Medicaid Cost Containment in Washington State

Presentation to the House Appropriations Committee
February 4, 2003

Overview of the Presentation

- Nature of the Engagement
- Cost Containment Efforts Already Underway
- What Other States are Doing to Contain Costs
- Cost Containment Strategies Going Forward
- Questions

Nature of the Engagement

Goal of the Project

To independently evaluate current and potential Medicaid cost containment strategies in Washington

The Washington State Legislature commissioned The Lewin Group to create three reports:

- *Report 1:* Summary of Cost Containment Efforts Already Underway in MAA
- *Report 2:* Evaluation of Savings Estimates Associated with Cost Containment Efforts Already Underway
- *Report 3:* Identify and Model Potential Strategies

Cost Containment Efforts Already Underway

Lewin reviewed several cost containment initiatives already underway

- Utilization and Cost Containment Initiative (UCCI)
- Pharmacy Initiatives, such as TCS
- New and Future Cost Containment Activities

UCCI programs have produced significant savings

- UCCI savings come from "work smarter" approaches.
- Lewin developed independent estimates of cost savings associated with several initiatives, including:
  - Rate Changes for Certain Drugs
  - Alternative Payers – VA
  - Coordination of Benefits
  - Medical and Independent Practitioner Audits
  - DME / Non-DME Quality Review Services
  - Non-Emergency Transportation

MAA and Lewin each developed estimates of UCCI savings for SFY 2002* . . .

Item	MAA	Lewin	Difference
Rate change for Schedule II Drugs	$0.6	$0.5	($0.1)
Alternative Payers – VA	$0.1	$0.1	$0.0
Coordination of Benefits	$27.9	$16.8 to $21.7	($6.2) to ($11.1)
Hospital Audits	$4.0	$3.1	($0.9)
Medical/Independent Practitioner Audits	$5.2	$2.8	($2.4)
DME/non-DME quality reviews	$1.0	$0.4	($0.7)
Pierce County Brokerage Model	$1.0	$1.3	($0.3)
Unique Transport Program	$0.3	$0.3	$0.0
Total	$40.2	$25.4 to $30.2	($10.0) to ($14.8)

* Savings estimates are expressed in millions of dollars and do not include the additional costs of administering the UCCI programs.

…and TCS has achieved significant savings

- MAA and Lewin calculated similar TCS savings estimates for SFY 2002*.

	MAA	Lewin	Difference
4-Brand Edit	$4.0	$5.1	$1.1
PDL Edits	$3.6	$3.6	$0.0
Loss of Rebates	N/A	($0.9)	($0.9)
ACS Contract	($1.3)	($1.3)	$0.0
Total Savings	**$6.4**	**$6.6**	**$0.2**

* Because TCS was implemented in February 2002, savings estimates cover the 5 month period from February 2002 to June 2002. Savings estimates are expressed in millions of dollars.

MAA continues to implement additional cost containment activities.

- MAA has just implemented or plans to implement several new cost containment strategies.
  - Disease Management
  - Medicare Eligibility Initiatives
  - Brokerage Model for Interpreter Services
  - HIFA Waiver
  - Take Charge (Family Planning Waiver)
  - Alternative Payers – Clark County Pilot

Lewin has several recommendations for MAA as it continues its cost containment efforts

- ✓ Continue rigorous measurement of costs and savings, which MAA recognized even before our engagement began
- ✓ Remain consistent in savings methodology
- ✓ Monitor on-going savings

What Other States are Doing to Contain Medicaid Costs

Almost every state is implementing Medicaid cost containment strategies…

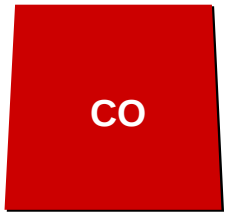
Cost Containment Strategy	Number of States
Implement pharmacy cost controls	40
Reduce or freeze provider payments	29
Reduce Medicaid benefits	15
Reduce Medicaid eligibility	18
Increase beneficiary co-payments	15

Source: Kaiser Family Foundation, data as of September 2002

…many are similar to those that Washington is considering…

- Eliminate eligibility for approximately 200,000 persons
- More frequent eligibility re-determinations
- Eliminate optional Medicaid services (e.g., adult dental)
- Reduce physician and other provider payments by 10%

- Eliminate eligibility for over 50,000 persons
- Eliminate optional Medicaid services (e.g., adult dental)
- Reduce provider payments



- Reduce hospital payments for indigent care
- Limit eligibility for Medicaid disability benefits
- Reduce nursing home payments

Source: Kaiser Family Foundation

…however, many states are encountering legal and other challenges as they attempt to reduce Medicaid expenditures

In 2002, Tennessee attempted to eliminate 200,000 enrollees from TennCare but is currently facing legal challenges from affected consumers. The State may not be able to save the projected $300 million associated with covering this group.

Texas recently attempted to implement consumer co-payments for pharmaceuticals. In late 2002, the pharmacy association obtained a restraining order, preventing the co-payment rule from taking effect.

Lessons Learned

1. Many Medicaid cost containment strategies can lead to litigation and other challenges that can prevent the strategies from being implemented.
2. States must be careful to consider ramifications of reliance on savings from cost containment strategies that may be stalled or thwarted.

Compared to other states, Washington's management of its Medicaid program is:

…a leader in its cost containment efforts, especially under UCCI.

…a leader in data-driven program management.

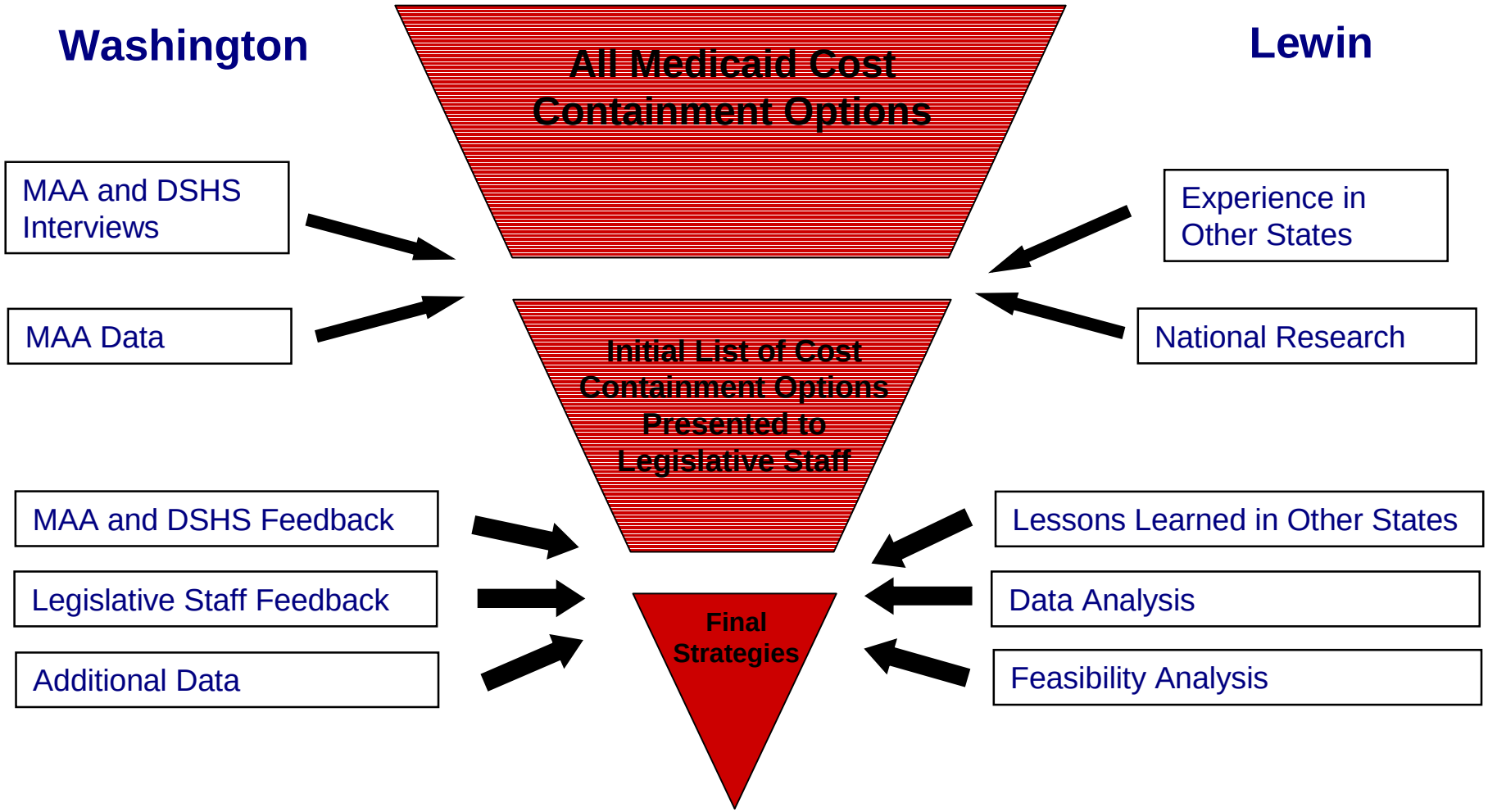
…a leader in its promotion of cost-effective prescription drug use.

Washington is currently considering many of the same program restructuring options as other states

- Eligibility reductions
- Tighter eligibility controls
- Benefit reductions
- Provider rate freezes / limitations

Medicaid Cost Containment Strategies Going Forward

For Report 3, Lewin undertook an iterative process to develop options for future cost containment and revenue enhancement



Lewin identified four strategies the State could consider for future cost containment

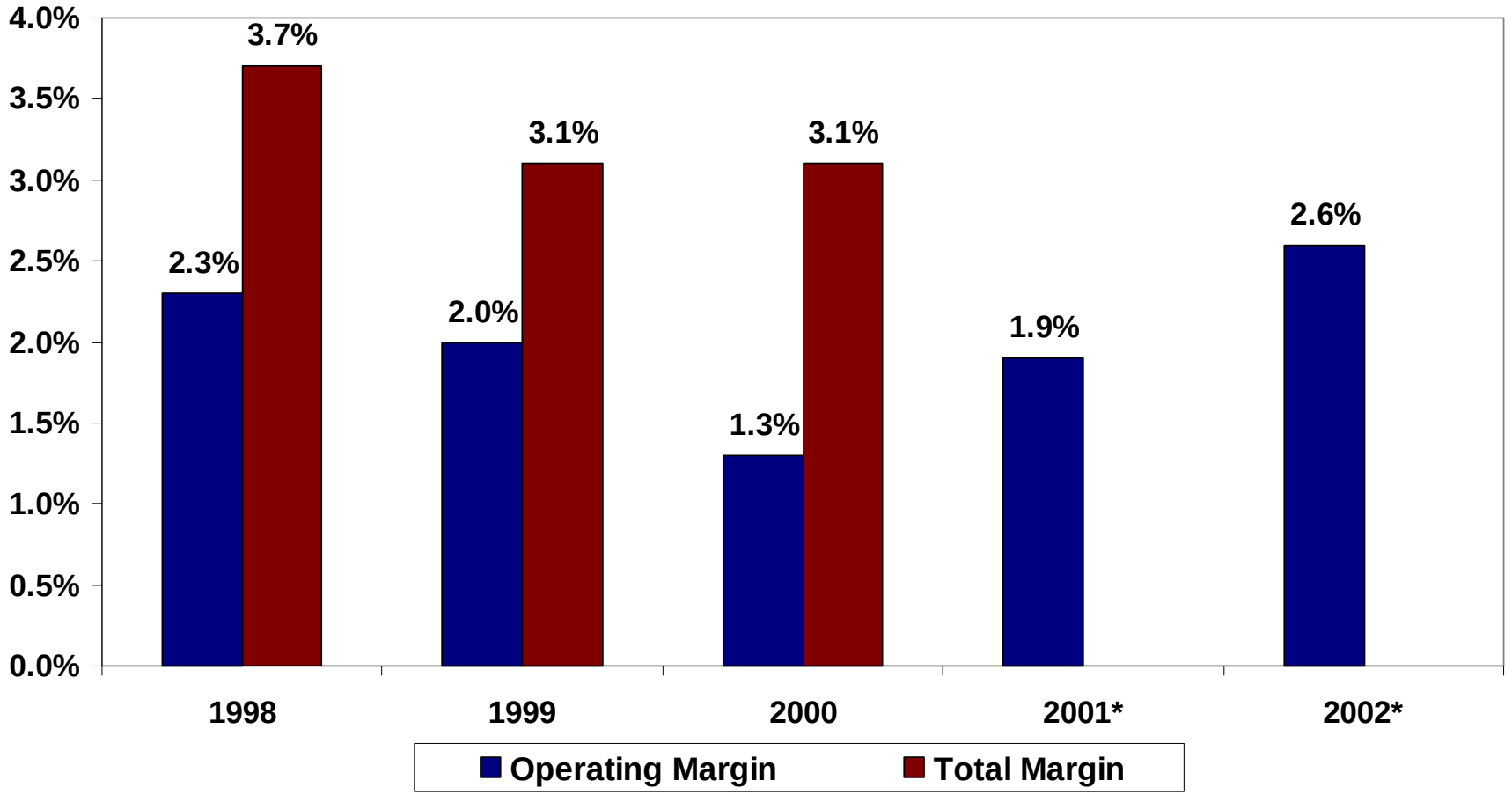
Cost Containment Approach	Estimated Savings*
Reduce Hospital Reimbursement	$87.2
Revise Managed Care Rates	$30.5
Implement 6 Month Eligibility Reporting Requirement	$56.4
Modify Long Term Care Service Delivery	$18.1 to $41.5

* Savings estimates are expressed in millions of dollars. Savings reflect different time periods. (See individual sections for details.)

Strategy 1: Reduce hospital reimbursement

- Hospitals generally have some advantages over other providers in times of financial stress:
  - Most private insurance programs cover hospital services, so hospitals have a greater ability to cost shift to private payers
  - Hospitals have investment income and significant reserves to draw upon
  - Washington hospitals have been profitable over the past several years
- Yet, special care must be accorded to hospitals because:
  - They are legally mandated to provide care for the uninsured
  - They cannot absorb lower reimbursement rates on a long-term basis
  - They cannot shift their payer mix by relocating, as other providers can

Washington hospitals have been profitable over the past several years



Washington may consider rate reductions at several levels

Hospital Operating Margin*	Payment Reductions (in millions)	Estimated Rate Reduction Percentage**
2.6% (current)	N/A	N/A
2.0%	$43.6	5.6%
1.5% (just above 2001 levels)	$87.2	11.2%
1.0%	$124.3	16.0%
0.5%	$163.5	21.0%
0.0%	$200.6	25.8%

* Includes net patient revenues for all payers and other operating revenues.

** Estimated percentage reduction in FFS hospital payments including inpatient, outpatient, and DSH payments. Assumes a base of $777.2 million in hospital payments from 2001 CMS-64 reports.

In general, hospitals receive the smallest portion of their revenue from Medicaid

Payer	Percentage of Net Patient Revenue by Payer	Weighted Patient Care Total Margin
All Other Payers	51.8%	6.5%
Medicare	33.4%	(2.0%)
Medicaid	14.7%	(1.1%)

Key considerations in reducing hospital reimbursement

- Some hospitals serve a disproportionate number of Medicaid clients. Any rate reductions should consider the margin impact to these hospitals.
- Any rate reduction is only feasible in the short-term and should not be continued into the long-term.
- Medicaid's payment policies should be developed in conjunction with the Medically Indigent proposal.

Strategy 2: Revise managed care rate setting approaches

- A review of financial statements from Healthy Options health plans revealed that many health plans have significant operating surpluses.
- For many plans, the Medicaid line of business has been more profitable than other lines of business.
- Had the plans been held to the 1.5 percent margin (one option for hospitals), the savings would have been between $27 and $34 million in CY 2002.

Many health plans in Healthy Options are realizing significant surpluses

Health Plan	Percent Gain/(Loss), Medicaid Line of Business		
	CY 2000	CY 2001	Jan-Jun 2002*
Aetna	4.4%	3.0%	3.9%
Columbia United Providers	3.2%	1.1%	1.2%
Community Health Plan	5.0%	4.7%	4.4%
Group Health	(6.7%)	(20.0%)	
Molina (unadjusted)	5.7%	6.5%	14.5%
Molina (adjusted)	7.3%	9.6%	8.2%
Premera	11.4%	4.1%	
6 HMOs combined	4.5%	3.1%	7.8%**

* Figures in the first half of 2002 represent all HMO lines of business combined. Figures in this column are shown only for those health plans whose Medicaid line of business represents more than half of the HMO's total revenue.

** Figure represents aggregate performance of the 4 HMOs for whom Medicaid is the primary line of business.

MAA possesses substantial rate setting leverage

Health Plan	% of Statewide Capitated Enrollment	% of Revenue from Medicaid Line of Business (CY 2001)	Jan-Jun 2002 Gain/(Loss)
Aetna	0%	71%	3.9%
Columbia United Providers	8%	83%	1.2%
Community Health Plan	28%	52%	4.4%
Group Health	7%	3%	N/A
Molina	38%	98%	8.2% (adjusted)
Premera	11%	3%	N/A
Regence	8%	<10%**	N/A
Total	100%	13%***	7.8%****

* Aetna participated in Healthy Options until mid-2002, at which point the Medicaid line of business was purchased by Molina.

** This figure is an estimate, due to insufficient data reported on Regence's financial statements.

*** This figure excludes Regence, for whom a precise figure is not known.

**** Figure represents aggregate performance of the 4 HMOs for whom Medicaid is the primary line of business.

Other observations about Healthy Options rate setting approaches

- The State's actuarial firm provides services to two health plans that together serve nearly half the enrollment (46%), including the most profitable plan (Molina).
- Important data are not being accessed.
  - Financial statements
  - Encounter data
- Annual rate increases do not appear well-correlated with health plan financial performance and the State's budget situation.

Strategy 3: Implement 6 month eligibility reporting requirement

- This option would require some children to submit a 6-month eligibility report in addition to 12-month eligibility re-determinations.
- Lewin provided an alternative to MAA's savings estimate for the 2003-2005 biennium*:

MAA Estimate	Lewin Estimate	Difference
$43.7	$56.4	$12.7

- Lewin's estimate is based on a study we performed in CA. MAA's estimate is based on WA specific data.

* Savings estimates are expressed in millions of dollars.

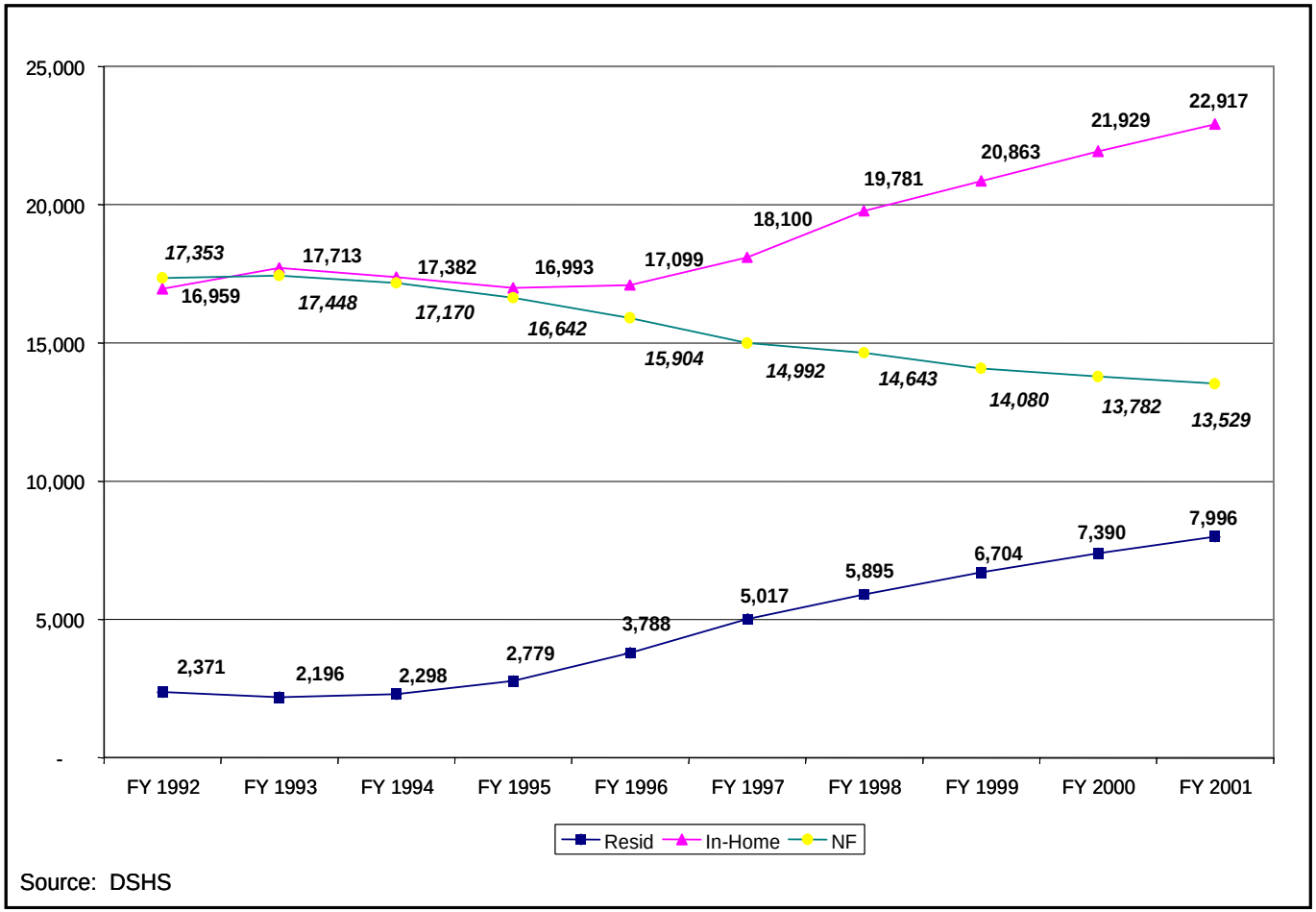
Strategy 4: Modify long term care service delivery

- Washington could look to three areas for long term care cost savings
  - Medicaid Personal Care
  - COPES
  - Nursing Facilities

Washington's long term care policies are progressive…

- Electing to use a low (relatively easy to meet) "level of care" criteria for institutional and COPES services
- Electing to use a low (relatively easy to meet) LOC criteria for Medicaid personal care
- Refusing to cap the number of consumers served in COPES

. . . and Washington altered its programs to provide more home and community- based services long before most states . . .



…which has led to rapid growth in home and community-based expenditures

	Avg. Monthly Caseloads (FY)			Percent Change '00-'02
	2000	2001	2002	
COPES	22,213	23,264	22,666	2.04
Personal Care	6,514	7,208	9,269	42.29
Nursing Facility	13,782	13,529	13,144	(4.63)
	Avg. Monthly Cost Per Case (FY)			Percent Change '00-'02
	2000	2001	2002	
COPES	$958	$1,015	$1,066	11.27
Personal Care	$505	$597	$751	48.71
Nursing Facility	$2,913	$2,996	$3,103	6.52
	Total FY Spending (in millions)			Percent Change '00-'02
	2000	2001	2002	
COPES	$255.4	$283.4	$289.9	13.54
Personal Care	$39.5	$51.6	$83.5	111.61
Nursing Facility	$481.8	$486.4	$489.4	1.59

Washington has several options for savings in long term care . . .

Strategy	Potential Savings*
Raise level of care criteria in COPES	$41.5
Cap COPES enrollment	$25.9
Eliminate Medicaid personal care, moving eligible persons to COPES	$18.1
Raise Medicaid personal care functional requirement to COPES standard	$22.7

* SFY 2002 savings estimates are expressed in millions of dollars.

. . . but DSHS believes that its expansive policies ultimately save money

- DSHS believes that early entry to COPES and MPC prevents consumers from deteriorating and needing more expensive nursing facility care sooner

- DSHS also believes that avoiding wait lists in COPES keeps people out of more expensive nursing facility settings

Lewin identified five potential revenue enhancement approaches…

- Home health claims for dually eligible beneficiaries
- Indian Health Services and Tribal 638 facilities
- Employer premium assistance
- Supplemental pharmacy rebates
- Nursing facility tax

…and potential increased revenue could be estimated for two of the strategies

Strategy	Estimated Increase in Revenue*
Supplemental pharmacy rebates for existing PDL drug classes	$1.4
Nursing facility tax	$1.8

* Revenue estimates are expressed in millions of dollars.

Conclusion

- MAA has made significant progress to reduce Medicaid costs under UCCI.
- MAA has been very diligent and careful in measuring the savings associated with UCCI.
- Pharmacy initiatives appear to be having a significant effect on cost and utilization.
- Washington has several options for additional cost containment strategies; however, these strategies must be considered in light of other proposed changes.
- Revenue enhancement strategies may provide short-term financial relief but will not solve long-term program concerns.

Questions