

Basic Health Plan Working Group

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Overview

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

Topics:

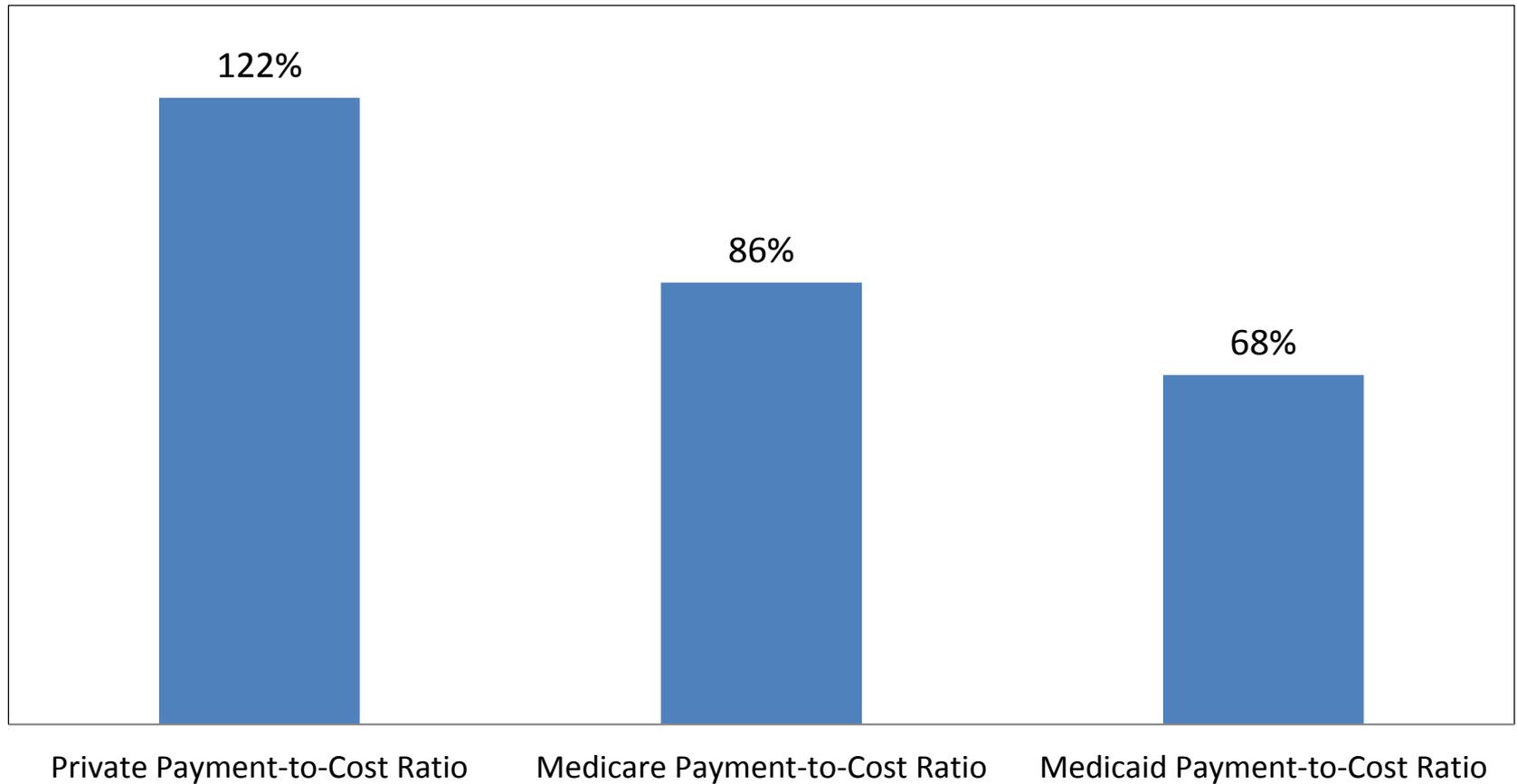
D. Provider Payments
Activity in other states

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)



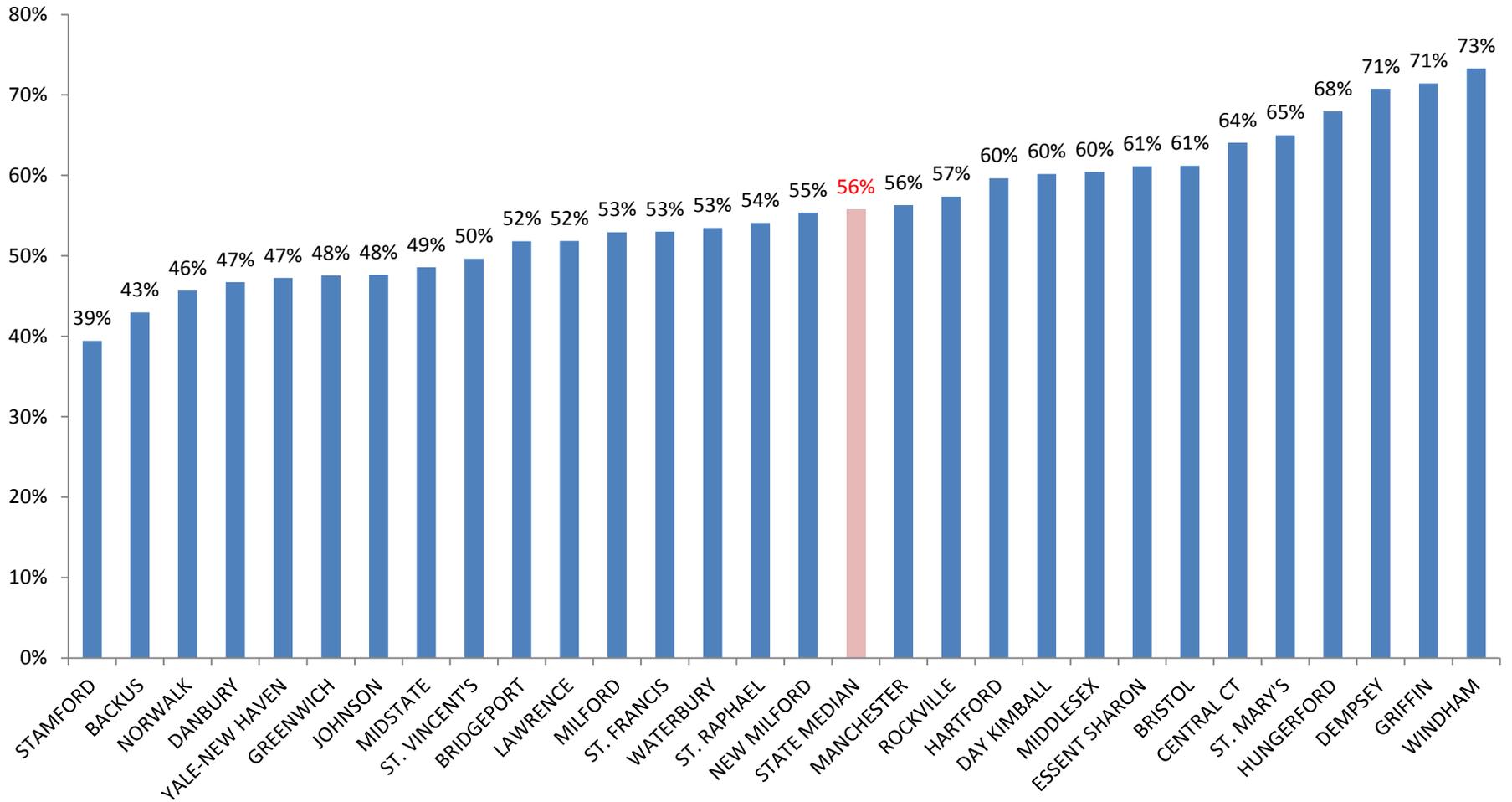
Source: CT Department of Public Health, Office of Health Care Access, 2010 filings by hospitals

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

Connecticut Hospital Payment-to-Cost Ratios

Medicaid Percent of Private Rates

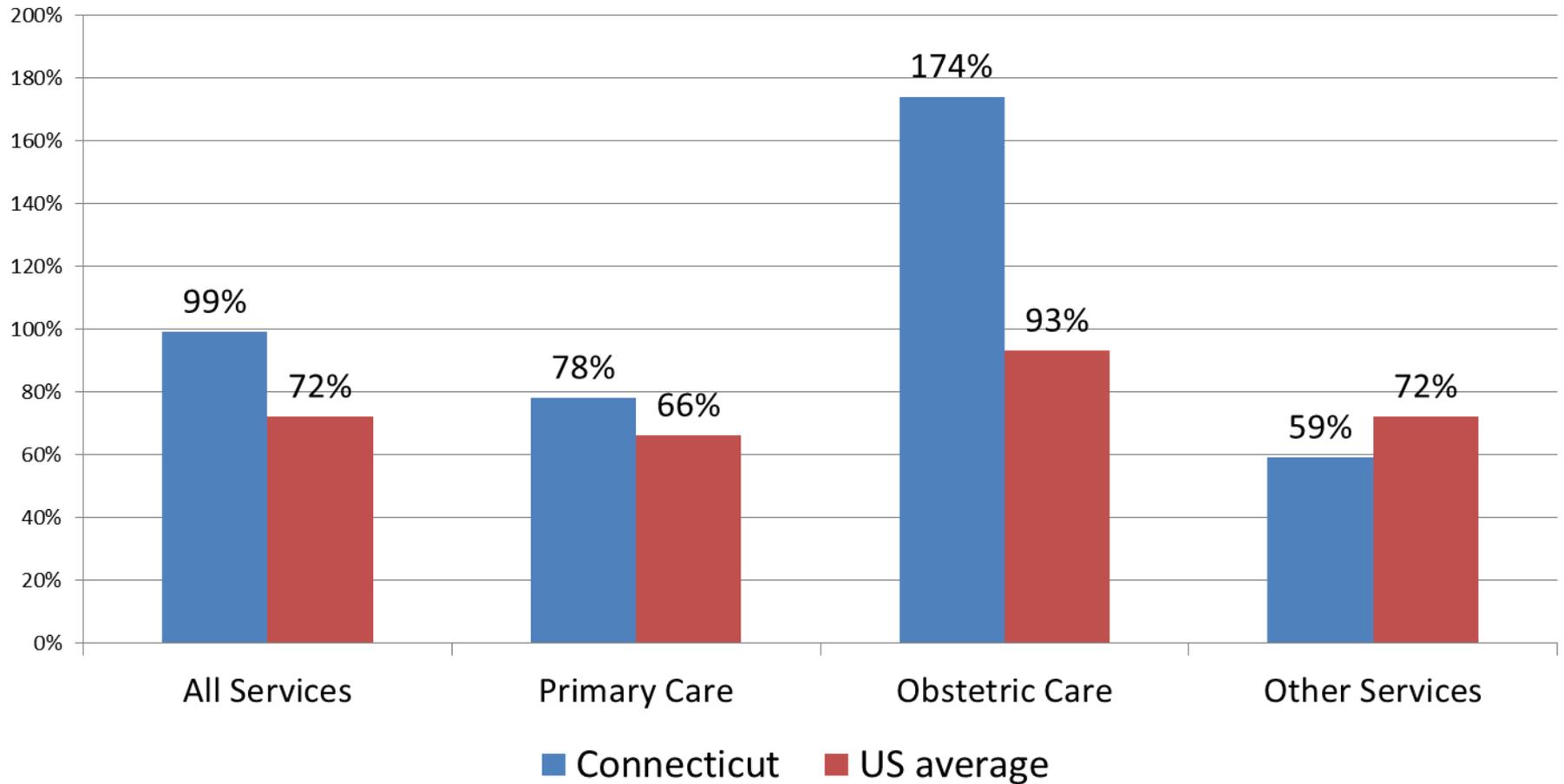
By Hospital (2010)



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; 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
Description	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
Spending Incentive	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
Quality Incentive	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
Financial risk for providers	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 stay¹
 - <http://www.geisinger.org/provencare/>

¹<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 metrics¹
 - <http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf>

¹Z. 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.”

BHP Activity in other states

Other states

- *Calls/meetings scheduled with Medicaid officials tasked with implementing a Basic Health Program in Washington, Massachusetts, Rhode Island*
- *More information next month ...*