Trends in Medicare and Medicaid Managed Care: Implications for the Future

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Trends in Medicare and Medicaid Managed Care: Implications for the Future

Peter Sonnenreich, MA, and Joanne Kaldy

Medicare and Medicaid benchmarking data, when compared between years, help medical directors, pharmacists, and other practitioners foresee changes in these programs. Tracking patterns of utilization, cost, and strategy is especially significant now, with health care reform at the center of political debate and with many Americans facing unemployment and economic uncertainty.

As part of its continuing commitment to provide the latest, most essential information on the evolution of health care, sanofi-aventis presents the Public Payer Digest, now in distribution. The newest addition to the sanofi-aventis Managed Care Digest Series®, the Public Payer Digest will help you better assess value, control costs, and develop business strategies. By combining insights from two predecessors—the Government Digest and the Senior Care Digest—it provides key information on the Medicare and Medicaid programs and on senior care in a single publication, both online and in print.

POTENTIAL IMPACT OF HEALTH CARE REFORM

It is nearly impossible to discuss any aspect of care without considering the potential effects of the economy and health care reform. During a July 22, 2009, press conference, President Barack Obama talked about requiring Congress to vote on recommendations by the Medicare Payment Advisory Commission (MEDPAC) to incentivize and empower important changes. He stressed that the recommendations would not change benefits but instead would change how benefits are delivered. Nonetheless, it is still unclear what shape reform will take or even how a public option might look.

Darlene M. Mednick, RPh, MBA, PhD, FAMCP, senior vice president of Strategic Business Development, Managed Markets, at CareMed Pharmaceutical Services, notes, “There are different health care reform components on the table. The government may gravitate toward initiatives modeled after those that already have been implemented—such as a Part D–like benefit.”

According to Dan Mendelson, president of Avalere Health, “What’s being proposed for health care reform sounds great, but the question remains how we will do it. It’s too early to tell what coverage might look like in a public option.” However, he says, “Controlling costs often involves saying no, and we haven’t seen the government do much of that to date.”

Derek van Amerongen, MD, MS, chief medical officer for Humana Health Plan of Ohio in Cincinnati, says, “Expect there to be a huge hit on Medicare Advantage plans and reductions in fees to private insurers. I also think we will be seeing continuing increases in Part D rates across the country, although—so far—most members are not switching plans as rates increase. This tells me that people are fairly satisfied with their plans. They are using more generics, and fewer people are hitting the donut hole where their medication costs are not covered.”

Whatever Congress ultimately approves and passes, says Dr. Mednick, do not expect a quick and painless implementation. “Think about Part D and the breadth of that program. Rolling it out was a monumental task, and the first year was incredibly confusing. Gaps and glitches had to be fixed,” she says, adding, “A broad national reform initiative would take tremendous time to get up and running; and there likely will be stops and starts and many adjustments and changes along the way.”

Dr. Mednick also stresses that beneficiary education is essential to the success of any initiative. “The number one reason people go bankrupt in this country is the cost of care. Medicare has improved access to prescription drugs, but many people often put the health plan or prescription benefit card in their wallet and throw the paperwork away. Then they find out that something is not covered, and there is a crisis. People need to be educated about their care and encouraged to manage their care and their benefits wisely and to understand how their coverage is designed,” she says.

Reform likely will create a paradigm shift for practitioners, says Winston Wong, PharmD, associate vice president of Pharmacy Management at CareFirst BlueCross BlueShield. “As pharmacists, we will have to start working with physicians and move more toward treatment pathways. For example, if we have a patient with glaucoma, we will have to work with the ophthalmologist to determine the most cost-effective treatment regimen,” he says, adding, “We need to be prepared for a paradigm shift and to focus more on treatment outcomes, quality of care, and partnerships with physicians.”
Medicare/Medicaid Data

**Medicare Penetration**

Medicare penetration grew at a similar rate in most regions (Figure 1). “It is not surprising to see penetration in areas such as West and East North Central, where there is more experience with managed care and the concept has been around longer,” says Dr. Mednick. For example, Medicare Advantage penetration is 34% in California and 41% in Oregon, where Kaiser and other managed plans have had a presence.

The enrollment numbers also probably reflect the path of Medicare beneficiaries as they retire and move to regions such as the South Atlantic, where enrollment surged in 2008 after dropping from 2006 to 2007. At the same time, Dr. Mednick says, “Some people may have decided they’re not going into a managed care plan for some reason—such as choosing supplemental insurance, going with Medicare A or B, or having good employer-provided benefits that they would lose if they went into a Medicare plan,” she says. Lower enrollment in some areas may have more to do with lack of accessibility. As Dr. Mednick explains, “There may be very few regional players, with long distances to travel to reach a network physician or hospital.”

“There always will be modest changes in these data, depending on where seniors migrate as they age and retire. In these areas, we will see increases of a few percentage points in the next years; and 10 years from now, these numbers will increase more dramatically,” says Mendelson.

Maria Martins-Lopes, MD, MS, former chief medical officer for Group Health, Inc., says consumers still have a fair amount of choice, even with preferred provider organizations (PPOs) and private fee-for-service (PFFS) plans. She notes, however, that “only time will tell if this will continue to be true” and that “if people find they can’t afford one of these plans, they will move into more affordable options.”

**Medicare Advantage Enrollment**

Medicare Advantage enrollment is rising in all regions, with several areas growing by more than 2% and the western regions continuing to lead (Figure 2). “The Medicare Advantage environment keeps increasing because supplemental and gap insurance prices keep going up,” says Dr. Mednick. The numbers also reflect population shifts as seniors age and move to warmer climates. Not surprisingly, census figures show that the South has the largest senior population, at more

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**FIGURE 1**

Medicare Penetration by Region

**FIGURE 2**

Medicare Advantage Enrollment by Region
than 12 million. Even though the 65-plus population in the West is lower than in any other region, with 7 million, the Medicare Advantage enrollment is higher, says Dr. Mednick, likely because seniors in this region are accustomed to managed care and are more comfortable with the system. “It’s not surprising that the West continues to be a leader in this area,” she says. “Managed care has long been an accepted concept in this region, and seniors there are used to it.”

There always will be seniors who prefer private fee-for-service and who do not want to be in managed care plans. However, this may change as fee-for-service (FFS) costs increase and the PFFS system no longer seems affordable or practical. Enrollment numbers by plan type bear out previous data, showing a steady increase over time. The largest increases are in the PFFS plans and PPOs; national enrollment in these plan types nearly doubled between 2007 and 2008. HMOs also showed strong growth (Figure 3).

The growth in the FFS arena is expected to abate. As Dr. Mednick observes, FFS plans attracted “the wealthiest people, who have money to pay out of pocket,” yet people who lost savings, jobs, or benefits, or a combination of these, during the recent economic and Wall Street crashes—especially seniors and baby boomers—may be seeking more cost-effective alternatives. Beneficiaries are increasingly likely to do their own research. Dr. Mednick explains, “I’m a boomer, and I’ve made it a point to be incredibly informed about my choices. I do not take anything I see on TV or read in the newspaper as fact. My approach is to research. Dr. Mednick explains, “I’m a boomer, and I’ve made it a point to be incredibly informed about my choices. I do not think you will see more people looking at plan designs more carefully, and more frequently considering managed care as an option.”

The steady increase in enrollment is apt to reverse in 2010 or 2011, predicts Jack Hoadley, MD, a health policy analyst at the Georgetown University Health Policy Institute, unless Congress “simply does nothing.” Otherwise, payment rates will probably be targeted for savings. “If we see reductions in payments, this will result in decreased enrollment. PFFS will be the biggest target, and this sector could be hit hard,” says Dr. Hoadley. Mendelson agrees that Medicare Advantage will take some hits. “The government already has started reducing funding for Medicare Advantage,” he says, “and we will probably see further cuts. As Medicare Advantage rates are pushed back, it will become less profitable to offer these products.”

Whatever setting they practice in, managed care medical directors and pharmacists will be busy in the coming years. Mendelson suggests, “As economic pressure mounts, more people are likely to enroll in managed care plans. Seniors will look for products that are associated with predictability and with lower out-of-pocket costs.”

More than 60% of Medicare members are enrolled in an HMO. Although the absolute number of Medicare HMO members grew, the percentage of HMO members dropped from 66% in 2007 to 63% in 2008. The difference was picked up by PPO plans, which grew by 3 percentage points, from 8% in 2007 to 11% in 2008. PFFS plans grew by 1%, from 22% to 23%. As for prescription drug plans (PDPs), stand-alone PDPs are still the most popular (Figure 4).

Medicare Advantage plans—MA and MA-PDs—are experiencing the most growth. Stand-alone PDPs continue to be popular partly because many seniors started with these when the PDP program began in 2006, and research shows that

<table>
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<tr>
<th>REGION</th>
<th>HMO</th>
<th>PFFS</th>
<th>PPO</th>
<th>COST</th>
<th>HCPP</th>
<th>PACE</th>
<th>PSO</th>
<th>CCRC</th>
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FIGURE 3 Medicare Advantage Enrollment by Plan Type

2007

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<tr>
<th>REGION</th>
<th>HMO</th>
<th>PFFS</th>
<th>PPO</th>
<th>COST</th>
<th>HCPP</th>
<th>PACE</th>
<th>PSO</th>
<th>CCRC</th>
<th>MSA</th>
<th>TOTAL MCO</th>
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<td>53,877</td>
<td>2,380</td>
<td>1,236</td>
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HMO: Health Maintenance Organization
PFFS: Private Fee-for-Service
PPO: Preferred Provider Organization
COST: Medicare Cost (manages patient care but does not assume risk)
HCPP: Health Care Prepayment Plan
PACE: Program of All-Inclusive Care for the Elderly
PSO: Provider-Sponsored Organization
CCRC: Continuing Care Retirement Community
MSA: Medical Savings Account

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many do not make a change during open enrollment time in November of each year. Some may be satisfied with the benefit design, as the data indicate, but some are reluctant to change to a new plan that they do not understand. This uncertainty about change pertains not only to coverage and care, but also to benefit designs, says Dr. Mednick. However, enrollment numbers may change as more specialty drugs become available and seniors put more effort into understanding and evaluating benefit design, its impact, and differences in coverage.

**MEDICARE HMO UTILIZATION**

Figure 5 shows Medicare HMO utilization by plan size and tax status. “Lengths of stay reflect how sick people are, although from these data it’s hard to identify the drivers,” notes Dr. Lopes, adding, “The fact that physician encounters are staying the same or decreasing may not be a positive trend. If you tie together pharmacy and medical utilization numbers, the trends may be more meaningful. As drugs for chronic diseases begin to decline, admission rates start to rise.”

Better communication between providers and health plans could help improve these numbers. Health information technology (HIT) “should improve this level of interaction,” says Dr. Lopes. “When a patient is admitted to the hospital, his or her PCP may not even know that the person is hospitalized. And the hospital may not know what medications the patient is taking or other pertinent details about his or her history.” Dr. Lopes suggests that information technology solutions can bridge communication gaps and notes that the federal government is incentivizing the use of these approaches. “President Obama signed the American Recovery and Reinvestment Act into law, and it includes money for IT,” she says, adding that the act also includes funding for ready-to-go projects designed to foster HIT initiatives and innovations in care coordination through technology. Technology is important, Dr. Lopes notes, because it provides ways for practitioners and others to be proactive about health care and prevention. “This is the new paradigm shift,” she says.

**FIGURE 4**

Prescription Drug Plan Enrollment

**FIGURE 5**

Medicare HMO Average Utilization by Plan Size and Tax Status*

**UTILIZATION BY HMO PLAN SIZE (ONLY HMOS WITH MEDICARE ENROLLEES)**

<table>
<thead>
<tr>
<th>Medicare HMO Members per Plan</th>
<th>&lt;2,000 Members</th>
<th>2,000–9,999 Members</th>
<th>10,000 Members or More</th>
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<td>1,273.8</td>
<td>1,368.5</td>
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<tr>
<td>Medicare hospital admissions per 1000 members</td>
<td>207.9</td>
<td>238.1</td>
<td>240.2</td>
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<tr>
<td>Medicare ALOS per hospital admission</td>
<td>6.2</td>
<td>5.5</td>
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<tr>
<td>Medicare physician encounters per member</td>
<td>8.5</td>
<td>9.3</td>
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<td>Medicare ambulatory visits per member</td>
<td>2.3</td>
<td>3.5</td>
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**UTILIZATION BY HMO TAX STATUS (ONLY HMOS WITH MEDICARE ENROLLEES)**

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<td>Medicare physician encounters per member</td>
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<td>9.5</td>
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<td>Medicare ambulatory visits per member</td>
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*Tax status is registration of not–for–profit status with the IRS.
There is a large discrepancy between 2007 and 2008 in average Medicare hospital days. For small plans (those with under 2,000 members), average days increased sharply—by just under 100 days per year—from 1,274 in 2007 to 1,369 in 2008. In medium-size plans (those with between 2,000 and 9,999 members), the number decreased by almost exactly 100 days—from 1,415 in 2007 to 1,316 in 2008. For large plans, the average number of days rose from 1,583 to 1,628. For-profit days decreased from 1,573 to 1,527, while the average number of days for not-for-profits increased from 1,355 to 1,451 (Figure 5).

Dr. Mednick suggests that the numbers for small plans reflect growing pains to some extent. “These plans didn’t staff appropriately; they underestimated the impact that growth would mean to their current business operations, and thus faltered. They didn’t have the ability to truly manage patients, which led to increased hospital days.” By comparison, she says, “the medium-size plans likely had more formal infrastructures and were able to manage patients and keep stays shorter.”

Average length of stay dropped for small plans from 6 days in 2007 to 5.5 days in 2008, and held relatively steady for all other categories at around 6 days. “These numbers are close to national averages for hospital days,” says Mendelson. “Reductions have been driven by payment systems and less invasive technology, which enable people to get out of the hospital more quickly,” he adds (Figure 5).

Plans and practitioners will need to address readmission rates. “Medicare will not be paying for readmission for the same diagnosis within 30 days,” says Dr. Lopes. “This is a problem for hospitals, because they won’t get paid. In many areas, there are significant differences in hospital readmit rates; and preventing readmissions likely will be a growing focus for hospitals and payers,” she observes.

Average physician encounters were up for medium-size and small plans. Medium-size plans grew more, by 1.4 visits—from 7.7 encounters in 2007 to 9.1 in 2008. Small plans saw 50% declines go from 8.5 to 9.3. Large-plan physician encounters declined from 9.3 to 8.9. Not-for-profit plans saw the lowest number of encounters, up from 7.6 in 2007 to 7.9 in 2008. For-profits saw little change, down from 9.6 in 2007 to 9.5 in 2008. “The rising numbers in some categories may have to do with an increase in preventive efforts and people looking to manage problems early on. They can do this better if they have a low co-pay,” says Dr. Mednick (Figure 5).

“It is a positive sign that physician management is more intensive,” says Mendelson. The market may see more of this as the concept of the medical home becomes more prevalent. Instead of running off to the specialist, patients can go to their primary care physician as the gatekeeper. This trend will continue, and we will probably see more physician encounters, he notes.

The concept of the medical home began in some settings with accountability and rewards for frontline PCPs as a way to manage chronic care and control the use of specialty care. “You can’t do this without technology, and it requires a strong team approach,” says Dr. Lopes. She adds, “Care managers in physicians’ offices do what health plans are doing in terms of disease management and adherence to medication and treatment. And the accountable physician will handle all pieces of this. In a sense, the physician’s office likely will face the same issues as the health plan. It’s a real opportunity to work in an aligned fashion with members across the health care continuum.”

The medical home concept already has been explored in some settings. For example, a 2007 Commonwealth Fund study documented results of a survey suggesting that the medical home can help eliminate racial and ethnic disparities in health care quality and access. The report also suggested that this model improves care and the management of chronic diseases.3

Dr. Lopes has been involved in another study through a grant from the Commonwealth Fund. “We selected 52 high-volume PCP groups. We gave half the groups resources, i.e., a care manager, and the other half received a dollar amount that they could use at their discretion to secure the resources they deemed necessary,” she says. The two-year experiment got off the ground in late 2008. “Different practices are in different stages of readiness for the medical home, and this study will probably bear that out,” notes Dr. Lopes.

Ambulatory visits grew significantly in small and not-for-profit plans, dropped in medium-size plans, and otherwise remained stable (Figure 6).

### MEDICATION COSTS AND MEDICARE

Pharmacy costs as a percentage of operating costs appear largely to have stabilized in 2008 (Figure 7). Dr. Mednick attributes this stabilization in part to increased oversight and to plans putting more effort into Medication Therapy Management (MTM) programs. “Plans identified MTM as a program they need to improve upon or to modify more extensively. CMS will focus more on MTM components this coming year and will ensure that the plans have implemented this clinical program with the right intentions. In the past,
many MTM programs were simply limited to a mailed newsletter,” she says.

“Plans are starting to recognize how valuable MTM can be, and they’re starting to look at models that have worked. CMS is monitoring these plans as well. I think we’ll see more effort put into MTM in the future,” says Dr. Mednick.

At the same time, according to Dr. Lopes, there is “not a lot of opportunity to improve the effectiveness of MTM and the outcomes it generates. The goals and outcomes of MTM will be defined in the near future in a more patient-centered approach, one that can reduce fragmentation of care, improve access to care, improve member education, and reduce health care gaps.”

The association between Duane Reade pharmacies and Lab Corp, says Dr. Lopes, provides a model for effective collaboration. “This is a good example of care integration; it presents a great opportunity to bring pharmacy, member education, and compliance management together to assist in managing members with complex issues and helping members understand their diseases. Improving access and care integration is what MTM should be about,” she says.

Dr. van Amerongen views his experience with MTM as positive. “We’ve had an MTM program since the beginning—for well over two years—and we’ve been very pleased with it. When you bring pharmacists into the process, it is tremendously valuable,” he advises. He suggests that pharmacists reach out to plans and physicians “to remind them that pharmacists are there as a resource and that they are willing to advise and work with patients.”

In the meantime, CMS reissued a draft Call Letter that is likely to further the MTM agenda. According to the letter, MTM program sponsors will be required, starting in 2010, to enroll targeted beneficiaries employing a means to opt out rather than opt in, and also will be required to target beneficiaries who have a minimum of three chronic diseases, are taking a minimum of eight drugs covered by Medicare Part D, and are likely to incur costs for these Part D–covered medications exceeding $3,000 (down from $4,000).

Medicare continued to pay a rising share of drug costs in all categories. Oncology moved up two rankings and had the second highest growth of 1.8 percentage points. New to the list, HIV had the largest growth—2% (Figure 8). This is not especially surprising, as HIV is now considered a chronic condition and involves a complex cocktail of drugs that patients must take for their entire life.

The growth in osteoporosis medications may be attributed to a few factors, many having to do with education. “We’re seeing more consumer-directed education about osteoporosis. More adult children are pushing their mothers to seek bone density testing, and more women are seeing the benefit of taking calcium,” says Dr. Mednick. In this area, she adds, direct-to-consumer advertising has resulted in a huge jump in medication utilization.

The growth in Parkinson’s disease (PD) medications is not necessarily surprising. New drugs are available to treat PD, and greater awareness of the disease—due in part to advocates such as Michael J. Fox—has encouraged more people to seek diagnosis and treatment.

Randi Vogenberg, RPh, PhD, executive director of the Biologic Finance and Access Council and principal of the Institute for Integrated Healthcare, as well as a long-time managed care pharmacist, says, “These numbers reflect utilization and enrollment.” He adds, “Oncology has been trending up as treatments have become more aggressive. As for osteoporosis, this area likely is growing because of the increasing treatment options. We could be seeing the effect of new products in the marketplace for conditions such as osteoporosis and Parkinson’s disease.”

Dr. van Amerongen expressed surprise that glaucoma is so high on the list; he expected to see diabetes moving up. “I never would have expected to see osteoporosis in the top 10. I think
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this reflects consumer demand, in large part as a result of the proliferation of direct-to-consumer advertising,” he says.

Watch for further increases in medications for conditions such as osteoporosis, suggests Dr. Vogenberg. “Physicians are more likely to prescribe osteoporosis medications for 65-year-olds, since these individuals may well live to be 90. Our thought processes on prescribing are changing as people live longer and age better,” he says.

In general, Dr. Vogenberg says, “You look at all these conditions, and more attention is being paid to diagnosis now than was being paid 10 years ago. And as we see enrollment rise, medication utilization will rise as well.”

Future numbers are apt to be affected by new changes to the donut hole. Recently, the Obama administration and the pharmaceutical industry reached an agreement to cover 50% of costs during the coverage gap. It is too early to tell what impact this may have on utilization of various medications or adherence to medication regimens. However, the initiative may help encourage beneficiaries to continue their drug regimens, instead of not filling or not refilling prescriptions they cannot afford while they are in the donut hole.

The hope, says Dr. Vogenberg, is that uninterrupted drug therapy will lead to fewer hospitalizations and ED visits and, ultimately, to lower costs. He explains, “The bad economy could have a huge impact on Medicare patients, especially those with chronic conditions. If people don’t take medications and manage their conditions, costs will go up because patients will end up in the ED or in a hospital.” He adds, “We need to figure out a way to make sure people continue to take medications for chronic conditions. The tide is going against us. More people are coming into the system, and they will not be able to afford as much. And we have limited time to get the message out about the importance of not sacrificing chronic medications as a personal cost-saving strategy.”

Today’s 65-year-old Part D beneficiary will be 79 when the donut hole is eliminated under present proposals, says Mendelson. Referring to a new analysis by Avalere Health, he says, “Fewer people will fall into the gap from now until 2023, although some of the sickest beneficiaries will spend upwards of $16,000 on drugs before reaching catastrophic coverage.”

### MEDICAID

#### MEDICAID UTILIZATION

While Medicaid hospital admissions per 1,000 members went down for small plans, they increased substantially for medium-size plans (from 100 in 2007 to 108 in 2008) and moderately in large plans (from 92 in 2007 to 94 in 2008). Hospital days per 1,000 members decreased for small and medium-size plans and increased for large plans. Average length of stay remained steady except for an increase for small plans. Physician encounters and ambulatory visits remained fairly steady across the board (Figure 9).

That hospital admissions increased while physician encounters remained flat is not unanticipated. As Mendelson notes, “Many Medicaid beneficiaries will use the emergency department if they can’t get in to see the physician. And it is documented that the Medicaid population doesn’t adequately use preventive care.”

Dr. van Amerongen says, “These data tell us there is high utilization for Medicaid in particular. I tend to focus on utilization. How do we get people to pick the site of service, and how do we shift people from specialist to primary care physician visits?” He adds, “As we see more and more services shift to the ambulatory side, this will be important for controlling costs.” He notes that imaging costs are worth watching, as “these are very expensive for Medicare and Medicaid.”

Access affects physician-encounter numbers. “As Medicaid reimbursement continues to lag behind, it is increasingly dif-
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Dr. van Amerongen notes, adding that “Medicaid is the largest item in state budgets and the first target when budgets need to be cut; and that means reimbursements get cut. It’s an ongoing challenge.”

Dual eligibles are an important focus. “These beneficiaries likely are going to be high cost and have significant psychosocial issues,” says Dr. Lopes. Other key populations will include pregnant mothers and children with asthma or HIV. These Medicare populations are challenging, Dr. Lopes notes. “Not only do they not use their PCP; they often don’t even know who their PCP is, and they use the emergency room instead,” she says.

Encouraging utilization of preventive care is an ongoing challenge both for physicians and for pharmacists. Some patients have psychiatric conditions that hinder adherence, or they may be homeless or transient, which makes ongoing communication and follow-up difficult. At the same time, there may be language barriers when patients do not speak English or have limited English comprehension.

MEDICAID PHARMACY COSTS

Medicaid pharmacy costs as a percentage of total operating costs...
costs dropped by a full percentage point in 2008; large and for-profit plans led the decline (Figure 10).

Medicaid payer share of total prescriptions dispensed dropped in most drug classes from 2007 to 2008. Antipsychotics continue to lead in the ranking, although the share dropped slightly in 2008. HIV was the only drug class that posted a significant gain of nearly 1% (Figure 11).

Dr. van Amerongen notes that numbers for antipsychotics would be even higher if depression were not included in a separate category. “If you added depression to antipsychotics, this would be a huge area that would dwarf other categories. Behavioral health is so complex because of the compliance issue. It is even more of a problem because of access problems in many parts of the country. It is a real concern when you have a population with a high rate of behavioral problems and less access to services and treatments than the commercial population,” he says.

Antipsychotics, HIV drugs, and asthma medications are the top three drug classes representing the Medicaid payer share of total prescriptions dispensed for two years running (Figure 12). These numbers are not unexpected. As Dr. Vogengberg notes, “We used to have a larger mix of drugs in Medicaid, but we now are seeing fewer drugs and more generics.” At the same time, he says, “The trend for Medicaid is to act more like a commercial plan, with increased use of generics and limited formularies.” He predicts that antipsychotics and HIV and asthma medications will continue to dominate the top three spots.

Medicaid will face challenges in the coming years. Health care constitutes a huge expenditure for states, in addition to bond applications and education; all these areas are likely to experience cuts as economic recovery efforts move forward. “Medicaid enrollment is growing with economic stress,” says Mendelson, adding, “With that growth will come Medicaid utilization of all drugs, but particularly antipsychotics, HIV medications, and asthma drugs—in late 2009 and 2010. Further growth will come if reform relies on the Medicaid program to cover the uninsured.” Current Medicaid patients will not be affected much by the economy because they already have qualified for benefits.
References


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