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November 29, 2010

Meridian Health Plan, Inc. is a managed Medicaid Health Plan operating in Illinois. Managed care is an approach to delivering and financing health care that is aimed at both improving the quality of care and saving costs. The fundamental idea is to improve access to care and coordination of care by assuring that enrollees have a "medical home" with a primary care provider, and to rely more heavily on preventive and primary care.

Cost growth in the traditional Medicaid program is partly driven by the underlying fragmentation of care delivery, itself reinforced by a fee-for-service (FFS) reimbursement mechanism. Traditional Medicaid's efforts to control spending simply by cutting back on provider reimbursements do nothing to ensure appropriate utilization, while exacerbating care access difficulties for vulnerable populations. The symptoms of the Medicaid FFS system therefore include well-documented gaps in needed preventive care, frequent visits to the emergency room, multiple and sometimes conflicting drug prescriptions, and over-reliance on 'revolving door' inpatient admissions for behavioral health problems.

The best way to reduce Medicaid costs without severely impacting services would be to encourage changing the delivery of health care along with changing the reimbursement model. The first and foremost consideration would be to change from the Illinois majority of FFS product (92.3% currently) to a Managed Care Model (7.7% currently).

In considering changing the delivery of health care to a Managed Care Model, financial savings would be recognized in several immediate ways. First, there would be a reduction in cost by removing the marketing component in the capitation payment. Second, the cost of the State's administrative burden of enrolling and disenrolling members would be transferred to the managed care organizations. Third, oversight of the issues below would be transferred to the Managed Care Organizations, negating the need for the State to hire employees to provide this oversight.

The control of cost oversight by the Managed Care Organizations should concentrate on the following efforts:

1. Encourage the patient centered medical home
2. Encourage the integration of care across the continuum of care
3. Develop a statewide definition of observation versus inpatient care
4. Decrease preventable readmissions within 30 days of discharge
5. Deny payment for hospital acquired infections/conditions or never events (wrong site surgery)

6. Control pharmacy costs

Each of these will be briefly described below.

Patient Centered Medical Home

According to the American College of Physicians, a Patient Centered Medical Home is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH practice is responsible for providing for all of a patient's health care needs or appropriately arranging care with other qualified professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues. It is a model of practice in which a team of health professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access and communication, care coordination and integration, and care quality and safety.

Integration of Care

Clinical integration is defined as the extent to which patient care services are coordinated across people, functions, activities, processes, and operating units so as to maximize the value of services delivered. Clinical integration includes both horizontal integration (the coordination of activities at the same stage of delivery of care) as well as vertical integration (the coordination of services at different stages).

Currently, the model of care delivered is fractionated, with records and IT systems not integrated so that providers have to repeat many tests and x-rays unnecessarily, and provide treatment that may be harmful because of incomplete information.

Develop a statewide definition of observation versus inpatient care

Outpatient observation services are defined as a set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether a patient requires further treatment as a hospital inpatient or if he or she is able to be discharged from the hospital. Observation services are furnished by a hospital on the hospital's premises, including the use of a bed and at least periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate a given patient's condition and/or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit a patient to the hospital or to order an outpatient test.

The quality of care and treatment of the patient should be the same whether an admission is Inpatient or Observation status. The difference is cost —an important consideration for patients, hospitals and Medicaid. Hospital inefficiencies and staffing issues are not to be a consideration

for the need for an inpatient stay. Proper enforcement of this care would result in efficiencies and decreased costs for Medicaid.

Decrease preventable readmissions within 30 days of discharge

At the national level, analysis based on the Medicare population shows 19.6% of Medicare patients discharged from the hospital have a readmission within 30 days. However, it is believed that a significant portion of these readmissions could have been avoided. The analysis on the Medicare population concludes that a reduction in avoidable hospitalizations would likely result in better provision of health care, appropriate discharge from the hospital, and a potential reduction in expenditures. Illinois Medicaid could benefit from encouraging methods to decrease readmissions.

Deny payment for hospital acquired infections/conditions or never events (wrong site surgery)

According to the AMA, the country's payment system offers hospitals little financial incentive to prevent complications because they stand to make more money for treating the conditions patients acquire during their stays, patient safety advocates charge. These medical errors are unacceptable, devastating to patients, and often result in litigation.
Errors also are costly in terms of loss of trust in the health care system by patients and diminished satisfaction by both patients and health professionals. Patients who experience a long hospital stay or disability as a result of errors pay with physical and psychological discomfort.

Control pharmacy costs

Balancing the cost of prescription drugs against the need for them has become a challenge for everyone in the health care system. Prescription drug costs increasing partly because more people are using more drugs. In many cases, it's because newer and costlier brand names are being prescribed. Also, drugs are coming to the market priced more expensively than the drugs they are often replacing, and drug companies are spending more money to advertise to consumers. In addition, people are living longer, and sedentary lifestyles are creating more health problems.

Illinois Medicaid can control pharmacy costs in the following manner:

Increased use of Generic Mandate Formularies. A formulary is a list of prescription medicines that a health plan covers. Some drugs cost a lot of money, but the price of a drug does not necessarily correlate to its benefit. Formularies guide drug selection so that the State can be certain their enrollees have access to effective medicines, including brand-name and generic drugs, at a reasonable cost.

Use therapeutic equivalents. Therapeutic equivalents are drugs in the same or a related class that do the same job, often at a lower cost. Set quantity limits. Quantity limits promote appropriate and cost-effective medication use.

Currently the formulary being used by the state of Illinois is in the 60s range for generic percentage as where HMOs traditionally operate in the 80 percentages. States may often believe that they can save big dollars through rebates with large drug companies but they will never compare to the dollars saved through the utilization of a generic mandate formulary.

Use of generic medicine is an practical way to save money. Generic drugs typically cost 20 to 70 percent less than their brand-name equivalents. According to the Congressional Budget Office, generic drugs save consumers an estimated $8 billion to $10 billion a year at retail pharmacies.