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Senate Special Committee on Aging

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"A Review of the Arizona Medicaid Program: Utilizing a Managed Care Approach to Address the Needs of a Growing Senior Population"

SENATE SPECIAL COMMITTEE ON AGING

GOVERNOR JANET NAPOLITANO'S TESTIMONY

JULY 13, 2006

Good morning.

I would like to thank Senator Smith and the other members of the Special Committee on Aging for inviting me to speak about Arizona's best practices in addressing some of the challenges that states and the federal government face with Medicaid. Congress has spent the last two years debating a variety of measures to stem the cost of Medicaid. Those efforts resulted in several cost containment measures found in the Deficit Reduction Act of 2005 (DRA). Although the DRA provides some tools for cost containment, the states themselves have developed best practices that will go farther than the DRA to reduce Medicaid spending while avoiding a reduction of services, or higher copayments that yield only nominal savings.

Mr. Wagoner's testimony this morning, which focuses on the impact that escalating health care costs have on the United States' business competitiveness, highlights the fact that health care reform must look to both the public and private sectors for solutions. I am reminded that the challenges we face with an increasingly aging population affect the employer retiree system as greatly as they affect Medicaid and Medicare. Solutions for providing health care for our aging population, however, must not involve cost shifting between the public or private sector. Rather, we must design a comprehensive approach with long-term cost containment strategies, but without sacrificing quality of care for the most medically vulnerable. Using the Arizona model we can both save states money and increase the quality of care for our aging population.

While my focus today is on specific areas for Medicaid reform, I want to caution all of us to avoid viewing the Medicaid program in isolation, but at the role Medicaid plays as part of the continuum of the entire health care system. Medicaid has moved well beyond its original mission in 1965 and the program must be both recognized as such and modernized to meet its changing role. After a period of sustained growth in the Medicaid program, it is now the largest insurer in the nation, covering the health care costs of half of all children, half of all nursing homes, and increasingly the health care costs of low-income workers.

Although Medicaid's growth has slowed in the last year, the pressures on Medicaid funding will continue to grow due to the following cost drivers:

- **Growth in the aging population**. The first baby boomers are turning 60 this year, notably former president Clinton and – just last week—President Bush. Estimates of the number of seniors in 2050 sound nearly apocalyptic. Therefore, we need to institute the right programs now that will create the capacity for future growth.
- **Growth in the 85+ year olds**. Not only are baby boomers turning 60, but the fastest growing segment of the aging population are those over 85 years of age. Advances in health care have lead to longer life spans and greater health care costs.
- **Chronic disease epidemic**. We are all aware of the epidemic of obesity in the country, which contributes to greater incidence of chronic conditions such as diabetes and heart disease. The growing prevalence of obesity and diabetes in our children have experts predicting that children under the age of 18 will be the first generation not to live longer than their parents.
- **The uninsured.** Lack of health insurance does not prohibit the uninsured from receiving health care services. They access services thought the largest primary care system in the

nation—the emergency room. Health care providers cannot remain profitable with the high cost of uncompensated care, so they are forced to negotiate increased reimbursement from other payors to offset these costs, including Medicaid. The financial pressures on our entire health care system that the uninsured present must be addressed.

- **Personalized medicine.** Innovations in health care research will provide medical treatments that are tailored to an individual's genetic profile. While this ensures the best outcomes, it also could mean higher medical costs.
- **Medical services inflation.** Medicaid, like all payors, must contend with annual inflationary increase for health care services—especially prescription drugs.

Because of these cost drivers, both states and the federal government recognize that Medicaid is not sustainable in the long term in its current form. Therefore, thoughtful and rational Medicaid reform is necessary to preserve the intended purpose of the program as a safety net, and to preserve its increasing role within the entire health care system. The federal budget deficit is one natural first impetus for addressing Medicaid reform; however, sound public policy-making beyond the budget process must be the vehicle for real reform to ensure both fiscal responsibility and the best solutions for the public good.

How can Arizona's Medicaid program offer some solutions? It can't solve the problem of the uninsured, or the broader fiscal and moral issues of personalized medicine. These issues must be the subject of a national debate that I hope this committee will precipitate. Arizona however, can offer its best practices in Medicaid management to other states while the larger issues of health care reform are debated.

Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), provides a robust, cost effective model for other states as they and the federal government seek alternative models that can sustain the Medicaid program. Expanding the Arizona model to new populations could cut Medicaid spending without eliminating services, limiting enrollment, or increasing cost sharing for the poor. Its proven best practices in purchasing prescription drugs, managing the health care of persons eligible for Medicare and Medicaid, and expanding home and community based (HCB) placements for those at risk of institutionalization deserve broad consideration.

Prudent Purchasing

AHCCCS is a national leader in cost effective purchasing of health care services. At its inception in 1982, the federal government granted Arizona an 1115 waiver, which gave it the authority to enroll every Medicaid eligible person into managed care organizations (MCOs). In 1989, that authority was extended to persons receiving long-term care services. AHCCCS' waiver creates an integrated, flexible health care system that has matured into a high quality, innovative, cost effective component of Arizona's entire health care infrastructure.

The hallmark of AHCCCS' success in containing costs while providing high quality health care services is the use of managed competition with private sector MCOs when contracting for services. Using market forces achieves the best quality for the best price. In addition to competing for contracts with AHCCCS, MCOs also compete for membership and provider networks. The need for a critical mass of enrollment and quality provider networks while remaining profitable forms a three-way tension that drives the necessary balance for high quality and cost effectiveness.

In addition to employing market forces to control costs, AHCCCS capitates the MCOs at full risk for all services, including pharmaceuticals. Full risk contracting means that MCOs are paid a fixed amount each month per enrollee to provide all medically necessary care. With fixed reimbursement, MCOs are at full financial risk for those health care services. Therefore in order to remain profitable, the plans are incentivized to manage a member's care to ensure that only medically necessary services are provided. Additionally, they are incentivized to use their purchasing power to negotiate favorable contracts for the most cost-effective services. Full risk contracting is a critical component in incentivizing cost effective care because it aligns the financial incentives of MCOs and the provider community with those of AHCCCS. What Arizona has known about the benefits of capitated contracts for nearly 25 years, has been formally recognized in a report issued by the Lewin Group in April of this year. Lewin estimates that full use of capitated contracting in Medicaid would save the program $83 billion over 10 years.

Full risk contracting also provides a flexible environment for effectively managing benefits. AHCCCS MCOs have the flexibility to:

- establish their own formularies based on evidence based medicine;
- leverage their purchasing power to negotiate for provider rates below AHCCCS' fee for service rates;
- case manage recipients in order to avoid expensive hospital and institutional care, and replace it with home and community based services; and
- establish prior authorization and utilization management processes that reduce unnecessary care and assure appropriate access to specialty care.

In 2003, the Lewin Group studied the Arizona model and prescription drug spending. The study's key finding was that Arizona's per capita drug spending was the lowest in the nation without compromising quality—38% below the national average. Generic drug utilization is an important factor in controlling drug spending. Arizona has achieved a 72% generic fill rate for its acute care population and a 71% fill rate for its long-term care population. This compares to around 50% or less for other states. These data show that MCO contracting and drug management are a best practice for controlling drug costs in Medicaid. This best practice is directly attributable to the MCOs' capitated, full risk contracts.

Long-term Care

Arizona is particularly successful using the managed competition model for its long-term care population. Arizona is the only state that has all of its long-term care recipients and dual eligibles enrolled into managed care plans. This is the best model for integrating all necessary care with a personalized case manager. The case manager is a degreed social worker or nurse who coordinates the full compendium of health care and behavioral health services for the member including planning and monitoring nursing home and home and community based care. This model integrates all services into a seamless delivery system that maximizes independence, dignity, and choice.

Under the 1115 waiver, Arizona is granted the flexibility to place persons in home or community settings when those are the appropriate level of care. Arizona has eliminated the oft-quoted concern of increasing the covered population through a woodwork effect by implementing a rigorous medical eligibility tool.

To illustrate Arizona's successful transition from traditional institutional placements for long-term care to home and community settings, please refer to Attachment A. This movement

away from institutionalization was mainly achieved by developing financial incentives from the state to the MCOs. In Arizona, AHCCCS pays the MCOs an average rate per person for all nursing facility and HCB costs. The rate is based on a set targeted percentage for HCBS placements, which are far less costly than nursing facilities. If the MCO achieves a higher HCBS placement percentage than what is factored into the monthly capitation rate, they get to keep a portion of the savings to the state. Conversely, if they don't meet their targeted percentage, they have to absorb a portion of the losses attributed to a higher institutionalized population. The federal government should identify similar appropriate incentives for states and their delivery systems to facilitate similar results.

Attachment A illustrates the results of good public policy making, and Attachment B shows the financial rewards. This graph shows the difference that AHCCCS pays MCOs for different placement settings. Since 1999, the increase in home and community placements has saved Arizona and the federal government an estimated $420 million through the end of fiscal year 2006. These are scorable savings that result from the sound policies of allowing people to age in place, in the least restrictive setting.

Medicare and Medicaid integration

One of the most recent innovations approved by the Centers for Medicare and Medicaid Services is the concept of the Medicare Advantage "special needs plans" (SNPs). SNPs are fully integrated Medicare and Medicaid MCOs that serve the dual eligible population. Nearly all of Arizona's Medicaid MCOs have either been approved to be a SNP or are partnering with a SNP for Medicare services. This is an important development in breaking down huge federal institutional silos to integrate care for our most vulnerable population. With the dual eligible prescription drug benefit moving from Medicaid to Medicare, the SNP model is necessary to

maintain the full integration of care that was provided prior to passage of the Medicare Modernization Act. Steps should be taken now to streamline this new authority and make it permanent so that this model can be expanded in conjunction with managed care.

Health Information Technology

No discussion of health care reform is complete without at least a nod to the dire need for modernizing how America delivers health care. An interoperable health information technology (HIT) system is critical in eliminating waste and inefficiency, and improving health care outcomes and patient safety.

Last year, I created the Arizona Health-e Connection initiative to develop a statewide interoperable health information technology and health information exchange system within five years. My steering committee developed a roadmap to achieve this goal, and Arizona is well on its way. In many cases, Medicaid has a captive audience with health care providers and therefore, should take the lead in implementation. Much of the benefit of an interoperable system accrues to payors, so both states and the federal government should have a strong interest in being the prime mover in developing interoperable systems through leveraging the right incentives.

I applaud the commitment of this subcommittee to continue exploring solutions to make Medicaid more modern and fiscally sound. Because it is the largest insurer in the nation, thoughtful reform that is driven by policy decisions and not merely quick budget solutions will be necessary to ensure that the benefits of Medicaid continue for the health of our most vulnerable citizens and to support the health care delivery system as a whole.

Arizona can help lead the way by offering its best practices in purchasing health care services through managed competition and capitated contracts, increasing home and community

placements so our seniors can age in place, embracing new innovative programs such as special needs plans, and engaging key stakeholders in developing interoperable health information technology.

I am committed in my role as incoming Chair of the National Governors Association to work with states and Congress to continue to develop meaningful reform that includes not just the public sector, but also the engagement of the private sector for solutions that improve the health of our health care system

Thank you.