

Cost Saving Reforms For Medicaid in Nebraska

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Submitted by: AARP, Arc of Nebraska, Association of Nebraska Community Action Agencies, Center for People in Need, Children and Family Coalition of Nebraska, March of Dimes-Nebraska Chapter, National Association of Social Workers-Nebraska Chapter, Nebraska Advocacy Services, Inc., Nebraska Appleseed Center for Law in the Public Interest, Nebraska Association of Behavioral Health Organizations, Nebraska Catholic Conference, Nebraska Hospital Association, Nebraska Psychological Association, Nebraska Statewide Independent Living Council, Visiting Nurse Association of Omaha, Voices for Children in Nebraska.

Strategy 1: Preferred Drug List or Open Formulary

A preferred drug list (PDL), sometimes referred to as an open formulary, is a list of drugs selected by a state's Medicaid program as drugs that are most useful in patient care, based on both clinical effectiveness and cost considerations. Preferred drug lists are combined with other rules, such as prior authorization, to create an incentive to use the preferred drugs. Information from the Drug Effectiveness Review Project (DERP) can be used to inform the drug selection decision-making process.¹ The DERP provides information on the relative effectiveness of similar pharmaceuticals in a number of drug classes. Preferred drug lists, usually in conjunction with prior authorization requirements, represent a relatively new approach for state Medicaid programs, one that is growing rapidly in popularity.

State Experiences

Michigan and Florida are two states that have implemented a PDL. *Michigan has saved about \$45 million as a result of its PDL and Florida claims that it has saved \$200 million.*² Savings are achieved through two methods: 1) shifting utilization to generic and cheaper brand name drugs within a class and 2) getting larger supplemental rebates from manufacturers for those drugs placed on the PDL.

On its PDL, Michigan includes: "1) the least expensive, clinically effective medications in each drug class; 2) those that bring supplemental rebates to the state; and 3) those that are 'clinically preferred' even if they are not the least expensive."³

Cost Savings

Wyoming recently added a preferred drug list to its Medicaid program. Wyoming, like Nebraska had been using a prior authorization process and then added a Preferred Drug List. According to Wyoming's Cost Containment Report, Wyoming's Medicaid program saved 6.8% in the first year. Assuming Nebraska could achieve similar savings, a Preferred Drug List could save over \$15 million in Nebraska's Medicaid budget. (See the chart below)

For more information see *Cost Containment Strategies For Prescription Drugs: Assessing The Evidence In The Literature*. <http://www.kff.org/rxdrugs/upload/Cost-Containment-Strategies-for-Precription-Drugs-Assessing-The-Evidence-in-the-Literature-Report.pdf>

¹ Drug Effectiveness Review Project website, available at: <http://www.ohsu.edu/drugeffectiveness/>; See also The Commonwealth Fund, p. 8, available at: http://www.cmwf.org/usr_doc/782_Silow-Carroll_stretching_pooledRx.pdf

² Kaiser Family Foundation, *Cost Containment Strategies for Prescription Drugs: Assessing the Evidence in the Literature*, March 2005, p. 30, available at: <http://www.kff.org/rxdrugs/7295.cfm>

³ The Commonwealth Fund, *Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing*, p. 17, available at: http://www.cmwf.org/usr_doc/782_Silow-Carroll_stretching_pooledRx.pdf

Wyoming's Cost Savings from a PDL and Nebraska's Projected Savings

Wyoming Department of Health
Prescription Drug Cost Containment Report
December 1, 2004

Calculated Annual Savings between Preferred Drug List and Prior Authorization (Net of Rebate)

Proton Pump Inhibitors ¹	\$1,178,256
COX II ¹	\$407,472
ACE Inhibitors ²	\$100,008
Statins ²	\$95,025
NSAIDs ²	\$473,246
Long-Acting Opioids ²	\$387,602
Skeletal Muscle Relaxants ²	\$128,607
Calcium Channel Blockers ²	\$113,826
Non-Sedating Antihistamines ²	\$394,594
	\$3,278,636
WY MA Rx Spending FY-04	\$48,322,010
% Savings	6.8%

NE MA Rx Spending FY-04 **\$232,803,647**
Estimated NE Savings **\$15,795,666**

¹ PDL implemented in 2004

² PDL planned in 2005

Strategy 2: Purchasing Pools

Some organizations and states have chosen to band together and form purchasing pools. Under these arrangements, organizations aim to increase their purchasing power through higher volume and shared expertise. Georgia implemented a program, starting in 2000, to combine management of its drug benefit for Medicaid, state employees, and other public programs. The program covers about 2 million state residents. Through use of a single pharmacy benefit manager (PBM) and a single preferred drug list, Georgia reduced its pharmacy cost growth trend from 26% in FY 2001 to 16% in FY 2002.

Cost Savings

A variety of efforts are also under way to combine negotiating power across states to get better drug prices.

- West Virginia, working with four other states (Delaware, Missouri, New Mexico, and Ohio) through RXIS (Rx Issuing States), entered into a contract with Express Scripts in July 2002 to manage their drug benefits jointly for state employees and certain other state programs (excluding Medicaid). RXIS uses preferred drug lists and rebate negotiations to lower the cost of prescription drugs through combined market power of about 700,000 lives. ***West Virginia realized net savings of \$7 million in the first year and estimates it will save \$25 million (5 percent of costs) over three years by being a part of this common effort*** (NCSL; Silow-Carroll and Alteras).

- The National Medicaid Pooling Initiative was created by Michigan to operate as a multi-state pool, with participation initially by Medicaid programs Alaska, Michigan, Nevada, New Hampshire, Vermont, and Minnesota. Each state establishes its own separate contract with the common PBM and makes its own decisions about preferred drugs. In April 2004, DHHS approved this purchasing pool for a total of over 900,000 persons with Medicaid. ***With this approval, the states estimated the following savings for 2004: Michigan, \$8 million; Vermont, \$1 million; Nevada, \$1.9 million; Alaska \$1 million; New Hampshire \$250,000; and Minnesota \$11 million – amounts that may represent savings of 25 to 50 percent beyond levels obtained previously with individual preferred drug lists*** (NCSL; DHHS; Silow-Carroll and Alteras).

Information is excerpted from *Cost Containment Strategies For Prescription Drugs: Assessing The Evidence In The Literature*.

<http://www.kff.org/rxdrugs/upload/Cost-Containment-Strategies-for-Precription-Drugs-Assessing-The-Evidence-in-the-Literature-Report.pdf>

Strategy 3: Counter Detailing or Academic Detailing

Counter detailing, also known as academic detailing, refers to providing physicians with alternative information to that provided to by the pharmaceutical manufacturers. Drug company educational strategies (known as detailing) provide drug samples and information about the value of a particular drug marketed by that company with the goal of increasing awareness and use of that drug. In counter detailing, groups such as insurers or purchasers – or groups affiliated with them – can provide alternative messages. For example, they may share with physicians studies showing that a much-advertised brand-name drug is no more effective than a less expensive, older alternative.

State Experiences

An example of this practice is a decision by Massachusetts Medicaid to target a counter-detailing program at physicians who prescribed as many as six psychiatric drugs in the same therapeutic class. If these physicians did not change their practices within three months of receiving letters on the subject, they received visits from state-employed pharmacists to discuss their prescribing behavior. The state's goal was to save \$10 million a year from this effort, representing about 2% of total spending on psychiatric drugs (Business News of the Week).

Cost Savings

- In a 1983 peer-reviewed study, researchers implemented an office-based physician education program to reduce excessive use of three drug groups. Prescribers were identified through Medicaid records, and one group was offered educational visits by clinical pharmacists together with mailings about the target drugs. *Compared with a control group, these doctors reduced prescriptions of the target drugs by 14 percent, resulting in significant cost savings. No change was seen for a group of doctors who only received the mailings* (Avorn and Soumerai).

- In study published in 2002, academic detailing was used in concert with physician profiling in a Texas staff-model managed-care organization. The result of the combined strategy was a decrease in the use of fluoxetine (Prozac) compared to the use of other selective serotonin reuptake inhibitors for the treatment of depression. On top of a national trend toward less use of fluoxetine, use by physicians in this plan declined more rapidly, *leading to annual savings of about \$0.61 per member* (Yokoyama et al.).

Information is excerpted from-*Cost Containment Strategies For Prescription Drugs: Assessing The Evidence In The Literature.*

<http://www.kff.org/rxdrugs/upload/Cost-Containment-Strategies-for-Precription-Drugs-Assessing-The-Evidence-in-the-Literature-Report.pdf>

Strategy 4: Expansion of Home and Community Based Care

Medicaid spending per recipient is much lower for home and community based care than for nursing home care. *A 2004 CBO study found that, on average, Medicaid spent \$3,135 per recipient for home and community based services, compared with \$20,220 per recipient for nursing home care.*⁴ The amount of savings, if any, from expanded home and community based care depends on the degree to which utilization of those services increases.

Cost Savings

- To the extent that utilization is not dramatically increased, home health care is considerably more cost effective than nursing home care. *In 2004, Independent Living Centers in Nebraska assisted 1,016 individuals to live outside of a nursing facility, reducing Medicaid nursing facility costs by \$7.4 million.*

- During the period of July-December of 2004, for people over the age of 65, the average cost of nursing facility care for the seven levels of care with the least needs, was \$74 per day. *In contrast, the average Medicaid waiver cost for in-home services was \$30 per day and assisted living cost was \$41 per day.*

- For disabled adults under the age of 65, the average cost of nursing facility care for the seven levels of care with the least needs was \$83 per day. *In comparison, in-home services were \$63 per day and assisted living was \$45 per day.*

- An analysis of a home and community based waiver program in Colorado in 1994 showed \$53 million in savings from its expansion of access to those programs.*⁵

⁴ Congressional Budget Office, *Financing Long-Term Care for the Elderly*, p. 37, April 2004, available at: <http://www.cbo.gov/ftpdocs/54xx/doc5400/04-26-LongTermCare.pdf>

⁵ Urban Institution, *Long-Term Care for the Elderly: Profiles of Thirteen States*, p. 25, available at: <http://www.urban.org/UploadedPDF/occa12.pdf>

Strategy 5: Expanding Coverage for Telemonitoring/Home Med Units

Tele-monitoring is a health monitoring system that a patient can use to take his or her own vital signs from within the comfort of his own home, and then transmitted to central station for clinical evaluation. This is more often used as a comprehensive, cost effective solution for chronic illness and disease management (i.e. congestive heart failure, respiratory-compromised individuals etc.).

On average Nebraska's Medicaid Program spends more than \$12,000 per aged person in Medicaid expenses. HomMed Health Monitoring could help bring those costs down for the Medicaid program. The cost of a HomMed monitor in a patient's home is \$150.00 per month. Daily monitoring allows clinicians to detect potential complications early, before it becomes a problem. HomMed has assisted in the reduction of patient's needs for emergency room care and/or hospitalization. Research indicates, "The use of HomMed monitors, when paired with a comprehensive clinical management program, significantly decreases hospitalization and emergent care visits in diagnoses known to consume health care resources."⁶

Cost Savings

In the second quarter of 2005⁷, of patients utilizing the HomMed Health Monitors:

- 99.4 % of all patient episodes of care avoided an unexpected admission to a skilled nursing facility;
- 92.09 % of all patient episodes of care avoided emergent care use;
- 89.4 % of all patient episodes of care avoided re-admission to the hospital.

Constant visits to the ER and regular admission to the hospital are a significant expense to the Medicaid system. In 2004, Inpatient Hospital care made up 13% of Nebraska's Medicaid expenditures.⁸ With the use of the HomMed units:

- Individuals are more able to take appropriate ownership for their health care through daily monitoring;
- Individuals receive identification of a change in health status. This creates an opportunity for proactive intervention and subsequent avoidance of costly hospitalizations and ER visits, and with less strain on the entire healthcare system.

⁶ Independent Analysis of Monitored/non-Monitored Patients, January 1, 2002 through March 31, 2004. Study conducted by SHP (Strategic Healthcare Programs), LLC. This study represented the largest independent study of telemonitor effectiveness in the United States.

⁷ Data taken in the second quarter 2005 from people receiving care from the Visiting Nurses Association in Omaha, Nebraska which serves Douglas and Sarpy Counties.

⁸ Testimony of Dick Nelson, Director of Finance and Support, Nebraska Department of Health and Human Services, before the Health and Human Services Committee of the Nebraska Legislature, February 9, 2005.

Strategy 6: Smoking Cessation Waivers

In Nebraska, 1 in 7 women continue to smoke during pregnancy according to the Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) 2000 Surveillance Report. Smoking during pregnancy is associated with increased risk for premature rupture of membranes, an increase in risk for preterm delivery, and lower average birth weight. Low birth weight is associated with increased risk for neonatal, prenatal, and infant morbidity and mortality (Women and Smoking, a Report of the Surgeon General, 2001).

Medicaid Cessation Waivers provide Medicaid dollars for pregnant women for cessation counseling and Pharmacotherapy (NRT), as well as cessation services to post-partum mothers to prevent the exposure of environmental tobacco smoke to their infant up to age 5 years.

Cost Savings

- Cost of smoking to Medicaid for the adult smoker in 1997 was estimated to be more than \$17 billion, or 12.1% of all Medicaid expenditures (Zhang et al., 1999).*

- Smoking cessation initiatives for pregnant women save an average of \$2-\$3 in health care costs for each dollar spent on smoking cessation (Women and Smoking, a Report of the Surgeon General, 2001).*

- A fully comprehensive smoking cessation benefit (counseling and pharmacotherapy) costs less than \$5.92 per member per year (Curry et al., 1998).*

- In 2001 Medicaid health care expenditures for Nebraskans were \$976, 813,196. The estimated smoking attributable Medicaid expenditures were \$47,265, 155. It is projected that if Medicaid covered cessation services and if a 25% decrease in smoking occurred; there would be a reduction of \$1,890,606 in Medicaid expenditures. Even with a more modest 5% reduction in smoking, the Medicaid savings for Nebraska would be \$378,121 (Campaign for Tobacco-Free Kids, American Cancer Society, American Heart Association, and American Lung Association press release, Mar. 2002).*

Strategy 7: Outpatient Mental Health Services

Under Nebraska's Medicaid program there is a current provision of unnecessary services related to Mental Status Exams (MSE). Mental Status Exams are performed by either a Psychiatrist or Psychologist to determine the diagnosis and medical necessity for therapy. For Medicaid recipients receiving outpatient mental health services from a Licensed Mental Health Practitioner (LMHP), an annual MSE is required. For clients who have not been diagnosed with a major mental illness condition and who are not taking psychotropic medication, an annual MSE may not be necessary. These clients are being seen regularly by the LMHP, who is supervised by a Psychiatrist or Psychologist and is trained to assess the client's condition. The LMHP and supervising practitioner together can determine if an MSE is necessary. By lifting the requirement for an annual MSE for those individuals without a major mental illness and who are not taking medications for that condition, unnecessary MSE's could be eliminated without harm to Medicaid clients.

For clients who have a major mental illness and who are taking medication for that condition, additional savings could be found by allowing the annual MSE to be performed by the clients chosen Psychiatrist or Psychologist with the understanding that the MSE would be shared with the LMHP providing the therapy. Under the present system the MSE has to be performed by the LMHP's supervising practitioner even when the Medicaid client is receiving psychiatric medical care from someone else. In these cases having the LMHP's supervising practitioner perform the MSE is redundant.

Cost Savings

The cost savings from this proposal would be in reducing the number of unnecessary MSE's performed under Nebraska's Medicaid program and reducing redundant care by having the MSE performed by the Psychiatrist or Psychologist who is already providing care to the client. Under Medicaid, an MSE completed by a psychiatrist costs \$140 and one completed by a psychologist costs \$100. There may also be a Pretreatment Assessment completed by the LMHP prior to the MSE at a cost of \$164. At the high end, one MSE can cost Nebraska's Medicaid program \$304. This would be the cost savings per client receiving an unnecessary MSE.

Strategy 8: Home Visitation

On Average, 30% of children in Nebraska are born to women on Medicaid.⁹ Home visits are a long-standing, well-known prevention strategy to improve the health and well-being of pregnant and parenting women with infants and young children, especially those that are most at-risk. Dr. David Old's, Deanna Gomby's (report published by the David and Lucille Packard Foundation) and other's research has shown that *early investments in public health nurse home visiting can reduce costs due to foster care placements, hospitalizations and emergency room visits, unintended pregnancies, and other maternal life course issues.*¹⁰

For decades, health care professionals have recommended early childhood home visitation services to help parents adjust to their new role as caregivers. Home visitation services are used to achieve a wide range of public health goals for visited children and their parents. They have been shown to positively affect health-related outcomes such as educational achievement, reduction in child abuse and neglect, juvenile socialization, workforce engagement for parents, and parents' ability to access other community supported social services.

Lancaster County Experience

Birth Statistics and Home Visitation Services in Lancaster County

- In 2003, a total of 4,043 babies were born in Lancaster County. Twenty-six percent of these children were born to single mothers and more than 300 of them were born to teen mothers. Within this teen category, 82.5% of new mothers are single parents.

- The Lincoln-Lancaster County Health Department (LLCHD) reports that over 13.1% of mothers giving birth in 2003 used tobacco during pregnancy. Fifty-two babies were born to mothers who used alcohol while pregnant and 31 babies were born to mothers who used illegal drugs during pregnancy.¹¹

These statistics are alarming and indicate the need for intervention to ensure the healthy birth and development of babies in Lancaster County. The LLCHD is trying to address these outcomes through its Healthy Homes program of home visitation. The program has eleven full-time equivalent staff positions and received 1,594 referrals during fiscal year 2002-2003, a number that has increased steadily over the last three years. The vast majority of the referrals to LLCHD are pregnant women on Medicaid, and over 40 percent of the women visited were teens.

⁹ Data abstracted from the Centers for Medicare and Medicaid Services, <http://www.cms.hhs.gov/researchers/statsdata.asp>

¹⁰ Visiting Nurse Association Position Statement, Presented to the Nebraska State Legislature in support of LB 264, February 2, 2005

¹¹ Data extracted from the Vital Statistics Birth Tables published by the Nebraska Health and Human Services System at <http://www.hhs.state.ne.us/ced/vs.htm#Births>.

The results of home visitations nationally clearly suggest that the program is beneficial for at-risk pregnant women, particularly when women participate in regular (i.e. more than one) prenatal and infant home visitation by trained professionals. Improvements have been seen in prenatal effects (such as increased birth weight, decrease in maternal smoking) and postnatal effects (fewer emergency room visits).¹² **Home visitations could be expanded in the state of Nebraska, which as research has shown, would have long term benefits as well as cost savings.**

Cost-Savings¹³

An expanded home visitation program in Nebraska could achieve savings within the Medicaid program by:

- Reducing hospitalizations associated with child abuse and neglect. One of the less severe injuries associated with abuse is a broken bone. The cost of treating a fracture or dislocation of the arm can cost up to \$10,983 per incident.¹⁴
- Reducing the incidence of chronic health problems. Thirty percent of maltreated children suffer chronic medical problems. The cost of treating a child with asthma per incident in the hospital is \$6,410.¹⁵
- Reducing the need for behavioral health services. Abused and neglected children often require counseling. The estimated cost per family for counseling services is \$2,860.
- Additional savings can be found by reducing the number of children who need special education, reducing juvenile delinquency, and reducing adult criminality.

A study of home visiting programs in Philadelphia in the early 1990s showed that low birth weight infants born to nurse-visited mothers were discharged from the hospital 11 days, on average, earlier than control group infants. *The mean hospital charge for the early discharge group was \$47,520 versus \$64,940 for the control group; the mean cost of the home visiting program was \$576, which produced a mean net savings of \$18,560 for each infant. Nurse-visited low- income families used about \$3,300 less in government services during the first four years of the child's life than the families in the comparison group. Roughly 80 percent of the cost-savings were concentrated in reductions in AFDC and food stamp payments. Further, about one-third of the savings for low-income families overall resulted from a reduction in unintended subsequent pregnancy.*

¹² Visiting Nurse Association Position Statement, Presented to the Nebraska State Legislature in support of LB 264, February 2, 2005

¹³ Olds, David L. and Harriet Kitzman. "Review of Research on Home Visiting for Pregnant Women and Parents of Young Children." The Future of Children 3.3 Winter 1993: 53-92.

¹⁴ "Total Estimated Costs of Child Abuse and Neglect in the United States, Statistical Evidence," 2001 Prevent Child Abuse America.

¹⁵ Id.