Questioning the Widely Publicized Savings

TO THE EDITORS:

The following is a response to the commentary entitled "Questioning the Widely Publicized Savings Reported for North Carolina Medicaid" by Al Lewis, JD,[1] published in the August 2012 issue of *The American Journal of Managed Care* (*AJMC*).

Milliman was asked by the Secretary of the North Carolina Department of Health and Human Services (DHHS) to review the *AJMC* article for factual errors related to the findings of our report "Analysis of Community Care of North Carolina Cost Savings."[2] We found that most if not all references to our findings misunderstood or misrepresented the report's description of those findings.

- The article states "Milliman concluded that roughly $250,000,000 of the 2009 savings came from children's admissions and emergency department (ED) visits, presumably relative to a 2006 baseline." This is incorrect in 2 ways. First, all estimates in our report reflect the savings in all healthcare costs, not just inpatient hospital and ED care. The author later acknowledges this fact, but this leading comment is incorrect and misleading. Second, "vs the 2006 baseline" is incorrect. Our report did not use 2006 as a baseline for cost savings estimates. All savings estimates were specific to a given year, and were estimated savings relative to what costs would have been in that same year if Community Care of North Carolina (CCNC) had not been in place. Nothing in our report suggested that our results were relative to 2006 or any other year as a baseline.
- The article states: "Over the full decade (2000 to 2009), both teams of consultants claim roughly a combined reduction in admissions in excess of 50%. (The Mercer report shows a 47% reduction through 2006, while the Milliman report shows an additional 15% reduction for adults and children and 3% for the disabled since 2006…)" The reference to the Milliman report is incorrect, as is the statement about a claim by both teams of consultants.

  The percentage reductions quoted from the Milliman report are clearly identified as estimated reductions in per member per month (PMPM) total healthcare costs. They are not estimated reductions in admissions. The long parenthetical in the abbreviated quote above acknowledges that the "Milliman report does not explicitly state that the 15% comes from admissions," and goes on to argue that it can be inferred from the report that Milliman's reported PMPM savings estimates could be used as estimates for the percentage reductions in inpatient admissions due to CCNC's activities.

  The above statement goes on to say that these reductions were additional reductions since 2006. As noted above, Milliman's estimated cost savings were not relative to a 2006 baseline. They represent the estimated cost savings due to CCNC in fiscal year 2010 (FY10) relative to the estimated costs that would have occurred in FY10 if CCNC had not been in place. As a result, adding a Milliman savings percentage to prior estimates for 2006 or any other year has

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no meaning. We can't address the accuracy of the author's interpretation of the Mercer report, but if the statement "both teams of consultants claim roughly a combined reduction in admissions of 50%" is meant to imply the Milliman report included an estimate of admissions reductions, or that the estimate was relative to the level of admissions in 2006, this statement is incorrect.

- The article states that Milliman found a "savings and utilization reduction" of "$382,000,000 per year after only 3 years." Our report estimated the CCNC program saved the state $382,000,000 in Fiscal Year 2010 (July 1, 2009, to June 30, 2010). Describing the savings as "per year" might imply that this value was averaged over a period of years. Our report also estimated lower cost savings in the immediately prior fiscal years, and we did not estimate savings in later years. Also, the reference to "after only 3 years" might imply that the CCNC program has been in place for only 3 years. In fact it has been in place for many years.

The authors of the Milliman report disagree with many other comments in the article, but we have limited our points, above, to what we believe are clearly errors in the interpretation or use of our report. We take specific issue with the phrase "CCNC and its consultants" in the article's concluding paragraph, and the implication that Milliman's report was commissioned or influenced by CCNC. Milliman performed its analysis for the North Carolina Division of Medical Assistance. Our results were not influenced in any way by the North Carolina Division of Medical Assistance or CCNC.

Thank you for the opportunity to correct the record on these important points.

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Author Affiliation: Milliman, San Diego, CA.

Funding Source: None.

Author Disclosure: The manuscript subject matter is a report that Milliman provided to the North Carolina Division of Medical Assistance under a consulting contract. Mr Cosway testified to 2 committees of the North Carolina Legislature regarding the results of the reports.

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REFERENCES

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2. Cosway R, Girod C, Abbott B. Analysis of Community Care of North Carolina Cost Savings: Milliman Report for the North Carolina Division of Medical Assistance. https://www.communitycarenc.org/elements/media/files/milliman-executive-summary.pdf. Published December 15, 2011. ■

TO THE EDITORS:

The following is a response from Community Care of North Carolina to inaccuracies in the commentary entitled "Questioning the Widely Publicized Savings Reported for North Carolina Medicaid" by Al Lewis, JD,[1] published in the August 2012 issue of *The American Journal of Managed Care*.

To estimate the savings to the State achieved by Community Care of North Carolina (CCNC), the NC Division of Medical Assistance hired Milliman, Inc, to conduct an independent review of 4 years of complete Medicaid membership and claims data. Evaluating complex programs is a difficult and evolving science, but Milliman's approach to estimating CCNC's impact is reasonable, measured, and up to the latest standards in the field. Its analysis plays by the same actuarial rules as everyone else—including disease management vendors calculating a return on investment and insurance companies setting rates.

It is disturbing that Mr Lewis would question Milliman's findings based on a facile analysis of the study's Executive Summary and references to Healthcare Cost and Utilization Project (HCUP) data, a collection of publicly available databases that includes only a small portion of the claims data on which the Milliman study relied.

While HCUP data can be extremely useful to health researchers studying disease prevalence and other issues, it is limited to community hospitals, capturing inpatient stays, emergency department visits, and some ambulatory surgery visits. Finally, HCUP information is based on hospital charges (not actual prices or revenue), and therefore it is of limited value in assessing what a particular payer is actually spending on care. Through weighting and estimation, HCUP can help researchers gain a sense of cost trends in the system. However, as useful as HCUP data can be for some purposes, it is a poor substitute for detailed information on the actual costs of a particular state's Medicaid program.

Relying on HCUP data as a substitute for Medicaid claims data leads Mr Lewis to make erroneous assumptions about the scale of actual costs, and therefore, possible savings. These significant mistakes invalidate his conclusions. For example, he suggests that the universe of possible savings for care provided to children in 2009 is limited to the $114M spent on pediatric inpatient care in 2006 according to HCUP. Yet actual 2009 pediatric care costs for NC Medicaid were in fact more than $711M, 7-fold more than Lewis suggests. Lacking the actual study data, he misjudges the scale of the program, and so grossly misrepresents potential savings. A response from Milliman (see previous page) outlines some of the specific factual errors in his analysis.

Throughout Mr Lewis' analysis, we see this pattern of errors: a misstatement of a study conclusion; an erroneous

assumption about the scale of possible savings based on incomplete, dated, or incompatible data; circular references to his own claims in other papers to create the illusion of a body of supporting evidence; and finally, a rush to an unsupported conclusion that Milliman's results are "impossible." As Mr Lewis is fond of saying—the math just doesn't work out.

The reality is that modest but sustained reductions in cost trend in a $9-billion-a-year program will produce substantial savings over time. The Milliman study that Mr Lewis attacks is the third detailed report to find that CCNC's efforts are indeed effective at reducing NC Medicaid's costs. Detailed studies by industry-leading consultants Mercer and Treo Solutions—each using different approaches and methodologies—reached a similar conclusion: CCNC is helping North Carolina to rein in Medicaid costs.

It is important to note that CCNC has achieved these savings through a "quality-first" approach that is both patient- and doctor-friendly. We work to improve efficiency, reduce duplication, and enhance coordination between providers. As quality goes up, costs naturally go down. This private-sector, nonprofit approach to managing cost and quality is working for North Carolina and continues to improve every day.

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Funding Source: None.
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REFERENCE

1. Lewis A. Questioning the widely publicized savings reported for North Carolina Medicaid. *Am J Manag Care.* 2012;18(8):e277-e279. ■

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