

Optional Working Session

Theme of the Week: Medicaid Payment Methodologies

May 27, 2015

7:30am

Attendees: Rebecca Kislak, John Andrews, Patrice Cooper, Linda Katz, Rick Jacobsen, Tom Pearson, Mark Adelman, Paco Trilla, Lauren Lapolla, Sam Marullo, Matthew Harvey, Chris Sternod, Holly Cekala, Mat Trimble, Chuck Jones, Elizabeth Burke Bryant, Peter Andruszkiewicz, Secretary Roberts, Dennis Keefe, Ira Wilson

Meeting Notes

- I. Secretary Roberts welcomed folks and thanked them for attending and making the time today, when they will be meeting later today as well. These are focus areas that need additional discussion, and more attention than the full working group schedule can allow, thus these additional optional open meetings were set up. Dr. Wilson also welcomed members and reminded everyone that this is a key two-way conversation, thus please give us all your feedback where we can. Dennis Keefe joined in the welcome, and noted that these are to be educational and informative, but also vehicles to foster discussion to long term plan development.

- II. Payment Methodologies (presentation available upon request)

- a. Comments/Questions:

Matt Trimble: So on these first few slides, you are saying that the Medicaid rates paid to hospitals are similar to the Medicaid rates?

Tom Pearson: Slightly above in the aggregate.

Dennis Keefe: A lot of the data here is 2012, will vary throughout, but what I say I believe applies to the MCO plans. Around 2013 the Office of the Health Insurance Commissioner (OHIC) enacted new regulations that really govern negotiations between health plans and providers, such that no agreement may exceed the Medicare hospital price index plus 1%. There is a cap now on those agreements.

Patrice Cooper: The OHIC regulations do apply mostly to commercial insurers; those do not apply necessarily to Medicaid.

Dennis Keefe: Right, but I am talking in themes and similarities.

Matthew Harvey: On the Medicaid side there is Article 20, the Market Basket controlled. Changed each year.

Secretary Roberts: Is that fairly comparable over all?

Rick Jacobsen: Yes.

Linda Katz: Also there are populations that are not in Managed Care and there is a third party payer. 77% of all the people in Medicaid are

in managed care, and thus served by one of two plans.

Rick Jacobsen: For kids and families, RIte Care, 100% of that population is in managed care, except for two: one is third party coverage (i.e. RIte Share), Medicaid eligible folks who have some access to commercial coverage. We then pay for the individual share of the employer sponsored coverage. There are several hundred people in there that we do not enroll in managed care as there is a third party payer. Another is Children with Special Healthcare Needs, Katie Beckett, substitute care – those are mandatory enrolled in managed care except in instances where there is a third party payer. On the adult side have Medicaid only, and then duals. The former are enrolled in one of three places: NHP, United, Connect Care Choice. With duals, about 75% of spend for duals is on LTSS related care. Always been in FFS system until November 2013. RI has a high percentage of population in nursing homes who have low levels of need. In November 2013 we began to move folks into Managed Care through Rhody Health Options. Discussion through ICI to have a three way joint contract to try to create a program that better integrates Medicare and Medicaid services. We have about 60K enrolled in managed care through the expansion population.

Secretary Roberts: Rates – It is unclear to me what we are paying in some areas of non-hospital based services, i.e. substance abuse treatment programs. Is the issue reimbursement rates, or capacity?

Paco Trilla: One thing about the info we are hearing, FFS is a small portion. NHP pays more for certain procedures than the average, another discussion we should have at some point. Re: Your question on substance abuse we agree there is trouble with access, we could try to engage with the providers directly. There are opportunities to adjust pricing, i.e. with alternative pain management programs, but would want to underscore that FFS is small.

Rick Jacobsen: One note is that there are performance requirements in our contracts with MCOs. To be honest we do not have that same thing in FFS, not the same kind of oversight or accountability.

Patrice Cooper: Access and quality. Pushback has been though BHDDH services. That is something that hasn't been a part of EOHHS world until last year – has a bit of its own world.

Linda Katz: Also dental care as an example.

Rick Jacobsen: Dental FFS rates are early minted from early 90s.

Patrice Cooper: United did go out and create a program, for kids, but did have to go raise the rates.

Matthew Harvey: On slide 5, one of the ways achieved that negative trend in PMPM was programmatic and also put the thumb on the rate scale, but I am curious what the impact has been for MCOs and

providers? We know what we pay on FFS, we know less about what is being paid/structure of payments on managed care side.

Elizabeth Roberts: We are interested in what the structures are?

Patrice Cooper: Pharmacy is a big driver. I would say that is a third big chunk area for cost management.

Linda Katz: Some of the trend is utilization based; some is based on rate cuts.

Paco Trilla: I think it is important to point to the complexity around Medicaid. Having the downward pressure on hospitals, on payers is important. All of those pieces, high-risk programs, all indicate a health Medicaid managed care environment, but it doesn't mean it isn't ready for reform. I am a bit struck by how well commercial plans have done on managing costs. I would like for NHP to share, since we have some of the hospitals here, useful to have transparency in this process.

Secretary Roberts: On slide 7 re: hospitals: If the budget goes through next week with a rate cut to hospitals, how will this change this chart. When is it that we actually have a say, and when is it that the MCO has a say?

Rick Jacobsen: My understanding, from what happened in article 20, these are the rates from this date, and when that would change, and the next year by market basket.

Patrice Cooper: You include that reduction in our rate setting. Our cap goes down.

Secretary Roberts: Yes, but do you have the authority...?

Patrice Cooper: We must follow any regulations, so those then allow us to make adjustments based on regulations, a pass-through negotiation of sorts.

Matt Harvey: Given what article 20 did, and what we are about to do, to what extent is that frozen or impacted?

Paco Trilla: I say this is the opportunity for payment reform. For instance, many think procedures are overvalued. I think that incentives are key, there are other areas that we can work with. Much of this is important to have a dialogue to keep it open, and sometimes it is about the details.

Dennis Keefe: And this is where you get into some difficult conversations. Some areas are overvalued, overpaid, whereas others are under. Balancing and understanding that, in a transparent way, is very important. Don't want to cherry pick certain areas.

Patrice Cooper: Then think in a way to understand statutes within ACOs – makes one's head spin a bit.

Dennis Keefe: To be determined.

Linda Katz: DSRIP will happen or may not happen and there may be something else. Looking at the rates, building a piece back in, is that a

part of the negotiation about the incentive period?

Secretary Roberts: The goal is to create the metrics this year, in a multi-participant discussion.

Peter Andruszkiewicz: The DSRIP thing, in NY, is around payment reform for institutional care, acute and post care, a set of institutions run together.

Elizabeth Burke Bryant: Slide 8, with the big difference between FFS rates in RI & US, is the data that you have difficulty finding seeing what happened with 77% of the spend now through MCOs, what did that do to average provider fees, or professional fees? How much did MCOs use that wiggle room, did the professional fees go up significantly?

John Andrews: We are much closer on the managed care side.

Dennis Keefe: This is one of the areas I would like to see more transparency. When talking about the payment system, talk about Medicaid specifically. At the end of the day it is all related. Going back to slide 1, when you look at that, it is fairly typical across the country, but much has changed since 2012. It had always been the case that the commercial payers make up that short fall, and you can see that is why it is 1.41 of Medicaid to cover that short fall. Continuing with the cutbacks in Medicare payments, there is pressure on the commercial payers with the OHIC regulations. Everyone is now really within 2-3% of each other with actual rates. Back in '08 rate increases for CareNE were double digits, now around 6%. A lot of the ACOs in RI do not have Medicaid patients (save children) and a lot of the reason is the rates. Get at a meaningful reform of the Emergency Rooms if we can get this population ACO access, weekend access. Health centers do a great job, but still a problem with excessive ER utilization. Many of these themes came out of health care leaders task force headed up by Senator Whitehouse.

Secretary Roberts: What is our take on the payers who do this work on our behalf – what percentage of their group is Medicaid and how to grow it?

Patrice Cooper: Coastal is about 8%, United's ACO is a bit more. The CTC and PCMH payments have dampened some of the concern around access. They do not push hard enough on the cost levers, how we move them up earlier into CTC arrangements.

Paco Trilla: About 50% of NHP patients are in CTC programs. Coastal is an important practice, not a lot of Medicare patients are at CTCs, many are small doc practices, with no one to follow. What is the model that works - large practices are hospital based. There are some differences, specifically for coastal, agree mostly children, but we are finding because we are not in the advance contract with them than we could. Need to ask if we can get into a shared value contract, in a risk-

adjusted population. A lot of detail, a lot of complexity in these discussions and really be open about what we are seeing, and we can have these conversations in RI.

Secretary Roberts: What is the pattern on expansion population in emergency room utilization?

Rick Jacobsen: Great question but I do not think we have received the data back on that yet.

Dennis Keefe: Access and hours is still very much a factor in terms over overall efficiency.

Chuck Jones: Because the Medicare ACO model has gone so far and we take that and project it onto our Medicaid ideals. It's not some of the general overall high use of Emergency Departments that raise costs in this population, but issues around substance abuse, behavioral health, homelessness. Caution about just moving that model over without seeing the root causes that make this population unique.

Elizabeth Burke Bryant: Can we use the model such as those used at your health centers, Chuck, to try to drive away from emergency room, not just high utilizer population, but those above it?

Chuck Jones: I think the most interesting work is with CMHCs, as many in the high utilizer or the group above that, is that they claim an emergency room doc as a PCP. Before we leave note that CMS has noted that RI Medicaid CHIP program is number one in the country, so a small hand for that.

Peter Andruszkiewicz: The 90:10 rule does apply in the state, for the Medicaid population. We can talk about solving access for a unique population, but at the end of the day the conclusion I come to is that it is about the payment system. Hospitals are getting cut every year, physicians are seeing cuts; trends are negative, yet we remain a high cost environment in the country – I think what is wrong with the system is our payment system. One that perhaps cuts across Medicaid, Medicare and commercial would be perhaps a step to far but one that we could look to truly achieve the reforms we need.

Dennis Keefe: That is the goal, get Medicaid expense at the same level as general CPI, or even below.

Rick Jacobsen: An alignment of payment issue though is the distribution of dollars. In some areas Medicaid is the major payer of dollars, in others the small payer. How to align all of that is key.

Secretary Roberts: The lack of transparency makes this conversation difficult. We need to know more about pharmacy, programs etc. to help us get a better handle on this in a general sense. We really want to cross an industry wide set of approaches to know what we face. For example, we have our FFS payments. If the MCOs know that there are payment problems and have the data on that, it would be helpful.

Patrice Cooper: It think that's fair, but it is also all the pieces: PCP payments, CTC payments, the bumps, where we need to be, lots of moving parts.

Secretary Roberts: I agree but what is key is to have the data to make sense of it all and make the right judgment calls for all.

Patrice Cooper: Our encounter data is much tighter, and easier to get a quicker snapshot of things.

Matthew Harvey: Ask and offer, we can do follow up on many areas in this presentation, but in order to do so we would need to know if our partners are able to provide more detailed data to put more specific things out there for what we actually pay for a given service for a given provider.

Paco Trilla: What is the inpatient rate percentage wise? For it to be valid, would need the hospitals to weigh in as well.

Dennis Keefe: What has happened over time, to me inpatient rate is less relevant than outpatient rate. I would advocate for both, perhaps pull out on inpatient and ambulatory, but do so in a way that looks at both sides.

Matthew Harvey: Perhaps an off-table e-conversation with some folks here, including the hospitals, to look at what would be paid. Look at some non-hospital stuff as well. Some professional fees data as well. Maybe over the next 24 hours send Sam and Matt some points to try to turn around to this group to have an additional discussion on - Secretary Roberts what is your take?

Secretary Roberts: To me this is important in terms of payment and access, but do not want to obsess on individual rates. More to get a sense of where we are, and the problems we have created from these structured. Where do you see the problems in the Medicaid payment structure? Quirky incentives that are not necessarily valuable to patient health.

Dennis Keefe: To me less about the rates and more about transferring the risk. Medicaid transferring risk to MCOs, then move towards ACOs and the risk may then be transferred to ACOs. I don't like to get too caught up in the rates.

Secretary Roberts: So at the next meeting we will begin the ACO, MCO conversation, and structurally where that risk lives. The current status of our risk sharing arrangement is information that may be more helpful. I think we overlapped with a behavioral health meeting this morning, we are attempting to move them off of Wednesdays, so hope to have a BH participants here, as well as telephone access.

Elizabeth Burke Bryant: Can we have staff here that does the contracting with the MCOs, so we have perspective on the evolution over time? I.e. whether some of the ACO type functions and values will

be in line.

Patrice Cooper: Constant seeping down of risk, quality, access, how much hold down, how much hold back, how to settle out against the budget.

III. Public Comment: none

IV. Adjourn