PENNSYLVANIA MEDICAL ASSISTANCE PROGRAM
REFORM OPTIONS

Jim Verdier
Senior Fellow
Mathematica Policy Research, Inc.

University of Pittsburgh
Institute of Politics/Health Policy Institute
Pittsburgh, PA
January 27, 2006
Introduction and Overview

- Medicaid spending patterns, Pennsylvania vs. U.S.
- Options for containing Medicaid spending growth
- Potential to control costs by improving care quality
- Conclusions
Medicaid Spending Trends

- National annual Medicaid spending growth dipped in 2003 (8.8%) and 2004 (7.9%) following two years of 10-12% growth (CMS, January 2006)
  - Reflects comprehensive and aggressive state cost containment efforts

- CBO projects national Medicaid spending growth at 4-5% a year in 2005 and 2006, and 8.4% a year from 2007 to 2015 (CBO, August 2005)

- State revenues are likely to grow at no more than half that rate

- Projected PA MA growth is similar to national trends
  - 6.9% in SFY 04-05 and 7.9% in SFY 05-06 (Fall 2005 estimates)
National Medicaid Enrollees and Expenditures by Enrollment Group, 2003

Enrollees
Total = 52 million

Expenditures
Total = $252 billion


NOTE: Total expenditures on benefits excludes DSH payments.
Distribution of Medicaid Enrollees and Expenditures, PA vs. US, FY 2002

- **Enrollees**
  - Children: 48.4% in PA, 49.6% in US
  - Adults: 16.6% in PA, 25.6% in US
  - Elderly: 12.4% in PA, 10.5% in US
  - Blind/Disabled: 22.6% in PA, 14.2% in US

- **Expenditures**
  - Children: 16.2% in PA, 16.9% in US
  - Adults: 7.4% in PA, 11.0% in US
  - Elderly: 34.8% in PA, 27.9% in US
  - Blind/Disabled: 41.2% in PA, 39.7% in US
  - Unknown: 0.4% in PA, 4.6% in US

**SOURCE:** Kaiser Family Foundation, statehealthfacts.org
# Medicaid Expenditures Per Enrollee, PA vs. US, FY 2002

<table>
<thead>
<tr>
<th>Category</th>
<th>PA</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>$1,670</td>
<td>$1,400</td>
</tr>
<tr>
<td>Adults</td>
<td>2,213</td>
<td>1,782</td>
</tr>
<tr>
<td>Elderly</td>
<td>13,938</td>
<td>10,971</td>
</tr>
<tr>
<td>Blind/Disabled</td>
<td>9,107</td>
<td>11,547</td>
</tr>
<tr>
<td>Total</td>
<td>4,965</td>
<td>3,947</td>
</tr>
</tbody>
</table>

**SOURCE:** Kaiser Family Foundation, statehealthfacts.org
### Medicaid Expenditures by Type of Provider, PA vs. US, FY 2004

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>PA</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>7.1%</td>
<td>23.0%</td>
</tr>
<tr>
<td>Physician, lab, X-ray</td>
<td>1.5</td>
<td>6.7</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>4.0</td>
<td>11.5</td>
</tr>
<tr>
<td>Rx drugs</td>
<td>10.5</td>
<td>17.9</td>
</tr>
<tr>
<td>Other services</td>
<td>5.6</td>
<td>10.2</td>
</tr>
<tr>
<td>Payments to Medicare</td>
<td>3.6</td>
<td>4.2</td>
</tr>
<tr>
<td>Managed care</td>
<td>67.8</td>
<td>26.4</td>
</tr>
<tr>
<td>Long-term care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing facilities</td>
<td>65.2</td>
<td>46.0</td>
</tr>
<tr>
<td>Home health/pers. care</td>
<td>24.4</td>
<td>37.3</td>
</tr>
<tr>
<td>ICF-MR</td>
<td>8.2</td>
<td>12.0</td>
</tr>
<tr>
<td>Mental health facilities</td>
<td>2.2</td>
<td>4.7</td>
</tr>
</tbody>
</table>

SOURCE: Kaiser Family Foundation, statehealthfacts.org
### Per Capita Medicaid Expenditures
#### PA vs. US, FY 2004

<table>
<thead>
<tr>
<th>Service</th>
<th>PA</th>
<th>US</th>
<th>PA Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing home services</td>
<td>$328</td>
<td>$156</td>
<td>#3</td>
</tr>
<tr>
<td>Home care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– HCBS waivers, home health, personal care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital care</td>
<td>43</td>
<td>132</td>
<td>#48</td>
</tr>
</tbody>
</table>

**NOTE:** Per capita Medicaid expenditures are total Medicaid expenditures divided by total state/U.S. population

**SOURCE:** Burwell, Sredl, and Eiken, “Medicaid Long-Term Care Expenditures in FY 2004,” May 11, 2005
Medicaid Managed Care Penetration Rates, PA vs. US, FY 2004

- **Risk-Based Managed Care Organizations**
  - PA: 70.7%
  - US: 39.5%

- **Primary Care Case Management**
  - PA: 8.8%
  - US: 13.3%

**NOTE:** Penetration rates equal MCO and PCCM enrollment as a share of total Medicaid enrollment

**SOURCE:** CMS, 2004 Medicaid Managed Care Enrollment Report
# Medicaid Rx Drug Reimbursement, PA vs. US, 1999

<table>
<thead>
<tr>
<th>Category</th>
<th>PA</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Rx $s per beneficiary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged</td>
<td>$1,408</td>
<td>$1,308</td>
</tr>
<tr>
<td>Disabled</td>
<td>1,324</td>
<td>1,587</td>
</tr>
<tr>
<td>Adults</td>
<td>174</td>
<td>182</td>
</tr>
<tr>
<td>Children</td>
<td>82</td>
<td>83</td>
</tr>
<tr>
<td>Dual eligibles</td>
<td>1,575</td>
<td>1,629</td>
</tr>
<tr>
<td>Under-65 disabled duals</td>
<td>1,854</td>
<td>2,143</td>
</tr>
<tr>
<td>Full-year NF residents</td>
<td>2,502</td>
<td>1,893</td>
</tr>
</tbody>
</table>

SOURCE: CMS/MPR Statistical Compendium at: https://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/11_MedicaidDataTables.asp#TopOfPage
Shift of Medicaid Rx Drug Coverage for Dual Eligibles to Medicare in 2006

- Medicaid Rx $s for dual eligibles as a share of total Medicaid Rx $s in 1999
  - PA: 54.5%
  - US: 55.5%

- Medicaid Rx for dual eligibles in nursing facilities
  - # of Rx’s per benefit month
    ♦ PA: 6.5
    ♦ US: 4.9
  - Rx $s per benefit month
    ♦ PA: $228
    ♦ US: $181

NOTE: A benefit month is a month in which a beneficiary is enrolled in Medicaid, whether or not services are used.
Shift of Medicaid Rx Coverage for Duals to Medicare (Cont.)

- Medicaid Rx reimbursement for all dual eligibles in NFs as a percent of total Medicaid Rx reimbursement in 1999
  - PA: 18.5%
  - US: 14.0%

- Dual eligibles as a share of full-year Medicaid NF residents
  - PA: 91.8%
  - US: 92.4%

- Under-65 disabled dual eligibles as a share of total Medicaid disabled beneficiaries
  - PA: 27.7%
  - US: 36.0%

- SOURCE: CMS/MPR Statistical Compendium
Medicaid Reimbursement for Antipsychotic Drugs, PA vs. US, 1999

- Total Medicaid reimbursement for antipsychotics
  - PA: $51.4 million
  - US: $1,653.1 million

- Reimbursement for antipsychotics as a percent of total Medicaid Rx reimbursement
  - PA: 10.5%
  - US: 10.6%

- Reimbursement for antipsychotics for dual eligibles as a percent of total Medicaid Rx reimbursement
  - PA: 5.8%
  - US: 6.1%

SOURCE: CMS/MPR Statistical Compendium
Cost Containment Options
Prescription Drugs

- Preferred drug list
  - Potential savings and clinical improvement depends on details
    - Which drugs are on which part of the list?
    - What evidence is used for clinical and cost-effectiveness? (Oregon Drug Effectiveness Review Project is a good source of evidence)
    - What are procedures for approval of non-preferred drugs?
    - What is role of beneficiary copays and coinsurance?

- All Rx drug cost containment options require re-thinking in light of movement of heaviest users of drugs (dual eligibles) to Medicare in 2006
  - Rx drugs in NFs present special problems
    - Medicaid may no longer have access to info on use, but still remains responsible for remainder of NF care
Cost Containment Options

- **Benefits**
  - Most costly benefits are concentrated on most needy beneficiaries
  - Often defended by well-organized advocacy and provider groups

- **Copayments and other beneficiary cost sharing**
  - Maximum copayment of $3 or 5% of cost of service
    - Unchanged since 1982
  - Greatest potential to change behavior and achieve savings is with Rx drug and emergency room use
  - Pending federal budget reconciliation bill would allow 10-20% “enforceable” coinsurance/copays
Cost Containment Options

- Consumer-directed care
  - Promising for some Medicaid services
    - Home health, personal care, HCBS
    - Cash and counseling demos in AR, FL, and NJ
  - Requires:
    - Significant consumer cost sharing
    - Information about relative value of health care services and providers
    - Consumer purchasing power (ability to move market share)
    - Willing and able providers and insurers
  - These conditions are generally not present in Medicaid
    - Setting appropriate “voucher” amounts is a major challenge
    - Pilots in FL and draft waiver in SC
Cost Containment Options

- Creative financing
  - DSH, IGTs, provider taxes, “Medicaid maximization”
    - CMS is cracking down
    - Existing and proposed legislative limits

- Durable medical equipment
  - Review cost and use trends
  - Tighter eligibility limits, prior authorization requirements, audits
  - Competitive bidding
  - Review Medicare and Missouri experience
Cost Containment Options

- Fraud and abuse
  - Crackdowns can be resource-intensive
    - Pharmacy
    - Medicaid estate planning
    - Billing for services not provided
  - A key to larger savings is analysis of provider and beneficiary use and costs to identify patterns (spikes, outliers)
  - Cooperative efforts with CMS are underway in a number of states, including PA
Cost Containment and Quality Improvement - Managed Care

- PA has already taken most steps other states have taken or are considering
  - Widespread risk-based managed care
  - Inclusion of SSI/disabled population and dual eligibles
  - PCCM and stand-alone disease management in rural and other areas where risk-based care is less feasible

- May want to rethink division of responsibility for Rx drugs between physical health and behavioral health MCOs
  - Align payment responsibility with prescribing and oversight responsibility

- Medicare Special Needs Plans present new opportunities
Medicare Special Needs Plans

- Authorized by MMA of 2003
  - Can specialize in serving dually eligible, institutionalized, and chronically ill and disabled Medicare beneficiaries
  - 11 SNPs approved in PA
    - AmeriChoice, AmeriHealth, Elder Health, Gateway, Health Partners, Keystone (2), Three Rivers/Unison, United (2), UPMC
  - 7 already serve duals in Medicaid
    - AmeriChoice, AmeriHealth, Gateway, Health Partners, Keystone, Three Rivers/Unison, UPMC

- Can be used to link and coordinate Medicare and Medicaid acute and long-term-care services
  - High NF use in PA presents opportunities
Conclusions

- Cost pressures in Medicaid will likely continue for many years
  - Reflects underlying health care costs and the special demographics of Medicaid
  - Medicaid functions as the nation’s high risk pool

- Opportunities for improved care abound
  - Not hard to improve on unmanaged fee-for-service Medicaid

- Improved care can contain costs in some areas over time
  - But savings are neither quick nor assured
  - Managed care and disease management will likely uncover unmet needs at the outset