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Medicaid Cost Efficiency and Transformation:

Ideas for achieving fiscally responsible results and improving the quality of services for beneficiaries

Testimony Before the Illinois Senate Deficit Reduction Committee on Health Care

March 10, 2009

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Illinois Medicaid Savings Opportunities Summary

Savings Summary ($ billions)	Gross Savings	General Fund Savings
Medicaid Cost Savings Opportunities		
Acute Care	310	130
Rebalancing long term care	260	110
Pharmacy cost containment	255	110
Waiver	695	435
DD/MR shared living community alternatives	150	75
Eligibility Modernization	120	120
Vendor Management	300	300
Total	***2,090***	***1,280***

Acute Care Cost Containment Strategies ($130 MM)

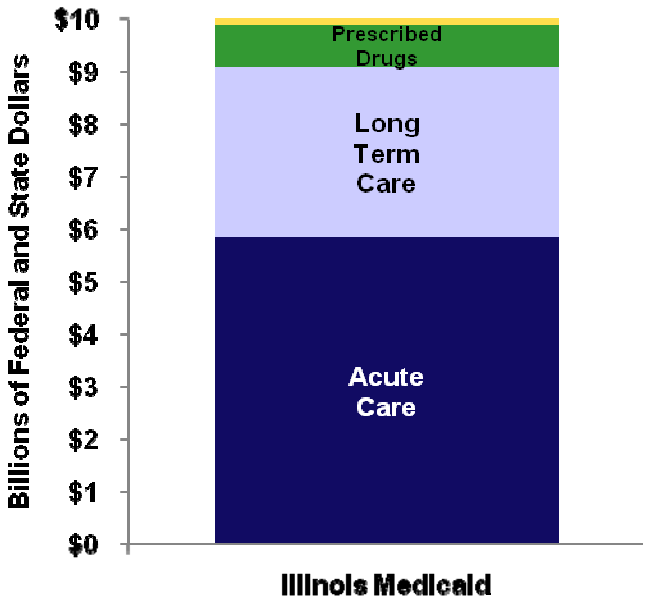
Statement of Problem: **Illinois Medicaid relies too heavily on costly inpatient hospital procedures and emergency room usage as primary care**

Illinois Data

- Highest quartile of Medicaid acute care costs in the nation – 66% vs. average 58%
- Costly inpatient hospital procedures are 48% of Acute vs. US average of 24%. 49th worst state.
- Illinois recently launched Illinois Health Connect, a PCCM network with 1.6 MM out of 1.9 MM eligible Medicaid clients enrolled
- In 2008, Illinois reported $34 million in savings during fiscal year 2007 on its disease management program. That is only 0.03% or $20 per enrollee. Should seek 10-20% savings
- High emergency department costs of $400 MM per year (22% of inpatient spending)

Steps to Control Costs

- Enhance Health Connect – a Primary Care Case Management program
- Emphasize outpatient over inpatient procedures
- Divert patients from emergency department
- Reduce inpatient pharmacy costs
- Reduce physician/lab costs through authorization
- Focus on disease management
- Expand selective contracting of medical procedures and durable medical equipment



Acute Care Cost Containment Strategies (cont.)

Case Study/Results in Other States

- Many states have PCCM programs.
  - Create medical homes and encourage consumer to engage in preventative healthcare in doctor's office or clinic
  - Enrollee chooses primary care provider who will coordinate and manage their care.
  - Primary care physicians incented to reduce costs through PMPM
- California passed legislation in 1982 allowing Medi-Cal to negotiate with selected hospitals to compete for Medicaid inpatient services. California obtained a Waiver. Saved an estimated $300 MM per year. Illinois had a similar program in early 90s that saved $100 MM per year. Program was discontinued following change in administration. Rhode Island most recent state to obtain selective contracting of inpatient and outpatient services Waiver from CMS
- Emergency room diversion strategies and studies – CMS funded emergency room diversion demonstration studies in 26 states (including Illinois)
- Outpatient procedures reduce costs. Deep Vein Thrombosis example. Inpatient $2,800 versus outpatient $300. Also, Tonsillectomy $3,000 inpatient versus $500 outpatient ambulatory surgical care facility.

Potential Savings to General Fund:	**$130 MM**
10% reduction in $3.6 BN (est. 2009) of inpatient expenditures	**$360 MM**
Net of 10% increase in outpatient expenditures $770 MM	**-80 MM**
Plus 2% decrease in lab and x-ray of $650 MM	**$13 MM**
Revised FMAP %	**44%**

Acute Care Cost Containment Strategies (cont.)

Benefit to the Public

- Improved access to high quality medical care for Medicaid recipients.
- Appropriate setting for medical procedure. Reduce unnecessary emergency department visits and hospitalizations
- Health management rather than simply acute care
- Strong focus on prevention and wellness with the medical home model
- Increase the provider network
- Reduce on-set of higher cost medical procedures
- Selective contracting results in less paperwork, fewer audits, and a more competitive environment. Also, contract ensures competitive price – usually reduction in expensive facility charges - access and quality.
- Ensure quality and retain medical necessity
- Expand community health center (CHC) sites on or near hospital campuses and partner with behavioral health providers sustainability of very important optional benefit under Medicaid program

Rebalance the Long Term Care System (LTC) ($110 MM)

Statement of Problem: Illinois' Spends More Than the National Average on Nursing Home Care and Places a Higher Portion of Seniors in Nursing Homes

Illinois Data

- Illinois spends approximately $2.6 billion a year on long term care services, of which approximately 60% is spent on nursing homes ($1.5 billion), vs. US average of 52%
- Medicaid nursing home reimbursement is approximately $60,000 per year compared to home and community based care which costs on average $15,000 per year
- 65 years or older population in Illinois was 12.1% in 2000 and will climb to 18% by 2030

Steps to Control Costs

- Continue vision of Older Adult Service Act and rebalance long term care system to focus on less costly community placements
- Enhance nursing home diversion and transition efforts
- Build capacity for shared and independent living models, including elder foster care
- Global budgeting, where money follows person in order to finance LTC system
- Goal 50/50 (50% of all LTC expenditures on community based care programs) in 5 years – follow lead of Missouri

Rebalance the Long Term Care System (cont.)

Case Study/Results in Other States

- Missouri spends $760 MM on nursing home care for Medicaid seniors and $770 MM on home and community based care
- US Average for home and community based care for seniors is 52% (Illinois is 40%)
- Vermont through its rebalancing efforts under a General Waiver reduced nursing home enrollment by 10% in one year
- Minnesota spends 62% of Medicaid LTC costs are on home and community care and only 30% on nursing homes

Benefit to the Public

- AARP study shows 99% of seniors prefer to live in the community
- Enhance quality of life
- Less reliance on costly institutional care
- Savings can be re-invested into community programs
- Provide for more sustainable Medicaid funding over the long run
- Effectively prepare for the future migration into higher population of seniors

Potential Net Savings for Illinois of	**$110 MM**
Annual LTC expenditures	**$2.6 BN**
Effective rebalancing strategy can result in LTC savings of at least	**10%**
State share	**44%**

Prescription Drug Cost Control Policies ($110 MM)

Statement of Problem: **Illinois Medicaid Prescription drug spending is higher than average among states and program lacks aggressive cost management strategies.**

Illinois Data

- Current Medicaid prescription drug spending $1.8 billion
- Illinois spends 27% more on prescription drugs as a percent of acute care than US average
- Pharmaceuticals per enrollee is $125 higher than US average
- No prior approval process
- No meaningful control of mental health prescription drugs (no mental health preferred drug list)
- No competitive purchasing strategies or pooling initiatives
- Dispensing fees ($3.40 per script for brand and $4.60 per script for generic) one of the highest in the US

Steps to Control Costs

- Institute more aggressive pharmacy benefit management, including preferred drug list (especially for mental health), PTCA, prior authorization, rebates, and supplemental rebates
- Consolidate pharmacy benefit management across all state agencies (include county). Create a state-wide public sector formulary
- Manage drug utilization through medication therapy management for high utilizers, automated prior authorization, and management of fraud, waste and abuse
- Optimize distribution channel through: preferred retail network, mail order and a specialty pharmaceutical management program
- Adjust co-pays as an incentive to use pharmaceuticals in medically correct manner

Prescription Drug Cost Control Policies (cont.)

Case Study/Results in Other States

- Majority of states have managed care and/or a pharmacy benefit manager that effectively controls costs without compromising access and quality.
- Most states have a much lower prescription drug costs as a percentage of acute care – Illinois (12%) Indiana (7.4%), Minnesota (5.9%), and Michigan (2.9%)
- Three quarters of all states have prior authorization programs
- 60% of states have a maximum allowable cost program for generic drugs
- 20% of states set limits on quantities dispensed per prescription drug
- Although Illinois has no mental health PDL, drug companies have used "illegal and highly dangerous" deceptive marketing practices according to Illinois Attorney General
- New Hampshire saved an estimated $10 million per year using a mental health PDL

Benefit to the Public

- Ensure access to prescription drugs for those in need
- Ensure quality and retain medical necessity
- Ensure sustainability of very important optional benefit under Medicaid program
- Control rising costs of prescription drugs

Potential Savings to General Fund:	**$110 MM**
Reduce acute care pharmacy expenditures of $1.1 BN by 15%	**$165 MM**
Reduce additional pharmacy expenditures of $880 MM by 10%	**$90 MM**
FMAP	**44%**

Development Disability Shared Living ($75 MM)

Statement of Problem: Illinois has a high development disability population living in high cost institutions – nursing facilities, ICF/MR and group homes

Definition: A shared living environment is a community placement where a person with developmental disabilities is placed into a home and his or her care and needs are provided for by an individual caretaker who is usually the homeowner. Services that are medically needed are brought into the home and the individual or provider have meaningful choice

Illinois Data:

- The total budget for individuals with developmental disabilities (DD) is $1.5 B
- Over 20,000 people are served and over 50% are currently in high cost institutions (13% state institutions, 7% nursing facilities, 32% ICF/MR), and 20% in group homes
- Illinois spends over $150 MM more than it receives from the federal government
- Only 30% of individuals with disabilities are living in homes or supported living arrangements with less than 6 people
- Many states have moved away from costly institutional care
- The cost of placement in a shared living environment can be less than ½ the cost of an institution
- Quality of life is sometimes compromised – ex: 2007 Howe Dev. Ctr is decertified for not meeting quality standards

Steps to Control Costs

- Illinois can transition to more shared living arrangements for those with developmental disabilities
- Reduce reliance on costly institutional care
- Limit further entry into group homes and institutions – diversion strategy with appropriate shared living providers and slots available
- Build capacity for shared living providers and enhance training and ensure quality
- Give individuals meaningful choice to remain in a community setting

Development Disability Shared Living (cont)

Case Study/Results in Other States:

- In New Hampshire, 94% of individuals with disabilities live in homes with less than 6 people. Only 1% live in ICF/MR institutions and only 4% in nursing facilities.
- In New Hampshire and Maine, the cost of DD home and community placements is an average $45,000 per year, whereas institutional care is approx $100,000 per year
- Additionally, in New Hampshire, a state with the same matching rate as Illinois, the state spends 44% on the DD population and the federal government spends 56%
- In Missouri, 21% of individuals with disabilities are in ICF/MR and other institutions, and the remainder in the community
- In Minnesota, 90% of individuals with developmental disabilities live in homes with less than 6. Only 13% of all funding for DD goes to ICF/MR

Benefit to the Public

- Community based care for DD is a preferred placement over high cost institutional care
- Independence

10% savings off the $1.5 B budget based on efforts of other states: NH, RI, Fl, Me. - states are seeing up to 50% savings in shared living environments

Section 1115 Medicaid Waiver ($435 MM)

Statement of Problem: **Illinois has not taken advantage of the federal negotiation process with CMS and the White House to transform its Medicaid program through the use of a Section 1115 Demonstration Waiver**

Illinois Data

- Illinois spends $11 billion per year on health care for individuals with developmental disabilities and mental health conditions, and children and seniors that are both determined to be medically and financially needy.
- Illinois currently has seven community based health care waivers
- Illinois does not currently have a Section 1115 Global Waiver for its entire Medicaid Program.
- Illinois relies on the traditional inflexible and time consuming state plan amendment approach to making changes to its health care deliver system.
- The average time period for a state plan amendment is over one year
- Any change to the rigid federal CMS regulatory process must be done through state plans or waivers

Steps to Control Costs

- Design a strategic plan to encompass all existing Waivers and state plans under one Global Section 1115 Demonstration Waiver
- Savings come from
  - Health care deliver re-design
  - Effective Care management throughout all Medicaid populations
  - Additional federal match – Costs Not Otherwise Matched (CNOM) opportunities
  - Flexibility

Section 1115 Medicaid Waiver (cont)

Case Study/Results in Other States

- 2005 – Vermont negotiated and obtained a Global Section 1115 Waiver from Federal Health and Human Services (Center for Medicare and Medicaid Services (CMS)) for rebalancing the LTC system
- Initial results show 10% reduction in nursing home, 50% increase in less costly community programs
- January of 2009 – Rhode Island negotiated and obtained a Global Section 1115 Waiver from CMS for its entire Medicaid program
  - Will save the State Medicaid program $388 million dollars over 5 years
  - Gives the State unprecedented flexibility in making any program and health care delivery system change
  - Focuses on three priority areas: Rebalancing LTC, effective care management and better purchasing strategies
- Rhode Island also expects to see $120 MM in additional federal dollars for the 5-year Demonstration

Benefit to the Public

- Re-designing health care delivery to focus on the person's needs
- Greater care management, better health outcomes and quality
- More efficient Medicaid program. Greater state flexibility to make changes. Less bureaucracy.
- Customized benefits, self-directed care and person-centered planning

Potential Savings for Illinois of	**$435 MM**
Impact on non-matched (state-only) LTC costs (.0562% of 260 MM)	**$150 MM**
Impact of non-matched (state-only) DD/MR (.0562% of $1.52 DD budget)	**$85 MM**
2009 Medicaid spending	**$11.6 B**
Waiver impact of 4% ($460 MM in savings X state share .0438)	**$200 MM**

Modernize Benefits Eligibility Determination Process ($120 MM)

Statement of Problem: Currently, Illinois' Benefits Eligibility Determination process appears prone to error

Illinois Data

- A study conducted by the Child Care Bureau in 2004-5 found errors in 24% of the 150 cases in the Illinois sample
- Results from the most recent PERM study are still pending

Steps to Control Costs

- Engage in a Public-Private Partnership to hand off determination of benefits eligibility to a private partner
- Savings come from
  - Operational savings
  - Capital costs being taken on by the private partner
  - Avoided Federal fines
  - Increased prevention and detection of fraud and abuse due to comprehensive retooling of paper-based legacy systems as well as process changes

Modernize Benefits Eligibility Determination Process (cont.)

Case Study/Results in Other States

- In December 2006, Indiana engaged an IBM-led coalition in a 10-year, $1.16 billion contract to provide administrative and technological support for the state's eligibility-determination process
- Before the transition, over 35% of Indiana's approved Medicaid long-term care applications had errors, over 65% of the Family and Social Services Administration's clients rated their satisfaction with the agency as 'below average,' and the FSSA had reported multiple instances of corruption on the part of eligibility determination employees
- Indiana expects to see $500 MM in savings through the initiative, and believes that the Public-Private Partnership paved the way for a more technologically advanced and efficient eligibility system that has better served and will continue to better serve Indiana residents

Benefit to the Public

- More efficient government
- Dramatic improvements in speed and efficiency of delivery of services
- Social workers who can spend more time helping their clients rather than filling out and filing paperwork through a variety of non-integrated systems
- Guaranteed improvements in work engagement and eligibility accuracy
- New high-tech jobs in the State

Potential Savings to General Fund:	**$120 MM**
▫ **Benefits eligibility determination cost**	**$400 MM**
▫ **If Illinois achieved savings similar to Indiana**	**30%**

Savings From Vendor Management of Illinois Purchases ($300 MM)

Statement of Problem: **Illinois spends $3 BN annually with outside vendors. Yet, we notice that a substantial proportion of their RFPs for services are simply roll-overs of the current vendor.**

Illinois Data

- Current third-party purchases $3 billion
- This is spread through the various agencies and includes: $1 billion for IT spending as well as a myriad of other items including fuel, chemicals, office supplies, fleets, maintenance, etc.
- In 2006, the state completed a concerted effort to recover from and manage vendors – netting $500 MM over 2 years

Steps to Control Costs

- Review current contracts to find and recover historic vendor mis-performance
- Review current contracts and make reductions in areas where there is duplication, unnecessary costs, including indirect costs, and other areas that can be reduced without impacting quality
- Create visibility and organization to manage from an enterprise perspective
- Develop risk management
- Create organizational partnership between agencies
- Develop reporting and tools to measure and manage performance
- Develop mechanics of vendor management

Savings From Vendor Management of Illinois Purchases (cont)

Case Study/Results in Other States

- Indiana reduced office expenditures by 8% by re-contracting and enforcing. Also created a Vendor Management Section within IDOA
- Colorado university system rigorously reviewing every contract for cost and performance, seeking 30% reduction
- Indiana DOA reduced office supplies costs 20-30% and printing costs 19% through vendor management.
- Connecticut has launched a Vendor Management Office
- Tennessee created a state-wide vendor management team with a well-designed approach and is targeting 20-25 reduction
- New Hampshire Agencies reduced all indirect costs in contracts across board to less than 10%
- During tight economic times there is a substantial benefit when the state closely scrutinizes all vendor agreements, and to re-negotiates contracts in order to find general fund savings

Benefit to the Public

- State manages customer service as well as financial impact of working with vendors
- State ensures that the full mission-focus of the contracted service is delivered, not merely a product

Potential Savings to General Fund:	**$300 MM**
Purchased services	**$3 BN**
Typical savings from vendor management efforts range from	**10-30%**
Assume an average benefit rate	**10%**

Additional Federal Medicaid Dollars under Stimulus ($880 MM)

Statement of Problem: **How to make use of Federal proceeds from the stimulus bill**

Definition: Under stimulus, the State's 50% Federal Medical Assistance Percentage (FMAP) will be increased by 6.2%.

Illinois Data

- According to Government Accountability Office, that increase will result in $880 MM in new Medicaid funding for FY2009, $1,340 MM in new spending for FY2010 and $680 in new spending in FY2011

Steps to Control Costs

This is simply a matter of how the State wants to use the new Federal match revenue:

1. Increase total Medicaid spending – in the amount of the additional Federal match
2. Reduce State match by the amount of the new Federal monies

Benefit to the Public

- Source of funding without cost to the State taxpayer
- If State chooses #2, budget neutral – total savings to general fund = $880 MM

Potential Savings to General Fund:	**$880 MM**
▪ **Additional Federal match**	**6.2%**

Other Federal Stimulus ($1,000 MM)

Statement of Problem: **How to make use of Federal proceeds from the stimulus bill to help solve current budget problems**

Definition: The stimulus package that recently passed the US Congress and was signed by President Obama on 2/17/09 may provide additional opportunities for the State of Illinois. Some areas that the State will see an influx of Federal dollars that have direct impacts on the State general fund portion of the budget over the next 18 months are as follows:

❑Highway infrastructure	$935 MM
❑Education grants	$1 B
❑Child care	$73 MM
❑Head Start	$29 MM
❑Unemployment benefits	$1.5 B
❑Unemployment Ins.	$405 MM
❑Community services grant	$47 MM
❑Seniors, disabled programs	$527 MM
❑State stabilization fund	$2 B
❑Food stamps	$903 MM
❑Child support	$37 MM