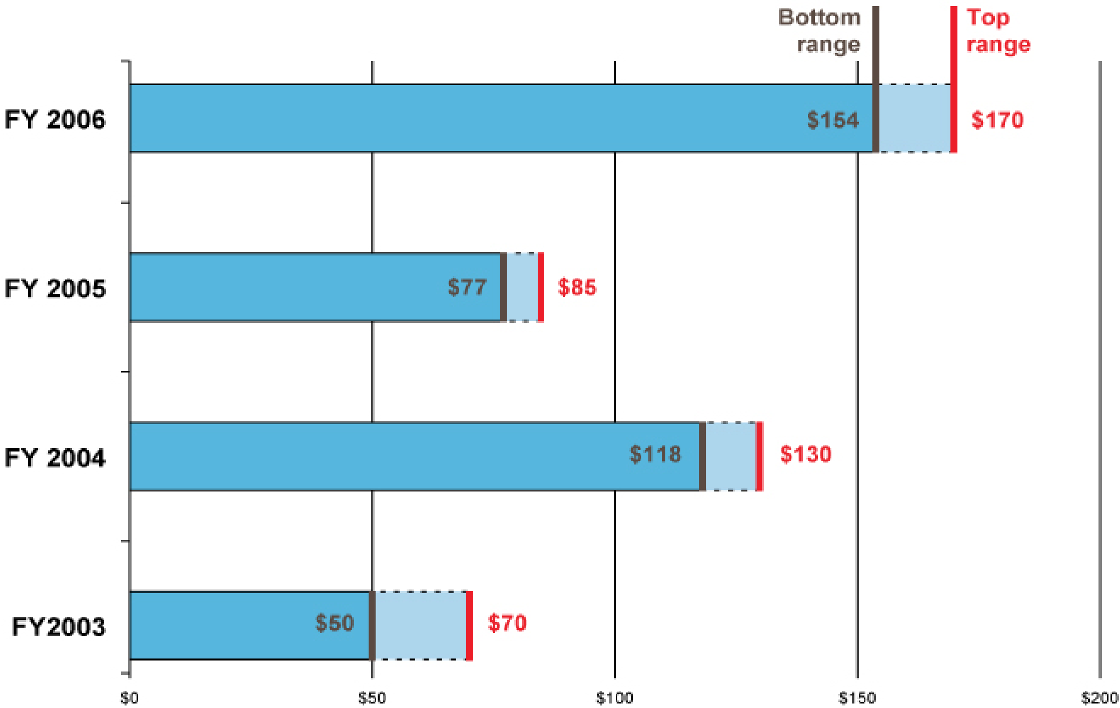
Figure 1
States cutting Medicaid in FY 2009

Medicaid cuts include provider payment freezes or cuts, benefit reductions, eligibility cuts, co-pay increases. Alaska and Hawaii reported no actions.
Source: Kaiser Commission on Medicaid and the Uninsured, *Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn*. September 2008

Figure 2



Source: Community Care of North Carolina, Program Impact. 2007. http://www.communitycarenc.com/

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