

Government Human Services Consulting

July 21, 2011

**State of California  
Medi-Cal Managed Care Program  
All Plan Meeting**

# MCO Tax

# MCO Tax

- MCO Tax (AB 1422) is last step in rating process
  - Sunset of tax would simply have rates divert back to amounts without tax

<b>12 Month Rates Summary (75% Plan-Specific / 25% County Average RAR)</b>					
County	Category of Aid	Display Mem. Months*	MERCER DEVELOPED RATES		
			Lower Bound	Midpoint	Upper Bound
County Name	Adult & Family	350,000	\$ 110.00	\$ 114.24	\$ 118.71
County Name	Aged/Disabled/Medi-Cal Only	25,000	\$ 450.00	\$ 464.54	\$ 479.71
County Name	Disabled/Dual Eligible	8,000	\$ 120.00	\$ 124.52	\$ 129.27
County Name	Aged/Dual Eligible	3,500	\$ 115.00	\$ 119.29	\$ 123.80
County Name	BCCTP	48	\$ 650.00	\$ 670.58	\$ 692.02
County Name	Maternity	950	\$ 7,200.00	\$ 7,420.28	\$ 7,648.90
County Name	<b>All Categories of Aid</b>	<b>386,548</b>	<b>\$ 150.004</b>	<b>\$ 155.464</b>	<b>\$ 161.192</b>
County Name	<b>TOTAL REVENUE</b>		<b>\$ 57,983,700</b>	<b>\$ 60,094,354</b>	<b>\$ 62,308,474</b>
<b>12 Month Rate Summary AB 1422 Impact @ 2.35%</b>					
County	Category of Aid	Display Mem. Months*	MERCER DEVELOPED RATES		
			Lower Bound	Midpoint	Upper Bound
County Name	Adult & Family	350,000	\$ 2.65	\$ 2.75	\$ 2.86
County Name	Aged/Disabled/Medi-Cal Only	25,000	\$ 10.83	\$ 11.18	\$ 11.55
County Name	Disabled/Dual Eligible	8,000	\$ 2.89	\$ 3.00	\$ 3.11
County Name	Aged/Dual Eligible	3,500	\$ 2.77	\$ 2.87	\$ 2.98
County Name	BCCTP	48	\$ 15.64	\$ 16.14	\$ 16.66
County Name	Maternity	950	\$ 173.27	\$ 178.57	\$ 184.08
County Name	<b>All Categories of Aid</b>	<b>386,548</b>	<b>\$ 3.613</b>	<b>\$ 3.738</b>	<b>\$ 3.882</b>
County Name	<b>TOTAL REVENUE</b>		<b>\$ 1,396,422</b>	<b>\$ 1,444,736</b>	<b>\$ 1,500,644</b>
<b>12 Month FINAL PMPM (Including AB 1422)</b>					
County	Category of Aid	Display Mem. Months*	MERCER DEVELOPED RATES		
			Lower Bound	Midpoint	Upper Bound
County Name	Adult & Family	350,000	\$ 112.65	\$ 116.99	\$ 121.57
County Name	Aged/Disabled/Medi-Cal Only	25,000	\$ 460.83	\$ 475.72	\$ 491.26
County Name	Disabled/Dual Eligible	8,000	\$ 122.89	\$ 127.52	\$ 132.38
County Name	Aged/Dual Eligible	3,500	\$ 117.77	\$ 122.16	\$ 126.78
County Name	BCCTP	48	\$ 665.64	\$ 686.72	\$ 708.68
County Name	Maternity	950	\$ 7,373.27	\$ 7,598.85	\$ 7,832.98
County Name	<b>All Categories of Aid</b>	<b>386,548</b>	<b>\$ 153.616</b>	<b>\$ 159.202</b>	<b>\$ 165.074</b>
County Name	<b>TOTAL REVENUE</b>		<b>\$ 59,380,122</b>	<b>\$ 61,539,090</b>	<b>\$ 63,809,118</b>

**CY2010  
Rate Development Template (RDT)**

# CY2010 Rate Development Template (RDT)

- Very few changes from CY2009 version. No changes to:
  - Schedule 1-A (Global Sub-capitation)
  - Schedule 1-B (Incentive Payment Arrangements)
  - Schedule 1-C (Enrollment Counts)
  - Schedule 1-D (Pharmacy Pricing Inputs - Fees, Discounts and Rebates)
  - Schedule 2 (Trend and Other Adjustments)
  - Schedule 3 (Projected Contract Period Health Care Costs)
  - Schedule D-1 (Delivery Counts)
  - Schedule D-2 (Maternity Utilization and Costs)
  - Schedule 4 (Projected Contract Period Administrative Costs)
  - Schedule 5 (Large Claim Recipients > \$100,000)
  - Schedule 6-B (Detailed Base Period Administrative Costs)

# CY2010 Rate Development Template (RDT) (cont'd)

## ■ Schedules with changes

- Instructions
  - New tab - “Big Picture” category of service layout
- Schedule 1 (Utilization and Cost Experience i.e. Base Data)
  - No change to the layout or inputs for this schedule
  - Do NOT include any AB 1653 (QAF) amounts in this schedule
- Schedule 6-A (Financial Report)
  - Will replace QIF with AB 1653 and SB90 (report in revenue)
  - “Net Revenue” figure should have all AB1422, AB1653 and SB90 costs excluded
  - Added a new category of service line “Other” to be consistent with Schedule 1 category of service lines
- Schedule 7 (Payment Lag Information)
  - Unlocked more cells to enable easier data entry
  - Added capability for more months of run out
  - Will include Schedule 1 totals to compare COSs

# CY2010 Rate Development Template (RDT) (cont'd)

- New tab
  - “Edit/Check” tab
    - Performs high-level submission comparison for Health Plan review before template is forwarded to DHCS
    - Results will compare the consistency of some of the totals in schedules
    - Examples of comparisons displayed:
      - Schedule 1 (Utilization and Cost Experience) vs. 6-A (Financial Report) vs. 7 (Payment Lag Information) total cost comparisons
      - Global Sub-cap vs. non-sub dollar distribution by Category of Service (Schedule 1-A)
      - Health Plan enrollment entry vs. DHCS enrollment counts (Schedule 1-C)
      - Health Plan delivery counts entry vs. DHCS delivery counts
      - Schedule 4 (Projected Contract Period Administrative Costs) vs. 6-B (Detailed Base Period Administrative Costs) entries
      - Large Claims as a percentage of Total Dollars

# CY2010 Rate Development Template (RDT) (cont'd)

- “Edit/Check” tab (example)

## Schedule 1 (Utilization and Cost Experience) and 6-A (Financial Report) Totals Comparison

	(a)	(b)	(c)
	Total Cost		=(b)/(a)-1
	Schedule 1	Schedule 6-A	Difference
<u>All State-Plan Health Care Services</u>			
Inpatient Hospital	\$ 64,391,888	\$ 63,476,369	1.4%
Outpatient Facility	\$ 5,134,287	\$ 4,649,394	<b>10.4%</b>
Emergency Room Facility	\$ 5,541,780	\$ 5,297,976	4.6%
Long-Term Care Facility	\$ 40,372,408	\$ 41,942,504	-3.7%
Physician Primary Care	\$ 4,492,450	\$ 3,702,895	<b>21.3%</b>
Physician Specialty	\$ 12,441,830	\$ 12,437,168	0.0%
FQHC	\$ 5,961,179	\$ 6,738,484	-11.5%
Other Medical Professional	\$ 1,765,199	\$ 2,670,868	<b>-33.9%</b>
Pharmacy	\$ 26,302,852	\$ 24,329,200	8.1%
Laboratory and Radiology	\$ 1,319,733	\$ 1,275,816	3.4%
Transportation	\$ 852,671	\$ 800,845	6.5%
Other	\$ 6,117,304	\$ 6,117,304	0.0%
Global Subcapitation	\$ -	\$ -	0.0%
Hospital Incentive Pmts.	\$ 69,533	\$ 103,035	-32.5%
Professional Incentive Pmts.	\$2,722,018.46	\$2,722,018.46	0.0%
Other Incentive Payments	\$ -	\$ -	0.0%
Net reinsurance costs	\$ (1,241,185)	\$ (1,248,849)	-0.6%
UM/QA Costs	\$ 2,007,847	\$ 2,007,847	0.0%
TPL Recoveries	\$ -	\$ -	0.0%
<b>Total Costs</b>	<b>\$ 178,251,795</b>	<b>\$ 177,022,874</b>	<b>0.7%</b>

# CY2010 Rate Development Template (RDT) (cont'd)

- “Edit/Check” tab (example) (cont'd)

## Health Plan Counts vs. DHCS records comparison (Schedule 1-C)

	(a)	(b)	(c)	(d)
COA Group	CY2010 DHCS MMs	Health Plan Entry	HP/DHCS MM Difference	HP/DHCS % Difference
Family	597,958	613,007	15,049	2.5%
Disabled/Dual Eligible	48,936	49,891	955	2.0%
Disabled/Medi-Cal Only	54,251	53,528	(723)	-1.3%
Aged/Dual Eligible	55,321	56,241	920	1.7%
Aged/Medi-Cal Only	7,333	7,199	(134)	-1.8%
Adult	1,271	1,411	140	11.0%
BCCTP	1,169	1,188	19	1.6%
AIDS/Dual Eligible	-	-	-	0.0%
AIDS/Medi-Cal Only	-	-	-	0.0%
LTC/Dual Eligible	5,684	5,846	162	2.9%
LTC/Medi-Cal Only	424	400	(24)	-5.7%
OBRA	-	-	-	0.0%
<b>Total</b>	<b>772,347</b>	<b>788,711</b>	<b>16,364</b>	<b>2.1%</b>

# CY2010 Rate Development Template (RDT) (cont'd)

- “Edit/Check” tab (example) (cont'd)

## Schedule 4 (Projected Contract Period Administrative Costs) vs. 6-B (Detailed Base Period Administrative Costs) PMPM comparison

	(a)	(b)	(c)	(d)	(e) = (c)-(a)	(f) = (c)/(a)-1	(g) = (d)-(b)
	CY2010 From Schedule 6b		Projected CY12-13 From Schedule 4		Comparison		
	Cost PMPM	Percent of Total Cost PMPM	Cost PMPM	Percent of Total Cost PMPM	PMPM Amount Change	PMPM Percentage Change	Percent of Total Cost change
<u>Administrative Costs</u>							
Compensation	\$ 3.43	2.95%	\$ 5.03	3.75%	\$ 1.60	46.6%	0.80%
Interest Expense	\$ 0.06	0.05%	\$ 0.06	0.05%	\$ 0.01	12.0%	0.00%
Occupancy, Dep. and Amortization	\$ 0.67	0.57%	\$ 0.78	0.58%	\$ 0.11	16.6%	0.01%
Management Fees	\$ -	0.00%	\$ -	0.00%	\$ -	0.0%	0.00%
Marketing	\$ 1.05	0.91%	\$ 1.24	0.93%	\$ 0.19	18.1%	0.02%
Affiliate Administration Services	\$ -	0.00%	\$ -	0.00%	\$ -	0.0%	0.00%
Other Administration (Details below)	\$ 1.80	1.55%	\$ 2.14	1.60%	\$ 0.34	18.8%	0.05%
<b>Total Administration</b>	<b>\$ 7.01</b>	<b>6.02%</b>	<b>\$ 9.26</b>	<b>6.91%</b>	<b>\$ 2.24</b>	<b>32.0%</b>	<b>0.88%</b>
Total health care costs	\$ 109.36	93.98%	\$ 124.79	93.09%	\$ 15.43	14.1%	-0.88%
<b>Total health care costs plus Admin</b>	<b>\$ 116.37</b>	<b>100.00%</b>	<b>\$ 134.05</b>	<b>100.00%</b>	<b>\$ 17.67</b>	<b>15.2%</b>	<b>0.00%</b>

## CY2010 Rate Development Template (RDT) (cont'd)

- Projected Timeframes for RDT Process
  - August 15 – DHCS will deliver CY2010 template to health plans
  - October 1 – deadline for completed RDT template submissions
    - October-November – potential preliminary questions to Health Plans from Mercer/DHCS
  - December–January – Health Plan/DHCS/Mercer conference calls to review RDT discussion guide

# **Medi-Cal Managed Care Clinical Efficiency Analyses**

Potentially Preventable Admissions (PPA)  
Inpatient Hospital Analysis

# Efficiency Analyses

## Criteria

- Clinical efficiency adjustments
  - Strong literature support that the service can be prevented or substituted with less expensive treatment or is not appropriate for the condition
  - Ability to evaluate using encounter data only (no chart review)
    - No medical necessity assessment required
  - Produces estimated lower cost in the short term; measures that are more likely to generate longer term savings may be more suitable for P4P approach

# PPA Analysis

- Objective
  - Analyze historical encounter data to identify situations where an IP admission was potentially preventable using criteria in the Agency for Healthcare Research and Quality (AHRQ), Guide to Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDI)
  - Quantify the level of inefficiency and/or potentially avoidable expenses present in the base data
- Potentially preventable hospital admissions are identified through the encounter data using criteria from the AHRQ, PQIs and PDI
- Additional filters are applied to this initial set of potentially preventable hospital admissions in order to determine a reasonable and achievable level of potentially preventable hospital admissions

# Overview

- Mercer believes the approach and analysis of PPA is consistent with recognized analyses and literature on both national and California-specific levels
  - April 2009 from the Healthcare Cost and Utilization Project (HCUP) via AHRQ, "...However, 12 percent of uninsured hospitalizations were potentially preventable, significantly higher than the 9 percent of Medicaid hospitalizations." <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp>
  - Milliman estimates "potentially avoidable" hospital days for California for Commercial and Medicare populations:
    - Commercial = 49 percent of days potentially avoidable  
<http://www.hospitalefficiencybenchmarks.com/CommercialChart.asp>
    - Medicare = 55 percent of days potentially avoidable  
<http://www.hospitalefficiencybenchmarks.com/MedicareChart.asp>

## Overview (cont'd)

Conservative approach to analyzing potentially unnecessary expenditures:

- The AHRQ definitions for each PQI and PDI contain specific exclusions (e.g., deaths, transfers to other facilities, etc.)
- Additional filters beyond AHRQ logic:
  - Only individuals with varying enrollment durations by PQI/PDI (ranging from 2 to 12 months) or greater in the same Medi-Cal health plan are considered for the analysis
  - Only individuals meeting specific Medicaid Rx risk score criteria are considered for the analysis
  - A credibility adjustment will be applied to the analysis to account for replacement costs and to build in additional conservatism

# Methodology

- Step 1: Identify IP related encounter data
- Step 2: Define the PQIs and PDIs
- Step 3: Extract and summarize IP encounter data that satisfies the PQI and PDI diagnosis code, procedure code and exclusion criteria
- Step 4: Analyze IP PQI and PDI data by Enrollment Duration
- Step 5: Analyze IP PQI and PDI data by Medicaid Rx Risk Score
- Step 6: Determine the dollars associated with PQI/PDI admissions and apply credibility factors.
- Step 7: Apply managed care model averages to health plan results determined to be unreliable due to data issues

## Step 1: Identify IP Related Encounter Data

- Encounter data related to IP visits were extracted for this analysis
- Encounter data summarization logic consistent with data used for Medi-Cal capitation rate setting

## Step 2: Define the PQIs and PDIs

As defined in the AHRQ Guide to PQIs:

- “The PQIs are a set of measures that can be used with hospital inpatient discharge data to identify ‘Ambulatory Care Sensitive Conditions’ (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.”
- The 13 individual PQIs are shown in the following tables:

PQI	PQI Description
01	Diabetes Short-term Complications Admission Rate
02	Perforated Appendix Admission Rate
03	Diabetes Long-term Complication Admission Rate
05	Chronic Obstructive Pulmonary Disease Admission Rate
07	Hypertension Admission Rate
08	Congestive Heart Failure Admission Rate
10	Dehydration Admission Rate

PQI	PQI Description
11	Bacterial Pneumonia Admission Rate
12	Urinary Tract Infection Admission Rate
13	Angina Admission without procedure
14	Uncontrolled Diabetes Admission Rate
15	Adult Asthma Admission Rate
16	Rate of lower-extremity Amputation among Diabetics

## Step 2: Define the PQIs and PDIs (cont'd)

As defined in the AHRQ Guide to PQIs (cont'd):

- “The PDIs are a set of measures that can be used with hospital inpatient discharge data to provide a perspective on the quality of pediatric healthcare. Specifically, PDIs screen for problems that pediatric patients experience as a result of exposure to the healthcare system and that may be amenable to prevention by changes at the system or provider level.”
- The 5 individual PDIs are shown in the following table:

<b>PDI</b>	<b>PDI Description</b>
<b>14</b>	<b>Asthma Admission Rate</b>
<b>15</b>	<b>Diabetes Short-term Complications Admission Rate</b>
<b>16</b>	<b>Gastroenteritis Admission Rate</b>
<b>17</b>	<b>Perforated Appendix Admission Rate</b>
<b>18</b>	<b>Urinary Tract Infection Admission Rate</b>

## Step 3: Extract and summarize IP encounter data that satisfies the PQI and PDI diagnosis code, procedure code and exclusion criteria

- Each PQI or PDI is defined by a set of diagnosis codes and/or procedure codes along with specific exclusions
- IP encounter data were extracted based on the PQI and PDI definitions developed by AHRQ
- The encounter data was categorized into a PQI or PDI based on the set of included diagnosis codes and procedure codes
  - Admissions can only be assigned to one PQI or PDI

## Step 4: Analyze IP PQI and PDI data by Enrollment Duration

- The PQI and PDI data were analyzed by enrollment duration
- The enrollment duration was calculated using the enrollment file
  - All eligibility records were extracted for each individual in the PQI data
  - Eligibility records for each recipient were “connected”, matching up the eligibility begin date and eligibility end date, as well as matching the health plan ID
  - The final enrollment duration “spans” consisted of consecutive months of health plan eligibility by recipient and health plan
- Individuals with an enrollment duration ranging from two to twelve months or greater (varies by PQI and PDI) will be considered for the analysis
- Applied so that the admits retained for the analysis reflect a reasonable opportunity for the health plan to engage the recipient and initiate assignment of a PCP, any appropriate treatment and education and/or enrollment into care management programs

## Step 5: Analyze IP PQI and PDI data by Medicaid Rx Risk Score

- Each recipient found in the PQI and PDI analysis was assigned a risk score from Medicaid Rx
- An average risk score is calculated for each quartile by population group and PQI or PDI, along with the top-end risk score for the quartile
- Admits associated with the top 25% of individuals in each population group who had the highest risk scores for each indicator are then excluded from the analysis
- This provides an additional layer of conservatism, acknowledging that a subset of the PQI/PDI admissions, even after the AHRQ exclusions for co-morbidities and the enrollment duration exclusions, may not be preventable within the Medi-Cal population

## Step 6: Determine the dollars associated with PQI/PDI admissions and apply credibility factors

- The total dollars for the remaining admits are then summarized by health plan, population and PQI/PDI
- A credibility adjustment is then applied to the resulting PQI/PDI dollars in the analysis to account for replacement costs and additional conservatism

## **Step 7: Apply managed care model averages to health plan results determined to be unreliable due to data issues**

- Calculated managed care model averages resulting from this analysis will be applied to those health plans' whose IP encounter data is determined to be unreliable due to data issues

# Health Plan Specific Results

- PQI

PQI	PQI Description	PQI Grand Total		Exclusion Criteria	Reducing PQI Total						
		Unique Events	Grand Total PQI Dollars		Minimum Health Plan enrollment duration prior to admission date (in months)	Unique Events After Considering Enrollment Duration	PQI Dollars After Considering Enrollment Duration	Unique Events After Considering Enrollment Duration and Risk Assessment	PQI Dollars After Considering Enrollment Duration and Risk Assessment	Credibility Factor	PQI Dollars After Applying Credibility Factor
01	Diabetes Short-term Complications Admission Rate	18	\$ 89,779	4	17	\$ 87,859	12	\$ 50,057	50%	\$ 25,029	27.9%
02	Perforated Appendix Admission Rate	10	\$ 74,332	2	9	\$ 69,286	6	\$ 49,472	50%	\$ 24,736	33.3%
03	Diabetes Long-term Complication Admission Rate	7	\$ 48,288	6	4	\$ 21,724	3	\$ 19,804	50%	\$ 9,902	20.5%
05	Chronic Obstructive Pulmonary Disease Admission Rate	3	\$ 19,735	6	3	\$ 19,735	2	\$ 11,325	50%	\$ 5,663	28.7%
07	Hypertension Admission Rate	1	\$ 974	4	1	\$ 974	1	\$ 974	50%	\$ 487	50.0%
08	Congestive Heart Failure Admission Rate	12	\$ 66,921	4	6	\$ 45,807	5	\$ 42,679	50%	\$ 21,340	31.9%
10	Dehydration Admission Rate	5	\$ 36,786	2	5	\$ 36,786	3	\$ 16,380	50%	\$ 8,190	22.3%
11	Bacterial Pneumonia Admission Rate	22	\$ 182,522	2	20	\$ 171,456	15	\$ 134,700	50%	\$ 67,350	36.9%
12	Urinary Tract Infection Admission Rate	14	\$ 66,802	2	13	\$ 63,438	9	\$ 37,219	50%	\$ 18,610	27.9%
13	Angina Admission without procedure	6	\$ 12,841	2	6	\$ 12,841	4	\$ 10,243	50%	\$ 5,122	39.9%
14	Uncontrolled Diabetes Admission Rate	2	\$ 11,774	4	2	\$ 11,774	1	\$ 6,728	50%	\$ 3,364	28.6%
15	Adult Asthma Admission Rate	15	\$ 102,271	4	11	\$ 50,431	8	\$ 37,705	50%	\$ 18,853	18.4%
16	Rate of lower-extremity Amputation among Diabetics	4	\$ 44,619	12	2	\$ 18,691	2	\$ 18,691	50%	\$ 9,346	20.9%
<b>Total</b>		<b>119</b>	<b>\$ 757,645</b>		<b>99</b>	<b>\$ 610,803</b>	<b>71</b>	<b>\$ 435,978</b>		<b>\$ 217,989</b>	<b>28.8%</b>

# Health Plan Specific Results (cont'd)

- PDI

PDI	PDI Description	PDI Grand Total		Exclusion Criteria	Reducing PDI Total						
		Unique Events	Grand Total PDI Dollars		Minimum Health Plan enrollment duration prior to admission date (in months)	Unique Events After Considering Enrollment Duration	PDI Dollars After Considering Enrollment Duration	Unique Events After Considering Enrollment Duration and Risk Assessment	PDI Dollars After Considering Enrollment Duration and Risk Assessment	Credibility Factor	PDI Dollars After Applying Credibility Factor
14	Asthma Admission Rate	32	\$ 97,184	3	29	\$ 90,046	22	\$ 69,067	50%	\$ 34,534	35.5%
15	Diabetes Short-term Complications Admission Rate	-	\$ -	4	-	\$ -	-	\$ -	50%	\$ -	0.0%
16	Gastroenteritis Admission Rate	27	\$ 78,551	2	20	\$ 51,212	15	\$ 35,297	50%	\$ 17,649	22.5%
17	Perforated Appendix Admission Rate	17	\$ 140,004	2	15	\$ 121,758	11	\$ 96,758	50%	\$ 48,379	34.6%
18	Urinary Tract Infection Admission Rate	20	\$ 81,031	2	13	\$ 43,224	10	\$ 36,311	50%	\$ 18,156	22.4%
<b>Total</b>		<b>96</b>	<b>\$ 396,770</b>		<b>77</b>	<b>\$ 306,240</b>	<b>58</b>	<b>\$ 237,433</b>		<b>\$ 118,717</b>	<b>29.9%</b>
<b>Grand Total</b>		<b>215</b>	<b>\$ 1,154,415</b>		<b>176</b>	<b>\$ 917,043</b>	<b>129</b>	<b>\$ 673,411</b>		<b>\$ 336,706</b>	<b>29.2%</b>

## Next Steps

- Run PPA analysis with CY09 data
- Provide health plan specific results to plans
- Collect written feedback and questions
- Continued discussions related to methodology

# MAC Analysis

# Medi-Cal Efficiency Analyses

## MAC Analysis

- Goal

- Evaluate Medi-Cal health plan MAC programs for breadth of MAC list (number of generic product price points) and aggressiveness of reimbursement price points
- Assess whether more aggressive MAC reimbursement is possible and calculate potential avoidable costs available based on comparison to a Medicaid-specific benchmark MAC list
  - Benchmark MAC list includes approximately 1,400 unique Generic Code Numbers (GCN)

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis (cont'd)

- Efficient MAC programs focus on the appropriate breadth and depth of their MAC list
  - A Medicaid MCO's MAC list should reflect the drug utilization patterns of the population covered
  - Timely management of MAC list updates is essential
    - Reimbursement savings opportunities occur rapidly when multiple generic manufacturers' products are introduced into the market
    - Frequent updating is necessary so MAC pricing does not become “stale” or outdated

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis (cont'd)

- Why focus on generic reimbursement?
  - Increased number of blockbuster generics launched in recent years and drug patent “cliff” expected in the near future
    - First-time generics expected to come to market over the next 3 years represent approximately 20% of current plan spending and 8% of total prescription claims volume
    - Lipitor, Seroquel, Singulair patent expirations during SFY 2012
  - Many Medicaid Managed Care Organizations (MCOs) and fee-for-service (FFS) programs nationally are reporting Generic Dispensing Rates (GDR) over 75%
    - GDR expected to increase nationally to over 80% by the end of 2012

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis (cont'd)

- Approach

- Data adjustments:

- Generic claims for which there was **not** a benchmark MAC price in place on the date of service were excluded from this analysis
    - Claims with a negative or zero paid amount were excluded from this analysis
    - Claims where the GCN linked to a product dispensed in a vial were excluded from this analysis due to potential differences in unit of measure, which could distort calculated paid amounts
    - Claims were excluded from the analysis if the sum of the paid amount and copayment was less than the dispensing fee
    - Claims with a positive value in the TPL field were excluded from the analysis
    - MCO-specific adjustments were made to the encounter data based on feedback received by Mercer through the rate development template (RDT) calls

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis (cont'd)

- Step 1: Claims re-pricing
  - CY 2009 pharmacy encounter data provided the base for this analysis
  - Re-priced encounter data for generic drugs utilizing a Medicaid-specific benchmark MAC list based on the GCN for the same base time period (CY 2009) to calculate a derived benchmark MAC paid amount
    - The derived paid amount was calculated using the encounter's quantity units multiplied by the lower of the Federal Upper Limit or benchmark MAC unit price on that date of service
    - The claim paid amount was compared to the derived (benchmark) paid amount to calculate the avoidable dollars for that claim

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis (cont'd)

- Step 2: Avoidable cost calculation
  - Avoidable costs were calculated as the difference between the claim paid amount and the derived benchmark MAC paid amount
    - For claims where the actual paid amount was less than the derived paid amount, the difference was counted against the benchmark MAC savings (i.e., negative avoidable cost value)
    - As depicted below, this methodology ensures a conservative financial adjustment

GCN	Drug Name	Benchmark Unit Price	Encounter Claim Unit Price	Claim Quantity Units	Avoidable Dollars
60563	Loratadine	\$0.0900	\$0.15	30	\$1.80
19388	Oxybutynin	\$2.5410	\$2.72	30	\$5.37
61761	Etodolac	\$0.1709	\$0.13	30	(\$1.22)

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis (cont'd)

- Step 3: Generic claim dispensing fee adjustment
  - For all generic claims included in the analysis, Mercer imputed a \$2.50 dispensing fee
    - Mercer determined that \$2.50 was the peer benchmark dispensing fee based on review of Medi-Cal MCO reimbursement terms
    - If a health plan negotiated and paid dispensing fees below \$2.50 per script, they were credited for the 'savings' for more aggressive contracting

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis (cont'd)

- Step 4: Brand Discount Analysis
  - Mercer completed an analysis to assess the commensurate brand pricing/discounts for each MCO
  - Mercer limited the analysis to the top 100 brand NDCs, excluding specialty and vials which could sway the analysis
  - Mercer found no correlation between MAC savings and aggressiveness of brand discounts therefore no adjustment was made to the MAC analysis results

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis – Results

- Top GCNs driving avoidable dollars
  - The following table depicts the top 20 GCNs by avoidable dollar savings across all MCOs

GCN	Name	Strength	Form	Savings
62263	fluticasone propionate	50 mcg	nasal spray	\$2,794,831
04348	omeprazole	20 mg	cap, dr	\$2,480,121
26533	simvastatin	20 mg	tab	\$1,293,848
26534	simvastatin	40 mg	tab	\$1,202,208
00781	gabapentin	300 mg	cap	\$1,188,130
02682	amlodipine besylate	10 mg	tab	\$1,014,900
70330	hydrocodone/apap	10 mg; 325 mg	tab	\$1,014,839
10810	metformin	500 mg	tab	\$996,205
47041	lovastatin	40 mg	tab	\$968,731
07221	tramadol	50 mg	tab	\$945,266

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis – Results (cont'd)

GCN	Name	Strength	Form	Savings
41681	albuterol sulfate	0.083%	inh soln	\$821,298
70331	hydrocodone/apap	5 mg; 500 mg	tab	\$791,185
02683	amlodipine besylate	5 mg	tab	\$777,586
16375	sertraline hcl	100 mg	tab	\$767,375
10857	metformin	1000 mg	tab	\$761,607
94624	gabapentin	600 mg	tab	\$744,973
12090	ranitidine hcl	150 mg/10 ml	syr	\$688,894
67153	amox/potassium clavulanate	400-57/5	pwdr for oral susp	\$687,940
39683	amoxicillin	250 mg/5 ml	pwdr for oral susp	\$683,322
60563	loratadine	10 mg	tab	\$669,312

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis – Results (cont'd)

Model Type	CY 2008 Avoidable Dollars as % of Generic Drug Paid Amount Covered by Benchmark MAC list	CY 2008 Avoidable Dollars as % of Total Reported Paid Rx Amount	CY 2009 Avoidable Dollars as % of Generic Drug Paid Amount Covered by Benchmark MAC list	CY 2009 Avoidable Dollars as % of Total Reported Paid Rx Amount
COHS	28.5%	7.7%	30.3%	6.8%
GMC	22.9%	6.6%	17.7%	6.2%
TWO PLAN	24.5%	8.0%	19.5%	7.2%
<b>Total</b>	<b>25.4%</b>	<b>7.8%</b>	<b>20.4%</b>	<b>6.97%</b>

- Individual plan savings percentages ranged from 1.4%–16.9% as percent of total reported drug spend
- MAC pricing trend – Using the top 100 most utilized GCNs in CY2009 data, Mercer found the year over year weighted average benchmark MAC rates for these GCNs decreased by 24.9% from 2008–2009 and 21.7% from 2009–2010

# Medi-Cal Efficiency Analyses (cont'd)

## MAC Analysis – Blockbuster Generics Projected

	Brand Name	Primary Use	2010 US Retail Sales (\$M)
<b>CY 2011</b>	Lipitor	High cholesterol	\$5,803
	Zyprexa	Schizophrenia	\$2,114
	Concerta	ADHD	\$1,560
	Xalatan	Glaucoma	\$572
<b>CY 2012</b>	Plavix	Prevention of arterial thrombotic events	\$5,020
	Singulair	Asthma, allergic rhinitis	\$3,823
	Seroquel	Schizophrenia	\$3,549
	Actos	Diabetes	\$2,913
	Lexapro	Depression	\$2,590

## Medi-Cal Efficiency Analyses (cont'd)

### MAC Analysis – Blockbuster Generics Projected (cont'd)

	Brand Name	Primary Use	2010 US Retail Sales (\$M)
CY 2013	Cymbalta	Depression	\$2,891
	Aciphex	GERD	\$1,006
	Niaspan	Dyslipidemia	\$888
	Lovaza	Hypertriglyceridemia	\$806

**Other Items**

## Other Items

- SPD Rates
  - Latest set of Two-Plan and GMC rates were for the managed care members only
  - Rates reflecting migration of FFS members to managed care will be developed in August/September (this will allow for a few months of actual selection)
  - Same process as was utilized for the June 2011 rates: blend of risk adjusted managed care rates and managed care adjusted FFS claims

## Other Items (cont'd)

- HAC (Hospital Acquired Conditions)
  - Medicare payment methodology being applied to Medicaid
  - Methodology pays the lesser DRG if condition generating higher DRG was hospital acquired
  - Question for Plans:

*Do any of you currently have this payment methodology in place for your Medicaid members or plan to do so?*

## Other Items (cont'd)

- Senate Bill 90
  - January to June 2011 cycle of AB 1653 (QAF)
  - Will apply to COHS, GMC and Two-Plan models
  - Will be implemented in the same manner as AB 1653
  - Late August/Early September timeframe

**MERCER**