

Assessment of Medicaid Managed Care Expansion Options

Presented To:
Illinois Commission on Government
Forecasting and Accountability

May 3, 2005



Overview of The Lewin Group

- ◆ Leading health care consulting firm since 1970
- ◆ Key strengths for this project: extensive knowledge of Medicaid managed care, analytical rigor & objectivity
- ◆ We've conducted a vast range of Medicaid work
 - Helped design, implement, operate, evaluate and/or strengthen Medicaid managed care programs in more than 20 states
 - Recent project focus for our state clients has been on achieving fiscal savings (while inflicting minimal damage)
- ◆ Our core Illinois project team: Joel Menges, Nancy Beronja, Brandon Maughan, & Melissa Rowan
 - several additional colleagues have contributed

Presentation Outline

1. Describe the project and the tasks conducted.
2. Present our findings and rationale.
3. Field questions.

Key Tasks

- ◆ Stakeholder interviews
- ◆ IDPA meetings and data request
- ◆ Data programming and cost modeling of each alternative approach
- ◆ Assess results of other states' programs
- ◆ Analyze options and develop recommendations
- ◆ Prepare draft and final written reports

Interviews Were Held With Several Illinois Stakeholders

Meetings & phone calls were held with the following Illinois organizations:

- Chicago Department of Public Health
- Health & Disability Advocates
- Illinois Association of Medicaid Health Plans
- Illinois Child and Maternal Health Coalition
- Illinois Department of Public Aid (IDPA)
- Illinois Hospital Association
- Illinois Medical Society
- Illinois Primary Health Care Association

Key Themes From Stakeholder Input

- ◆ The common ground: Those we spoke with share a strong commitment to the Illinois Medicaid population and to supporting the role of safety net providers
- ◆ The dividing line: The HMO model's role in the Medicaid program was the central issue most parties wanted to discuss with us
 - opinions on this approach were strong and varied; other managed care models are much more “under the radar”
 - many parties' views about the HMO model are (understandably) driven by past experience in Illinois

IDPA Staff Provided Extensive And Vital Support To This Engagement

- ◆ IDPA explained special financing arrangements -- IGTs, hospital assessments, Rx rebates, cash flow, etc.
- ◆ Data discussions led to IDPA preparing tailored data files for Lewin. For every beneficiary we received:
 - FY2003 and FY2004 eligibility information (days of Medicaid coverage, county, Medicare and spend-down status, etc.)
 - FY2003 and FY2004 claims costs by type of service
 - Indicators for each of four diseases: asthma, diabetes, cardiovascular and AIDS (based on IDPA identifiers)
 - Cook County Bureau of Health Services enhanced claims amounts vs. “repriced” claims
- ◆ IDPA also provided a “factual review” of draft report

Several Medicaid Managed Care Approaches Were Assessed

- ◆ Primary Care Case Management (PCCM)
- ◆ Disease Management (DM) for AIDS, asthma, cardiovascular & diabetes
- ◆ Complex Care Coordination (CCC)
- ◆ Health Maintenance Organizations (HMOs)
- ◆ Combination Models
 - HMO/PCCM
 - PCCM/DM
 - PCCM/DM/CCC
 - PCCM/CCC

In Assessing HMO Model, We Assume Major Changes Versus Current Illinois Program

- ◆ Mandatory enrollment into HMO model (no FFS option preserved for targeted beneficiaries)
- ◆ No direct marketing by HMOs
 - focus HMO efforts on “serving” rather than “selling”
 - objective enrollment broker contractor engaged by IDPA to explain options to beneficiaries
- ◆ Competitive bid for all contracts
 - State sets forth its requirements in all aspects of the program (provider network composition, enrollee education & outreach, provider payment, EPSDT tracking and facilitation, etc.)
- ◆ State invests heavily in staff & systems to support & oversee a large-scale initiative

To Assess Managed FFS Options, We Also Assume Adoption Of Optimal Design Features

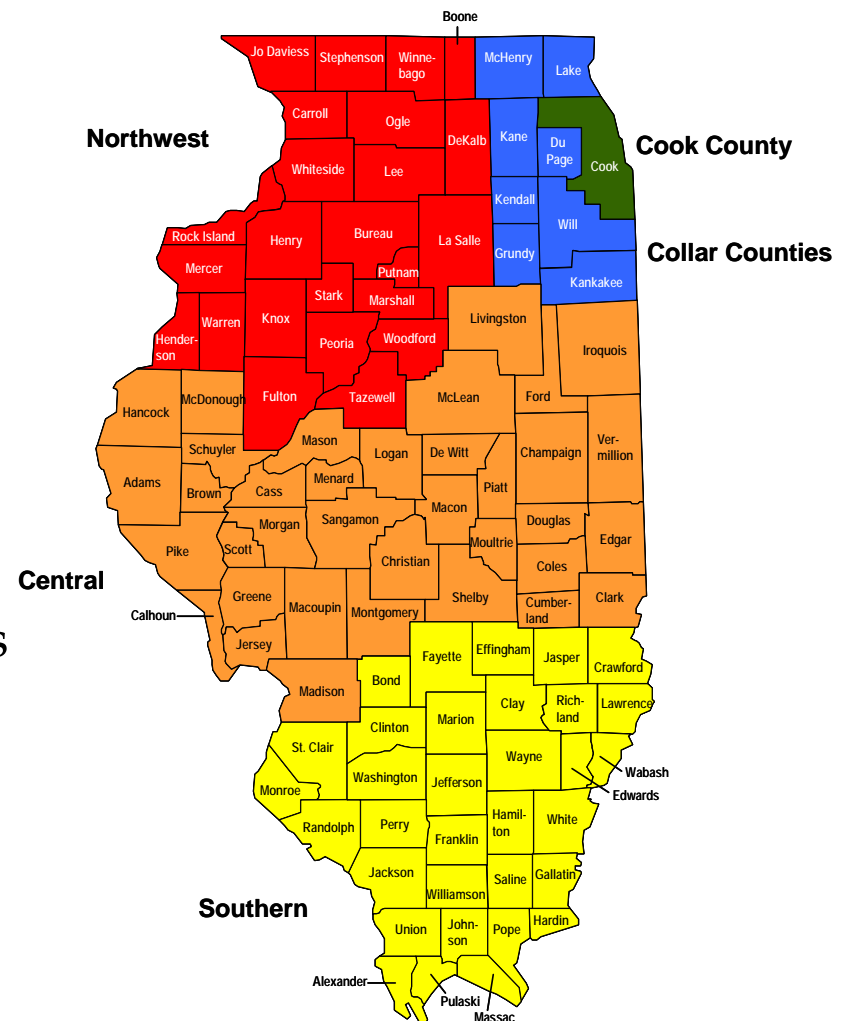
- ◆ We assume that private contractors will be engaged to administer each model (with extensive IDPA oversight)
 - competitive procurement for contract(s)
 - State delineates extensive set of requirements to all bidders
- ◆ Payment models that motivate and reward State's desired cost, access and clinical outcomes
 - e.g., motivate primary care physicians through performance-based structure (statewide amount of extra funds based on aggregate cost performance; size of individual reward based on individual performance)
 - place contractors' fees at substantial risk for achieving targeted outcomes

For All Managed Care Models, An Extraordinary “Seller’s Market” Exists

- ◆ A large field of highly qualified organizations exists
 - e.g., roughly 12 national chain HMOs have extensive, multi-state Medicaid experience
- ◆ For Managed FFS models (e.g., DM, PCCM, case management), sophistication and tailored Medicaid expertise of industry contractors is exploding upwards
- ◆ Recent Georgia procurement is telling:
 - bidder’s conference held in auditorium due to level of interest their RFP generated
 - State stipulated extensive set of requirements to get the program it wants
 - bidders forced to compete aggressively on price and quality

All Geographic Areas Were Assessed

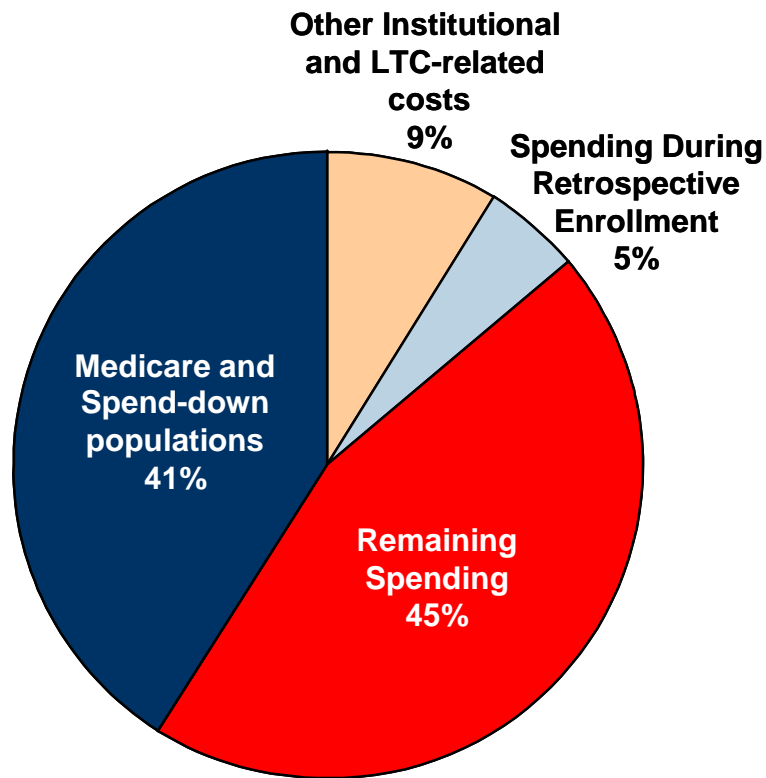
- ◆ Most of our analyses grouped the 102 counties into five regions as defined by IDPA:
 - Northwest, Central, Southern, Cook County, Collar Counties
- ◆ Lewin also “created” mini-regions based on characteristics of each county (population and density, physicians and hospitals, rural designation code)



Different Major Eligibility Categories Were Assessed Separately

- ◆ Persons with Medicare and/or Spend-Down coverage were excluded from all analyses
- ◆ Remaining population was assessed using four major IDPA-defined groupings:
 - Disabled
 - Family Health
 - DCFS Wards
 - SCHIP

Less Than Half Of Total Medicaid Spending Can Be Influenced By Models We Assessed



Approximately \$3.9 billion of the \$8.5 billion total expenditures in 2004 (45%) can be influenced by the models assessed in this study.

FY2004 Baseline Overview: Our Study's Target Population And Claims Costs

Eligibility Category	Average Persons	Claims Costs*	Percent Of Persons	Percent Of Costs	PMPM Claims Cost*
Disabled	158,859	\$1,671,615,899	11%	39%	\$877
Family Health	1,196,001	\$2,157,430,883	79%	50%	\$150
DCFS Wards	68,055	\$240,728,381	5%	6%	\$295
SCHIP	81,539	\$226,331,792	5%	5%	\$231
Total	1,504,454	\$4,296,106,955	100%	100%	\$238

* Costs shown exclude nursing home, other residential/institutional, and waiver claims.

Prevalence Of Targeted Diseases, FY2004

Region	Percentage of Disabled Population With One or More of Targeted Diseases	Percentage of Family Health Population With One or More of Targeted Diseases
Northwestern	36.7%	8.7%
Central	38.8%	9.4%
Southern	39.6%	6.8%
Cook County	47.1%	6.4%
Collar Counties	39.0%	8.3%

Targeted diseases are AIDS, asthma, cardiovascular illness and diabetes.

Persons with Medicare and/or spend-down coverage excluded.

Distribution Of Target Population By FY2004 Claims Cost Level

Cost Corridor	Percent of People				Percent of Cost			
	ABD	DCFS	FHP	SCHIP	ABD	DCFS	FHP	SCHIP
\$0	7.0%	12.1%	8.8%	9.5%	0.0%	0.0%	0.0%	0.0%
\$1-\$999	25.9%	60.6%	67.0%	57.2%	0.8%	5.3%	13.4%	10.6%
\$1000-\$9999	41.6%	21.3%	22.3%	31.1%	16.4%	21.5%	45.5%	52.3%
\$10,000-\$24,999	15.1%	3.2%	1.3%	1.5%	22.5%	16.2%	13.0%	11.6%
\$25,000-\$49,999	6.2%	1.7%	0.3%	0.4%	20.3%	19.7%	7.5%	6.5%
\$50,000-\$99,999	3.0%	0.7%	0.1%	0.2%	19.1%	16.0%	6.3%	6.2%
\$100,000+	1.2%	0.3%	0.1%	0.1%	20.8%	21.4%	14.3%	12.8%
Subtotal, Persons Above \$25,000	10.4%	2.7%	0.5%	0.7%	60.2%	57.1%	28.1%	25.5%

Medicare and spend-down eligibles excluded; long-term care claims also excluded

Once FY2004 Baseline Data Were Arrayed, Cost Modeling Involved Several Steps

- ◆ Trend baseline to five-year period (CY2006 - CY2010)
- ◆ Create medical cost factors for each Medicaid managed care model (including combination options), eligibility category, and year
 - factors are based on the medical cost containment attributes of each approach, published studies, Lewin's own data sources and knowledge of other states' initiatives
- ◆ Factor in administrative costs and profit
 - administrative cost estimates include State costs of implementing each approach, as well as contractor's fees

Comparison Of Medical Cost Containment Attributes

KEY:	
●	Model fully implements the cost containment measure shown
◐	Model employs a limited use of the cost containment measure shown, or broad use for small portion of beneficiary population
○	Model does not use the cost containment measure shown

Medical Cost Containment Techniques	UNMANAGED FFS	PCCM/ DISEASE MGMT	COMPLEX CASE CARE MGMT	PCCM/ DM/ CARE COORD	HMO
General Attributes					
Channels Patient Volume Using Contracted Network	○	◐	○	◐	●
Eliminates Unnecessary Services	○	◐	◐	◐	●
Uses Lower-Cost Services Where Available	○	◐	◐	◐	●
Vendor At Risk For Medical Costs	○	◐	◐	◐	●
Directly Pays For Services and Negotiates Prices	●	○	○	○	●
Specific Attributes					
Primary Care Physician Required	○	●	○	●	●
Prior Authorization for Costly Services	○	●	◐	●	●
Referrals Required for Outpatient Specialty Care	○	◐	○	◐	●
Disease Management	○	●	◐	●	◐
Individually Tailored Care Management	◐	◐	◐	●	●
Enrollee Outreach and Education	○	◐	◐	◐	●
Can Pay for Uncovered Services on Exception Basis	○	○	○	○	●
Provider Profiling/Reporting	◐	◐	◐	◐	●

Summary Of Cost Modeling Findings

◆ Disabled:

- HMO model creates the largest savings in each region
- Most cost-effective managed FFS option involves combining PCCM, DM, and CCC
- Savings from HMO model are 2-3 times larger than those occurring through the PCCM/DM/CCC approach

◆ Family Health

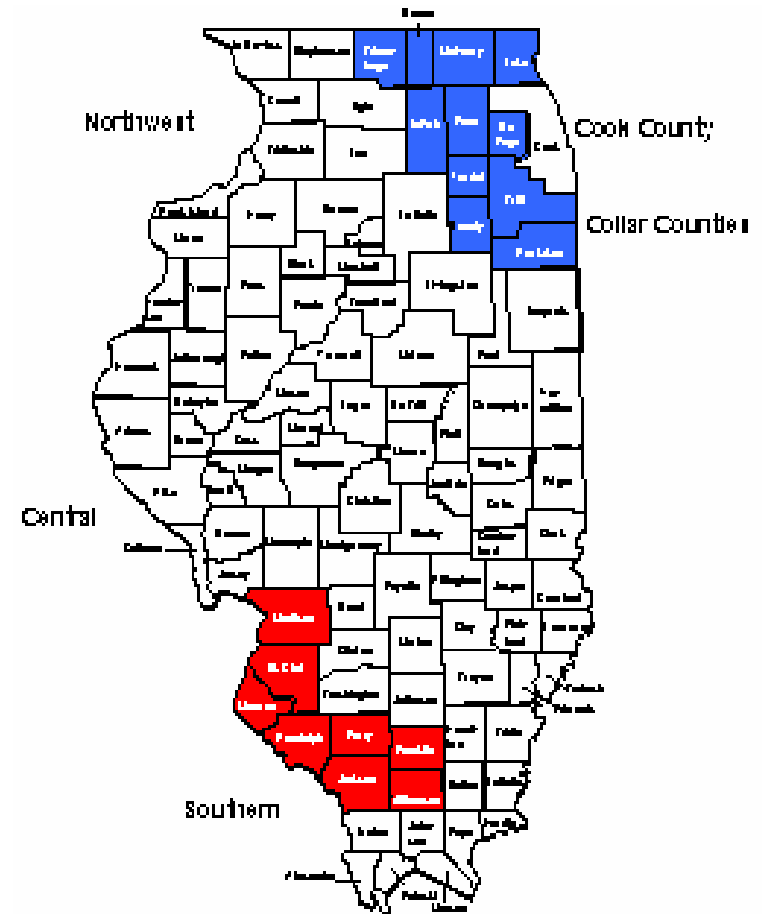
- In urban regions (Cook & Collar), HMO model yields largest savings (50% above those of closest alternative approach)
- Best managed FFS alternative combines PCCM and CCC (but not DM)

Several Additional Cost Estimates Were Produced

- ◆ Assessed impacts of each model on Cook County Bureau of Health Services & IGT arrangement
 - calculated savings under each approach if the Bureau is held harmless from cost containment efforts
- ◆ Evaluated savings if HMOs were required to pay for inpatient & physician care at 5% above Medicaid FFS

Additional Cost Estimates: Reconfigured Regions

- ◆ Assessed models in two modified regions:
 - Extended Collar County Region (11 counties): Boone, DeKalb, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will, and Winnebago
 - East St. Louis Region (8 counties): Franklin, Jackson, Madison, Monroe, Perry, Randolph, St. Clair, and Williamson



Additional Cost Estimates: Cash Flow Impacts Across 19 County Area

- ◆ A 3-4 month payment delay exists in FFS setting, vs. a one-month delay in HMO model
- ◆ Immediate and “all at once” HMO enrollment in the 19 counties in previous slide would create short-term cash flow cost of \$117 million (50% of which is state share)
 - these costs are reduced to \$87 million if enrollment is phased in across a 24 month timeframe
 - if HMO capitation payments are delayed by two months and enrollment is phased in across 24 months, worst cumulative cash flow impact is \$19 million
- ◆ Since accrued savings from HMO model average more than \$100 million *per year*, avoiding capitation for cash flow reasons is “penny wise and pound foolish”

We Offer Five Recommendations

- ◆ **Recommendation 1.** Immediate development of mandatory enrollment, HMO-only program in 19 counties: extended Collar and East St. Louis areas
- ◆ **Recommendation 2.** Eliminate existing voluntary HMO enrollment program in conjunction with immediate insertion of a mandatory HMO-only program in Cook County. Initially limit HMO program to selected zip codes where there is relatively low use of IGT providers
- ◆ **Recommendation 3.** Immediate exploration of ways to solve IGT barriers; implement mandatory HMO program in entirety of Cook County upon resolution of IGT issues

Lewin's Recommendations (continued)

- ◆ **Recommendation 4.** In all other regions (82 counties), immediate development of a PCCM/DM/CCC managed FFS model
- ◆ **Recommendation 5.** Also explore with CMS opportunities to utilize the PCCM/DM/CCC model for the dually eligible population, through a shared savings demonstration that would involve Medicare and Medicaid funds

Many Additional Details Regarding Recommendations Are Discussed In Report

- ◆ Anticipated implementation date of Recommendation #1, #2 & #4 is July 2006
 - immediate needs are legislative approval, development of RFPs for various contractors (through which details of each program's design can be shaped and finalized), CMS waivers
- ◆ Timeframe for resolution of IGT issues is unknown
 - if this becomes prolonged, we recommend implementing PCCM/DM/CCC in non-mandatory Cook County zip codes on interim basis to achieve some near-term savings
- ◆ Report discusses rationale for each recommendation, as well as rationale for approaches not being recommended (e.g., Affirmative Choice model)

Benefits Of Adopting These Recommendations Are Compelling

- ◆ Better coverage
 - recipients would be matched to a PCP “medical home”
 - broad range of proactive education and outreach initiatives would occur under all models
- ◆ Accountability & tracking
 - multiple points of accountability would be created (IDPA’s contractors, the contractors’ providers, etc.) to promote & track outcomes
 - improved cost, access & quality measurement/monitoring
- ◆ Savings
 - Annual savings (Federal and state funds) projected to be \$193 million in Year 1, growing to \$460 million in Year 5
 - Helps preserve/expand coverage, raise provider rates, etc.

Annual Savings Projections By Region (figures represent Federal & State savings)

	Collar County Area: HMO Model (11 Counties)	Selected Zip Codes in Cook County: HMO Model	Remainder of Cook County: (Managed FFS Yrs 1-2, HMO Yrs 3-5)	East St. Louis Area: HMO Model (8 Counties)	Remaining 82 Counties (Managed FFS)	Total Federal & State Savings
Year 1	\$49,476,232	\$19,426,345	\$73,120,559	\$13,721,981	\$36,977,406	\$192,722,523
Year 2	\$61,382,542	\$25,065,503	\$91,261,447	\$17,966,146	\$46,202,486	\$241,878,124
Year 3	\$75,301,316	\$31,669,322	\$110,082,622	\$22,977,462	\$57,118,050	\$297,148,773
Year 4	\$91,585,510	\$39,404,835	\$142,037,850	\$28,896,864	\$70,039,224	\$371,964,284
Year 5	\$110,655,987	\$48,470,613	\$179,459,494	\$35,893,326	\$85,343,431	\$459,822,852

Estimates reflect all funds -- Federal and State shares. State savings would be 50% of each figure shown. Figures assume Cook County Bureau of Health Services will be held harmless. If Bureau's revenues are lowered, total savings would be larger although State savings would not increase.

Our Recommended Approach Represents A Major Change To Your Medicaid Program

- ◆ Substantive Barriers That Must Be Overcome:
 - work is needed to develop the details of the desired models
 - each approach has potential weaknesses that need to be addressed at the design stage (and thereafter)
 - adequate resources need to be committed to this effort
- ◆ Political Issues
 - our role is to objectively chart out your best programmatic approach; we have not attempted to craft political compromise solutions across those with different interests & beliefs
 - saving money means saving money – somebody has to get less
 - a tremendous opportunity exists here for Illinois policymakers; better coverage at less cost should not become a partisan issue

We Welcome Your Questions & Comments
