

# Basic Health Plan Working Group

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# Overview

Data and information to support decision-making regarding Working Group questions.

## Topics:

C. Provider Access

F. Benefit Structure

H. BHP-Eligible Individuals

D. Provider Payments

Activity in other states

# C. Provider Access

## Question C1: What is the standard of network adequacy?

- ACA requirement for BHP:  
“Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers.”
- ASO contractor requirement (from RFP):  
“facilitate expansion of the CMAP provider network to support adequate client access to a complete range of provider types and specialties”

## Question C1: What is the standard of network adequacy?

- We are investigating Medicaid contract requirements regarding network adequacy for ASO, BH, Dental carve-out.

## Question C2: Is the current Medicaid network of physicians and hospitals sufficient to handle the BHP caseload, in addition to serving the increase in Medicaid beneficiaries?

- Few formal grievances regarding access

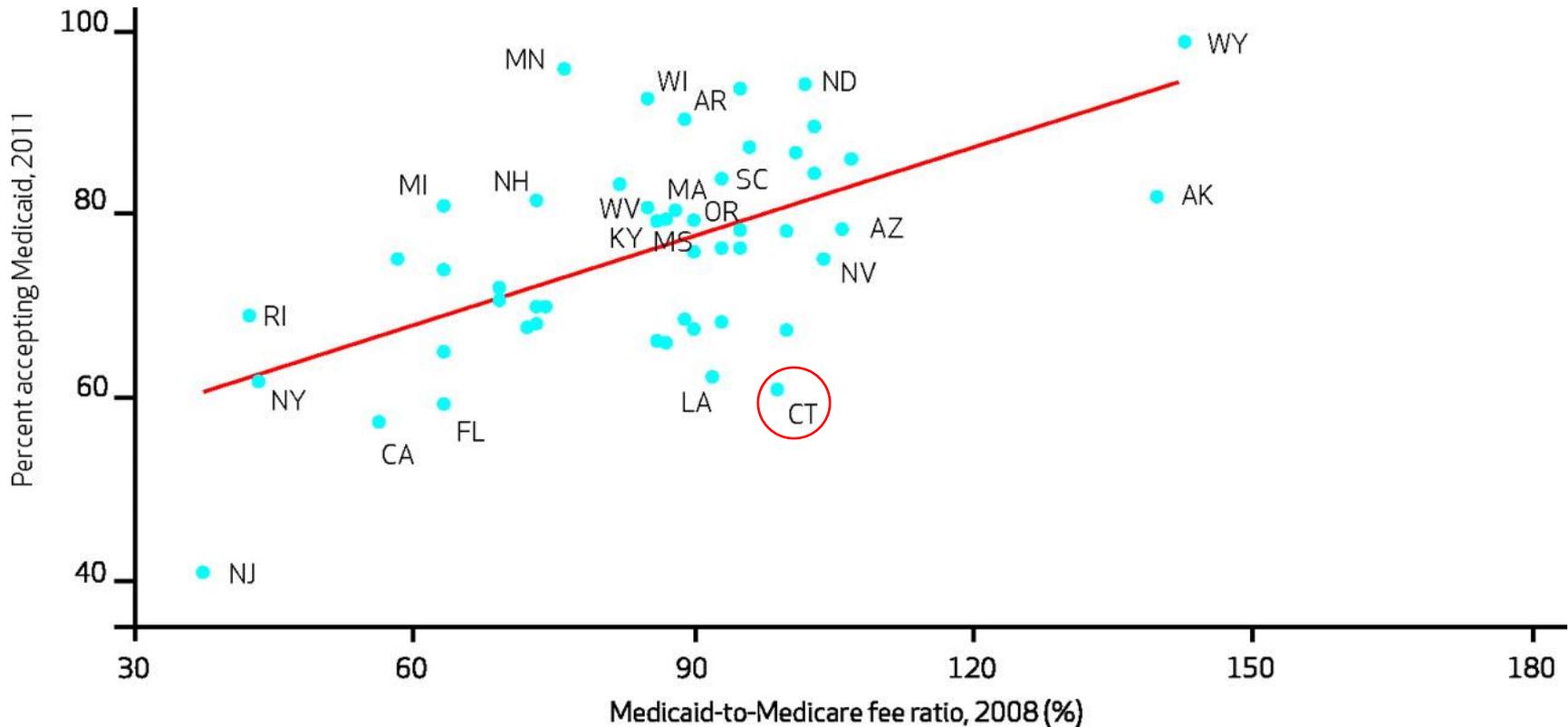
### Grievance reports, CMAPO

Grievance	1/1/12-3/31/12	4/1/12-6/30/12
<b>All access grievances</b>	<b>61</b>	<b>16</b>
No access <sup>1</sup>	47	4
Delayed access <sup>2</sup>	14	12
<b>Total grievances</b>	<b>209</b>	<b>152</b>
<b>HUSKY MM</b>	<b>1,890,544</b>	<b>1,906,318</b>

<sup>1</sup> Location, closed panel, selection, no provider in area

<sup>2</sup> Wait time to appointment

# Some evidence of office-based physicians' reluctance to accept new Medicaid patients



Source: Decker S L Health Aff 2012;31:1673-1679

# Primary care capacity

- Study\* published December 2008
  - Urban/suburban counties (Fairfield, Hartford, New Haven) have highest uninsured rates, but relatively high numbers of PCP/100,000 pop.; may be better positioned to absorb increases in coverage. CHCs and hospital clinics also important sources of care here.
  - Rural counties (Windham, Tolland, Litchfield) have lower uninsured rate (and lower absolute numbers of uninsured), but fewer PCPS, so may be less able to absorb increases in coverage.
  - “Connecticut ... has a sufficient supply of health care resources and an adequate overall supply of licenses primary care providers... However, the geographic distribution of primary care providers currently poses some challenges in rural and inner-city areas, which are likely to be exacerbated by expanded insurance coverage... Even if Connecticut is able to absorb near term increase in primary care services demand, this may not be the case in ten to fifteen years.”

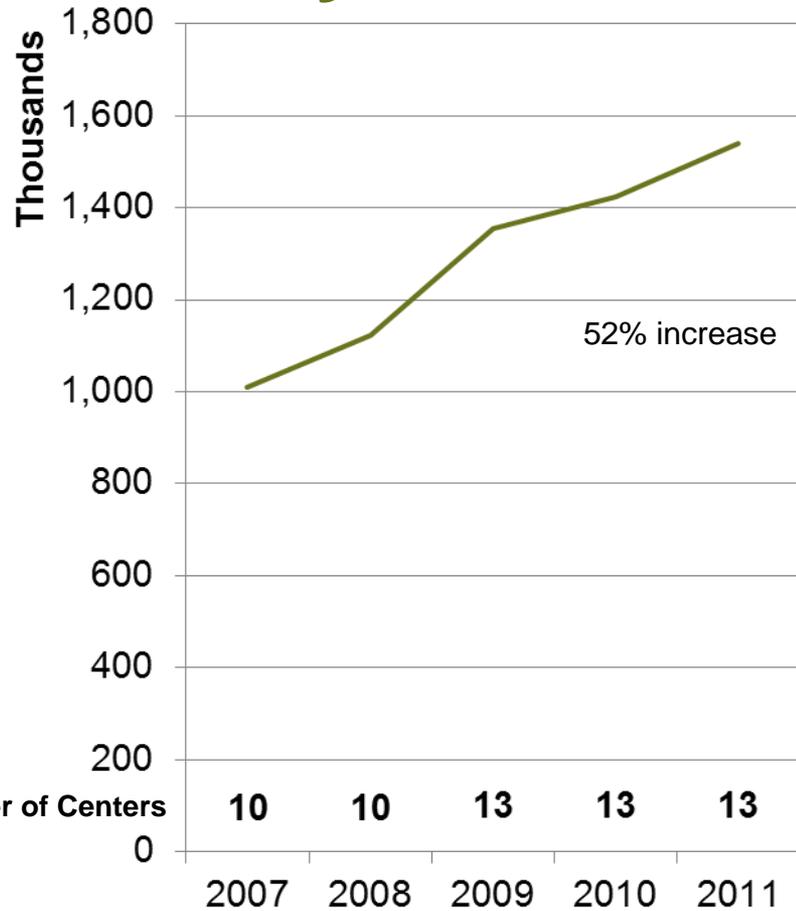
\*Center for Health Policy, University of Connecticut. *Assessment of Primary Care Capacity in Connecticut*. December 2008, revised February 2009

## Health Professional Shortage Areas (HPSA): Slightly lower need in CT than national average

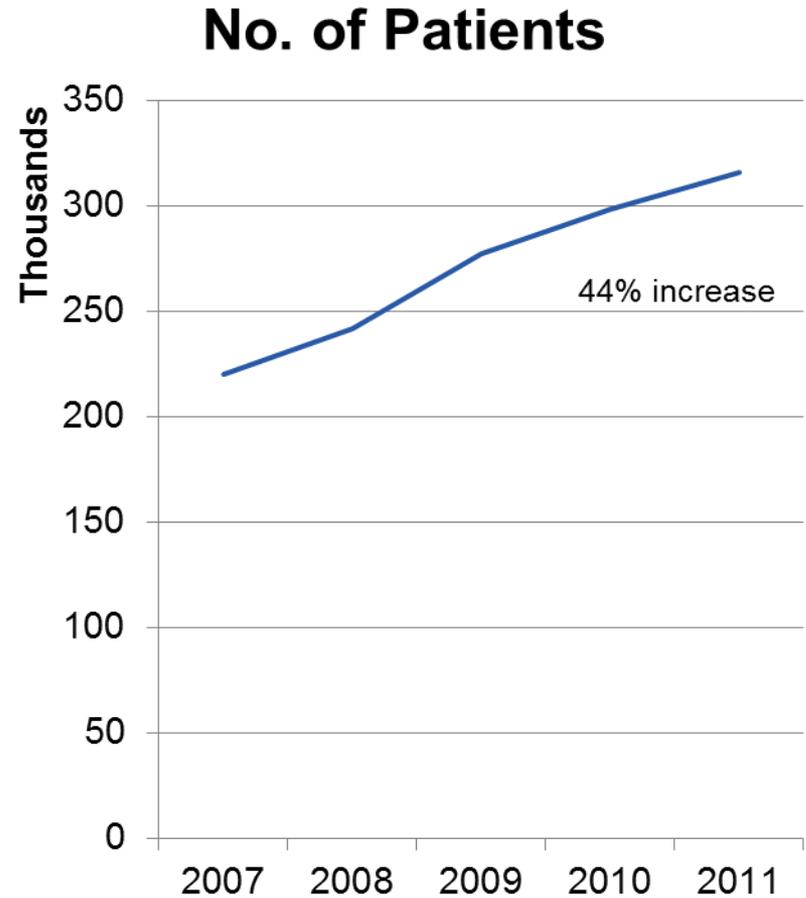
	CT	US
<b>Primary care HPSAs</b>		
Total designations	38	5,796
Est. underserved population	292,485	35,057,608
% of population underserved	8.2%	11.4%
Practitioners needed to achieve target practitioner to population ratio (2000:1)	136	16,030
<b>Dental HPSAs</b>		
Total designations	40	4,438
Est. underserved population	339,677	31,707,007
% of population underserved	9.5%	10.3%
Practitioners needed to achieve target practitioner to population ratio (3000:1)	102	9,427

Source: Kaiser statehealthfacts.org. 2012 data

# Utilization of FQHCs has increased steadily



Source: HRSA



# F. Benefit Structure

# BHP benefits – ACA requirements

BHP is required to cover:

- at least “essential health benefits.”

Essential health benefits (EHB) are the package of items and services that must be covered by individual & small group products both within and outside the Exchange

- “innovative features in the plan, including:

“(i) care coordination and care management for enrollees, especially for those with chronic health conditions;

“(ii) incentives for use of preventive services; and

“(iii) the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan.”

Source: ACA Sec.1331(b)(2) and Sec.1331(c)(2)(A)

# BHP benefits – additional options

HUSKY A offers benefits beyond EHB that could be included in a BHP, such as:

- Intensive care management
- Coordination between primary care and mental health and substance abuse services through the Behavioral Health Partnership
- Dental care and coordination through the Dental Health Partnership
- Vision testing and eyeglasses
- Hearing testing and hearing aids
- Non-emergency medical transportation

Source: ACA Sec.1331(b)(2) and Sec.1331(c)(2)(A)

# H. BHP-Eligible Individuals

# Question H1: What is the financial risk to individuals in the BHP vs. Exchange?

- Risk in BHP would be no higher, and most likely lower, than in Exchange
  - BHP premiums may not exceed Exchange premiums
  - Subsidized cost sharing in Exchange: 6% of income (up to 150% FPL), 13% of income (150-200%)
  - Mercer estimate: BHP premiums and cost sharing equal to 1% of income (at 138% FPL) and 2% of income (at 200%) would produce a margin for the state of 22% of costs
  - Therefore, BHP premiums and cost sharing significantly lower than Exchange is likely to be economically viable
  - Individuals purchasing coverage through Exchange may be at additional financial risk if income increases during the year because of year-end reconciliation of tax credits

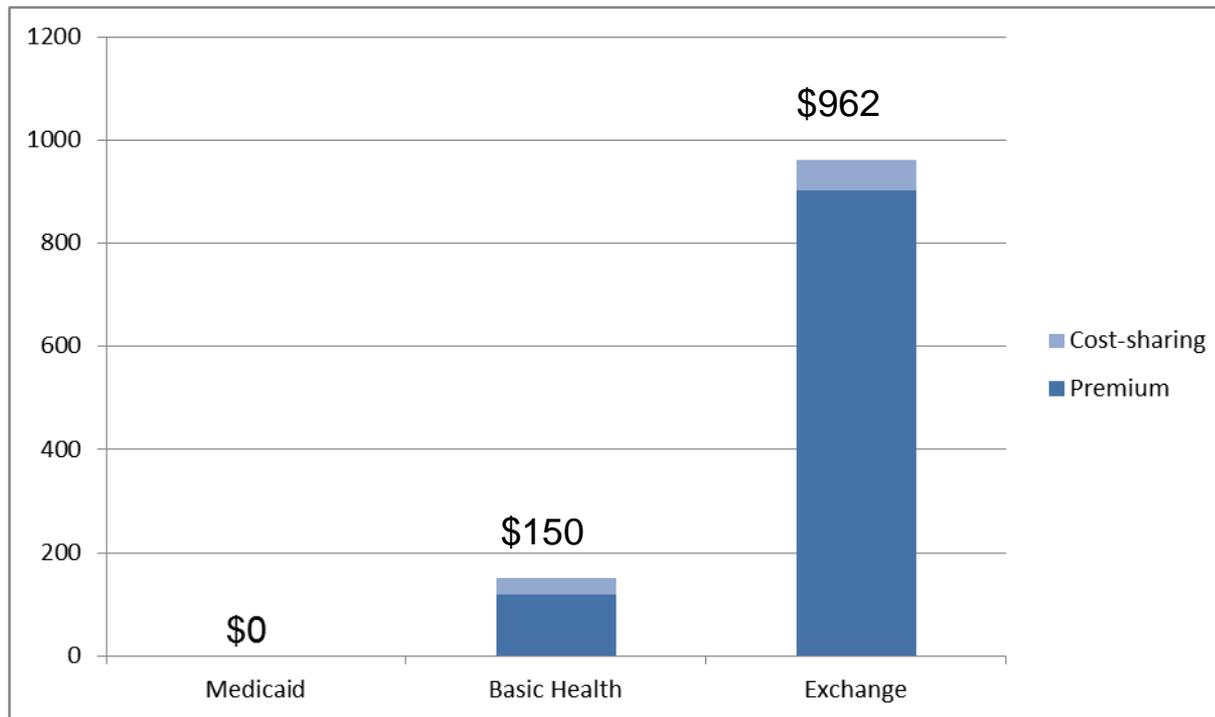
Source: ACA Sec.1331(b)(2) and Sec.1331(c)(2)(A)

## **Question H2:**

**What is the experience of care likely to be in the BHP vs. the Exchange?**

# Vignette #1

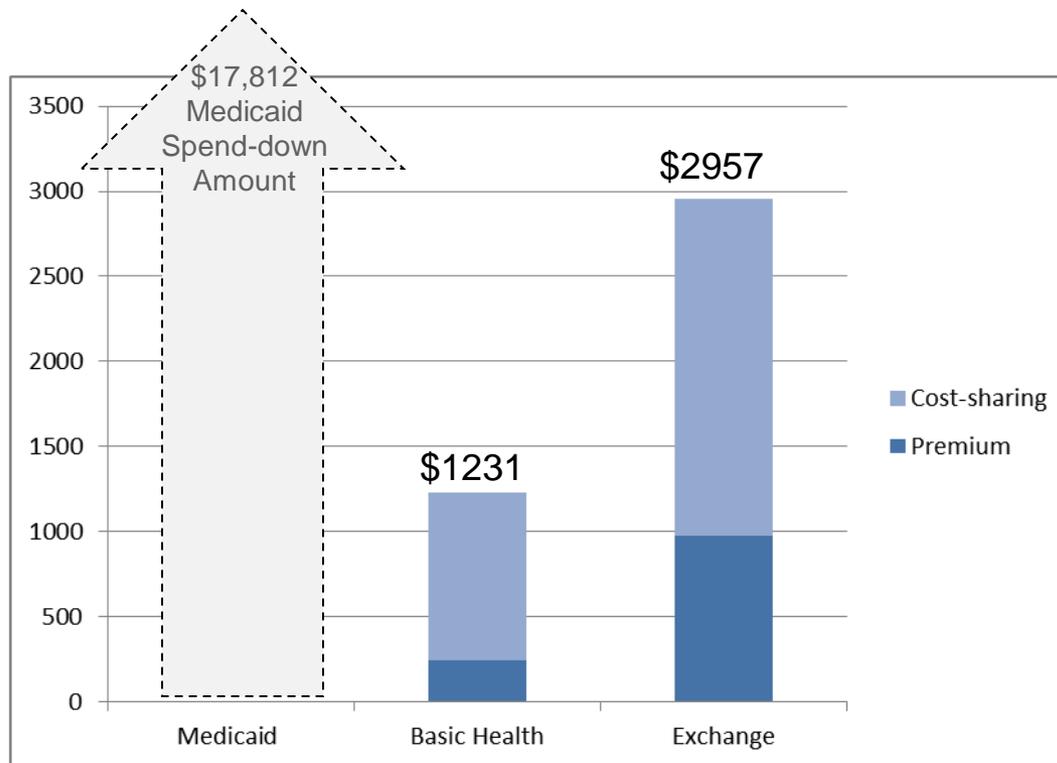
Maria is a working single mother who makes around \$24,000/year (146% FPL) in 2014. Both she and her daughter Wendy are enrolled in the HUSKY program. Maria's medical costs total about \$1,000/year. Wendy remains eligible for HUSKY in 2014.



See handout for detailed calculations

# Vignette #2

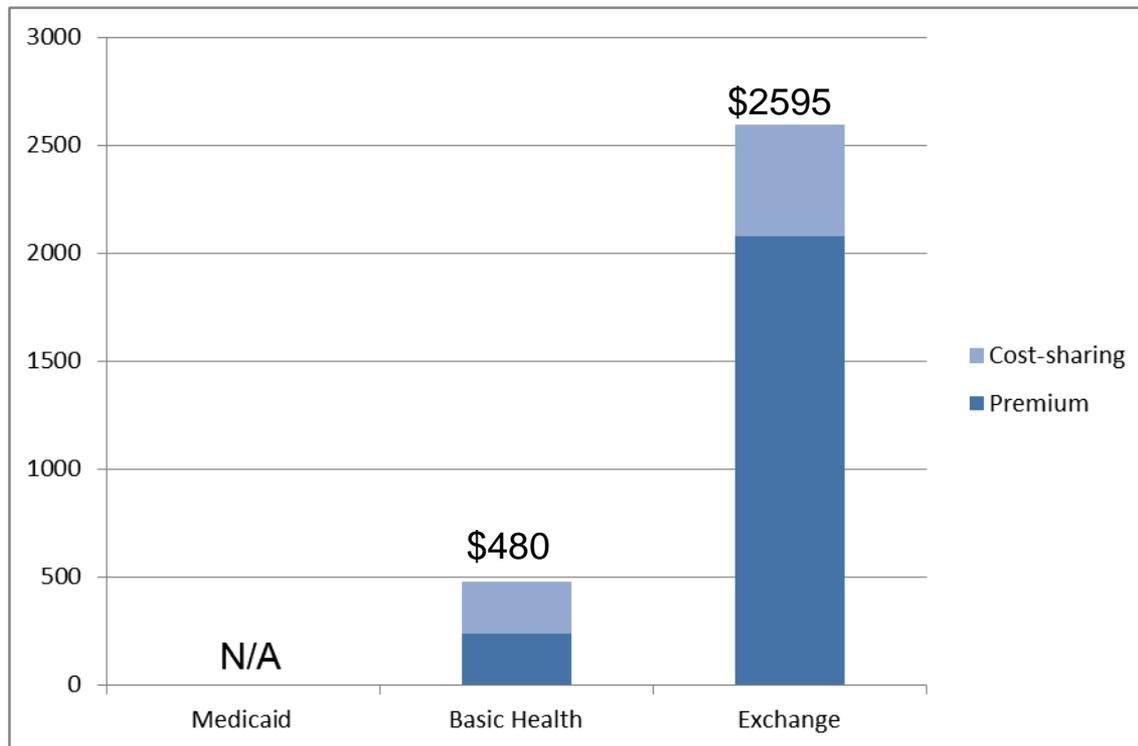
John is a young adult with high medical needs. He earns \$24,400/year (200% FPL). His medical costs are about \$17,000/year. John's level of medical spending is likely just under the amount necessary to trigger Medicaid spend-down.



See handout for detailed calculations

# Vignette #3

Susan lives with her husband. Together, they make an income of \$32,940/year (200% FPL). Susan has \$4,000/year in medical care costs. Her husband is insured through his employer.



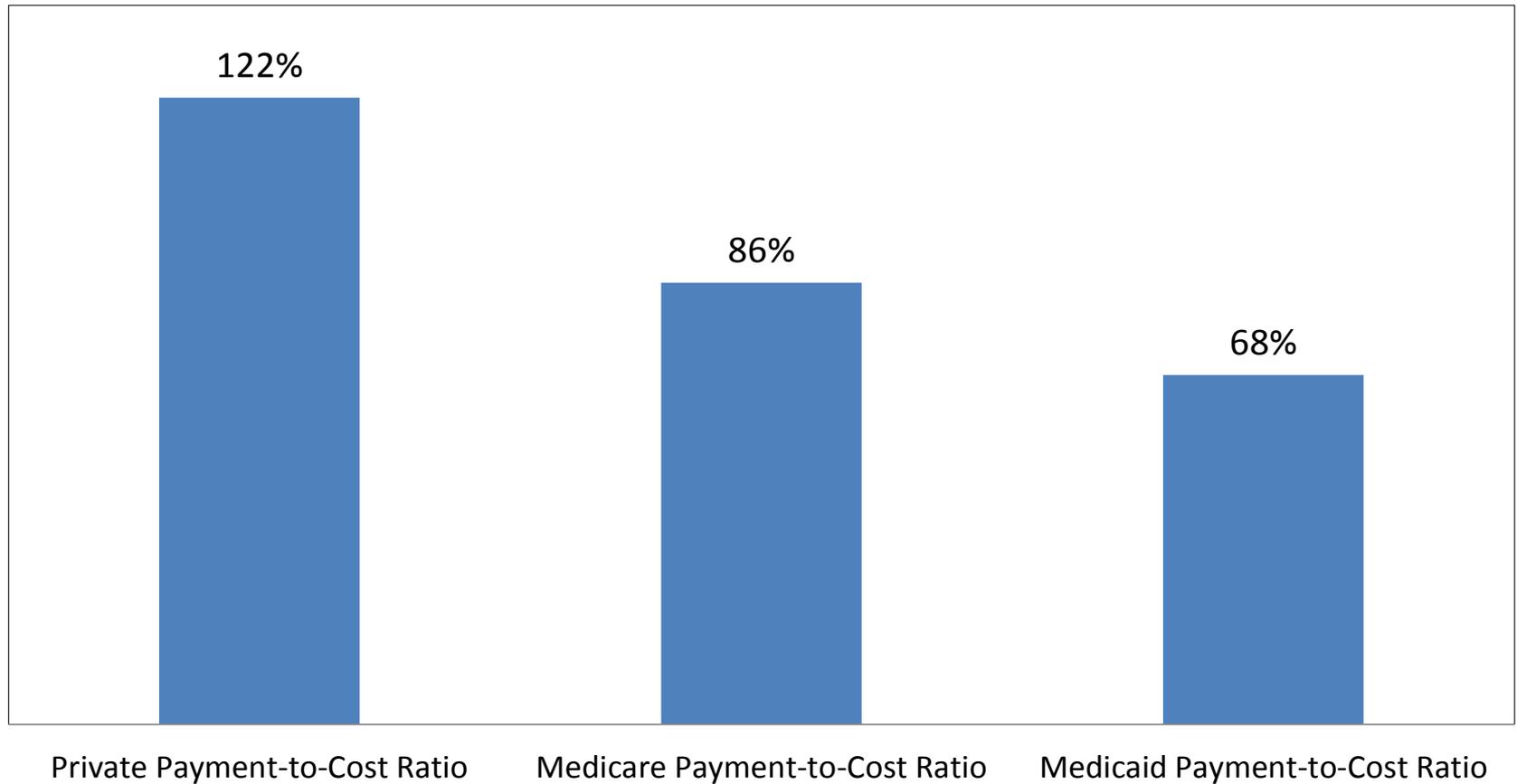
See handout for detailed calculations

# D. Provider Payments

# Question D1: Payment levels

**Working group question:** How do Medicaid provider payments compare to commercial insurers' provider payments?

## Connecticut Hospital Payment-to-Cost Ratios Statewide Median Ratios (2010)



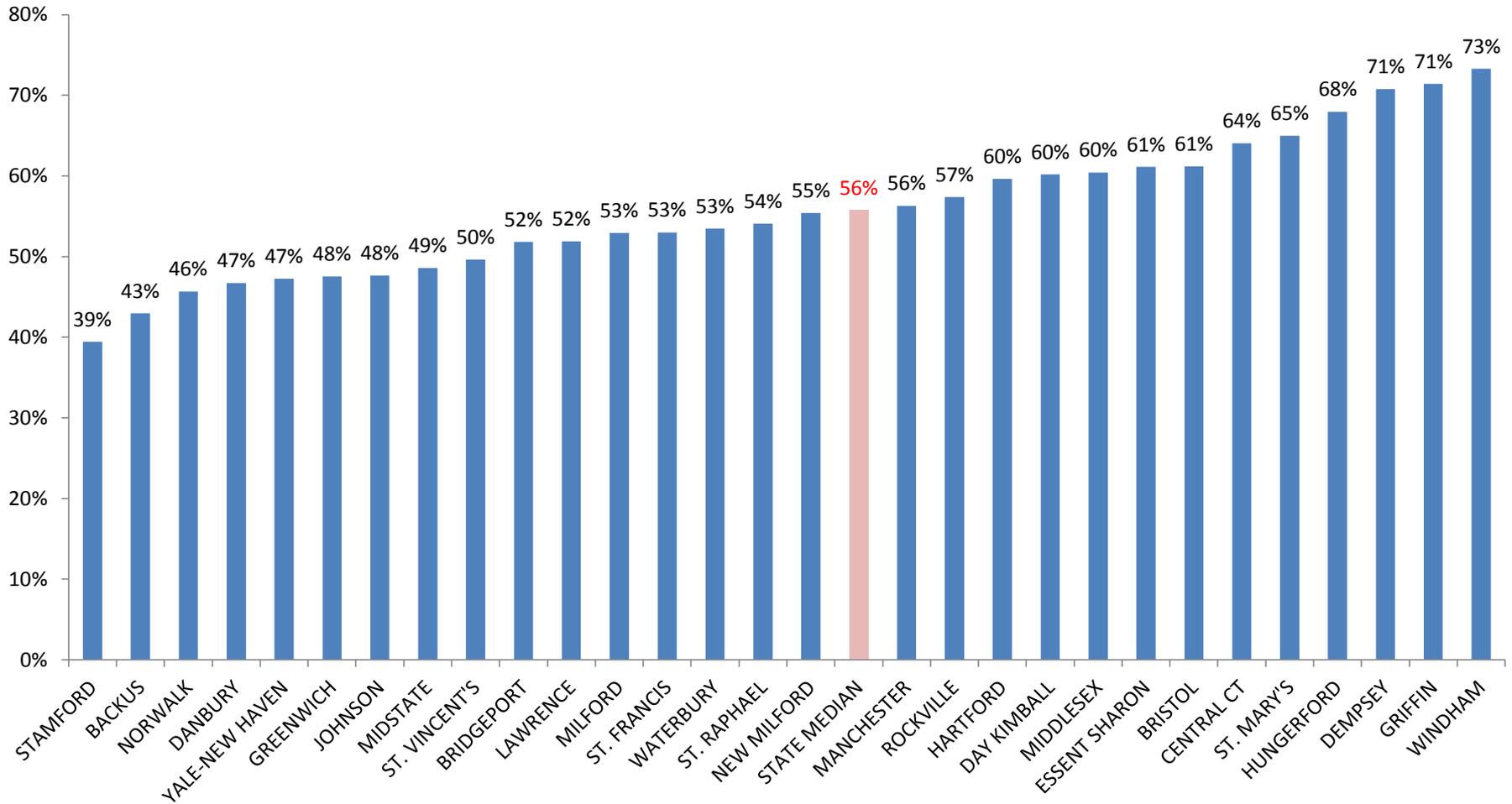
*Source: CT Department of Public Health, Office of Health Care Access, 2010 filings by hospitals*

*Note: CT Children's Hospital Excluded due to outlier data*

# Connecticut Hospital Payment-to-Cost Ratios

## Medicaid Percent of Private Rates

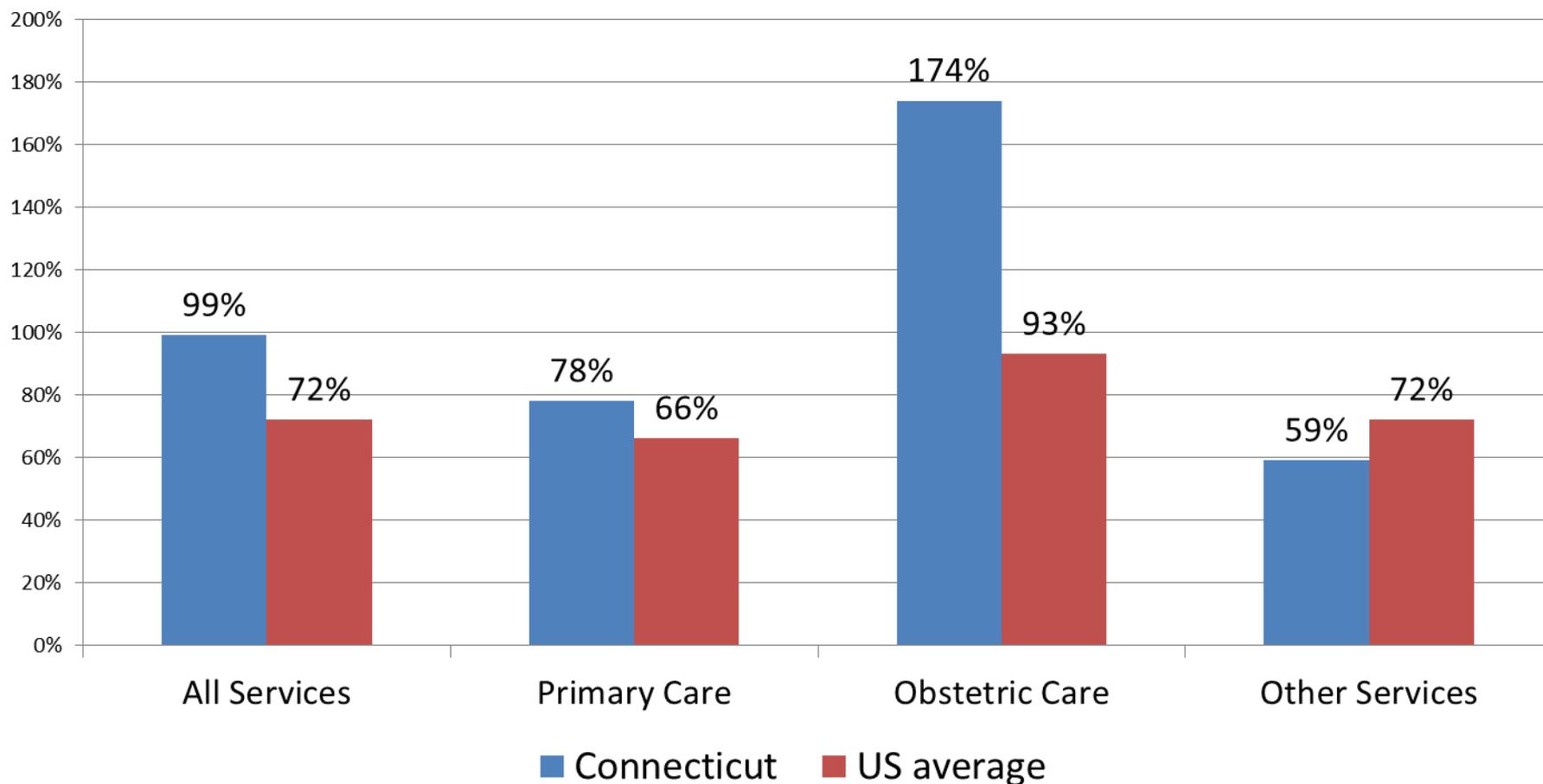
### By Hospital (2010)



Source: CT Department of Public Health, Office of Health Care Access, 2010 filings by hospitals

Note: CT Children's Hospital Excluded due to outlier data

## Medicaid Physician Fees as a Percent of Medicare Fees



Source: [www.statehealthfacts.org](http://www.statehealthfacts.org); taken from Stephen Zuckerman, Aimee Williams, and Karen Stockley, "Medicaid Physician Fees Grew By More Than 15 Percent From 2003 to 2008, Narrowing Gap With Medicare Physician Payment Rates," Health Affairs, April 2009.

# Question D2: Payment methods

**Working group question:** What payment methods and rates would best promote value and access?

# Overview of Health Care Payment Models

## Base Payment Methods

## Complementary Strategies

	Fee-for-Service	Episodic Payment	Global & Capitation	Pay-for-Performance	Shared Savings
<b>Description</b>	Payments per procedure code or diagnosis	Payments made for particular conditions, e.g. knee replacement	Payment made on pre-determined budget per patient	Additional payments for achieving quality or cost goals	Actual spending compared to baseline, provider and payers share savings
<b>Spending Incentive</b>	Encourages overutilization	Encourages economy for selected conditions	High incentive to keep costs down	Encourages longer-term savings due to improved population health	Encourages efficiency to meet savings goal
<b>Quality Incentive</b>	Minimal, no incentive to skimp on care	Encourages cost-effective care to reduce complications	Encourages cost-effective care to reduce complications	Potentially high for selected metrics, dependent on \$ bonus	In long-run, encourages high quality to reduce costs
<b>Financial risk for providers</b>	Minimal	High for selected conditions	High, requires risk-adjustment	None	None, if upside only; higher if provider assumes risk

# Episodic Payment Examples

- Prometheus
  - Payments for episodes of care using clinical guidelines
  - Payment bundle includes physician, hospital, ancillary payments
  - Pilots implemented across country, not fully evaluated
  - <http://www.hci3.org/content/what-prometheus-payment>
  
- Geisinger ProvenCare
  - Bundled payment for selected episodes
  - “Warranty”—if patient experiences avoidable complication within 90 days, follow-up care is covered by Geisinger
  - Lower readmissions, average length of stay<sup>1</sup>
  - <http://www.geisinger.org/provencare/>

<sup>1</sup><http://www.geisinger.org/provencare/numbers.html>

# Alternative Payment Examples: Global Budget

- Blue Cross of MA Alternative Quality Contract
  - Global budget
  - May be either full-risk model or shared risk model
  - Quality bonuses for both ambulatory and hospital measures
  - Includes risk adjustment
  - Initial results indicated 2.8% savings over two-years, with improvements in quality metrics<sup>1</sup>
  - <http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf>

<sup>1</sup>Z. Song et al, 'The Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending and Improved Quality, *Health Affairs*, August 2012.

# Alternative Payment Examples: Medicare

- Pioneer Accountable Care Organization (ACO)
  - 32 organizations nationally
  - First 2 years, FFS payments with shared savings and shared loss model
  - Year 3, high-performing practices will be paid capitated amounts
  - Includes quality incentives
  - <http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf>
  
- Medicare Shared Savings Program
  - 88 organizations nationally
  - FFS with shared savings and shared loss option
  - Includes quality incentives
  - <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/>

# Question D3: Effect on commercial insurance payment rates

**Working group question:** What effect will the expansion of enrollment in Medicaid and the BHP have on commercial insurance rates?

# Question D3: Effect on commercial insurance payment rates

## Study 1:

Frakt, “How much do hospitals cost shift? A review of the evidence,” The Milbank Quarterly, 89:1, 2011, pp. 90-130.

Review of existing evidence to determine “if one payer (Medicare, say) pays less relative to costs, another (a private insurer, say) will necessarily pay more.”

## Findings:

- “Although some cost shifting may result from changes in public payment policy, it is just one of many possible effects.”
- “Changes in the balance of market power between hospitals and health care plans also significantly affect private prices.”
- “To the extent that hospitals still have some unexploited market power, perhaps some cost shifting is possible, but ... it is likely to be a rate closer to twenty cents on the dollar than [a] dollar-for-dollar rate.”

# Question D3: Effect on commercial insurance payment rates

## Study 2:

Stensland, Gaumer & Miller, “Private-payer profits can induce negative Medicare margins,” Health Affairs, May 2010, pp. 2045-1051.

National study challenging the “common assumption is that hospitals have little control over their costs and must charge high rates to private health insurers when Medicare rates are lower than hospital costs.”

## Findings:

- “Hospitals with strong market power and higher private-payer and other revenues appear to have less pressure to constrain their costs. Thus, these hospitals have higher costs per unit of service, which can lead to losses on Medicare patients.”
- “Hospitals under more financial pressure—with less market share and less ability to charge higher private rates—often constrain costs and can generate profits on Medicare patients.”

# Question D3: Effect on commercial insurance payment rates

## Study 3:

Recommendations of the Special Commission on Provider Price Reform, Commonwealth of Massachusetts, November 9, 2011.

MA state law required the Commission: “to examine provider variation in relative prices, costs, volume of care, and correlations between price and quality, patient acuity, payer mix, and the provision of unique services”

## Findings:

- “This analysis indicates that a *higher* public payer mix was associated with *lower* private payer prices.” (statistically significance at p-value <0.05 level)

# Question D3: Effect on commercial insurance payment rates

## Study 4:

London, Grenier, et al, “Analysis of Price Variations in New Hampshire Hospitals” prepared for the New Hampshire Insurance Division, April 2012.

NH state law required NHID to determine whether variations in commercial prices correlate with the relative proportion of patients on Medicare or Medicaid or uninsured.

## Findings:

- a *higher* Medicare mix was associated with *higher* commercial prices
- *Higher* Medicaid inpatient utilizations was associated with *lower* commercial prices (no outpatient relationship)
- No relationship between uninsured charges and commercial prices
- “Hospitals with a higher public payer mix likely utilize a variety of strategies to compensate for lower public prices, including accepting reduced margins or reducing their costs.”

# Activity in other states

# New York

- NY Health Benefit Exchange is seeking input from its Regional Advisory Committees on the Basic Health Plan option during meetings Sept 13-25, 2012. This is the summary that the NY HBX provided for their RACs:
- Urban Institute Findings:
  - Estimated enrollment: 468,000
  - Exchange size declines from 1.1 million to 820,000
  - Advantages: potential for \$600 million annual State savings, increased affordability for consumers, and improved continuity of coverage
  - Disadvantages: concerns about access to care because provider payment rates may be below commercial rates, potential impact on the Exchange due to adverse selection impact on premiums, reduced negotiating leverage with plans
  - Uncertainties: calculation of the federal payment is uncertain pending federal guidance

Source: New York State Health Benefit Exchange presentation available at [http://www.healthcarereform.ny.gov/health\\_insurance\\_exchange/docs/2012-09\\_rac\\_meeting\\_presentation.pdf](http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/2012-09_rac_meeting_presentation.pdf)

## Other New England states

- Massachusetts: Developing BHP pursuant to authorization in FY13 budget; to be administered by MassHealth (Office of Medicaid)
- Vermont: Decided not to pursue BHP; does not fit state's large vision for single payer

## Other states

- California: SB 703 introduced but not passed in last session
    - Concerns about provider rates and viability of Exchange
    - Gov. Brown plans to call special session in Dec. or Jan. to deal with ACA issues
- “... many important issues and questions cannot be addressed or answered without further guidance from the federal government and additional analysis to understand the interrelationship of the decisions we must make.”*