HOW STATES PRIVATIZE—AND CAN UNPRIVATIZE MEDICAID

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Lunch & Learn

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(adapted by bzpearson to be more generic-10-2022)

A brief history of privatization of public health insurance programs – Medicare, Medicaid, public employee health benefits

Why privatize?

- A lot of money flows through publicly funded healthcare programs:
  - Medicare
  - Medicaid
  - Government employee health benefits.
- Private business interests seek to tap into it.
  - Just processing claims: 2% of healthcare dollar.
  - Taking on insurance risk and managing care: 12-40% of healthcare dollar.

Private interests offer this self-serving--and false--rationale

- Government is always inefficient. Private insurance companies can manage health care to make it more cost-effective.
- Fee-for-service incentivizes doctors to deliver excessive "volume" of largely unnecessary care, and this is the major driver of excess cost in US healthcare.
- Care is "fragmented" under FFS and private health plans and integrated delivery systems can more effectively coordinate care, restrain unnecessary care, improve access, and reduce cost.
- Turning health care funding over to capitated private entities makes cost predictable, and competition and market forces will control cost.

The Affordable Care Act has accelerated privatization

- To control cost, we must “move away from FFS” with its ”volume” incentives and replace it with ”value-based payment” – shifting insurance risk onto providers of care via capitation and bundled payments,
- We can eliminate “fragmentation” and improve quality by organizing doctors and hospitals into “Accountable Care Organizations” that can accept insurance risk.
- Or have large insurance plans and hospital chains paid via capitation buy up physician practices and “integrate” them.

Evidence shows that Over-utilization is NOT the problem

- U.S. doctor visits and hospital days per capita are among the lowest among industrialized countries.
  - OECD data
- Inadequate access to appropriate care driving costly complications is a far greater problem than unnecessary care due to FFS.
- Excessive administrative cost driving much higher prices is biggest cost driver.
  - Papanicolas, Woskie, Jha. Health Care Spending in the United States and Other High-Income Countries. JAMA 03-13-18
- Exorbitant drug prices is 2nd biggest cost driver

But corporate fraud and abuse by insurance plans, HMOs, Medicare Advantage, and Medicaid Managed Care is widespread and hugely expensive

- Cherry picking and lemon dropping
- Upcoding to inflate severity of diagnoses
- Deceptive marketing
- Denial of necessary care
- Narrow networks, restricted access to care
- Slow claims processing, high rate of denials
- Meaningless “quality” metrics

UPCODING – Physician coding drives "Risk Scores"

Risk Scores Drive Medicare Advantage Payment

Healthy 76F	HCC
Baseline for age	.45
No extra codes	0
	0
	0
	0
	0
	0
	0
Risk Score = 0.45	
CMS pays MA $4,000	

Typical Coding	HCC
Baseline for age	.45
Obesity	0
Type 2 Diabetes	.104
Major Depression	0
CHF	.323
Asthma	0
Ulcer, unspecified	0
CHF*DM	.154
Risk Score = 1.03	
CMS pays MA $9,000	

Detailed Coding	HCC
Baseline for age	.45
Morbid Obesity	.273
DM w/ retinopathy	.318
MD, Sing Ep, Mild	.395
CHF, Class 3	.323
COPD	.328
Ulcer, stage 3	1.204
CHF*DM,COPD	.154, .19
Risk Score = 3.63	
CMS pays MA $32,000	

Source: https://downloads.healthcatalyst.com/wp-content/uploads/2019/04/HCC-coding.png

"Government lawsuit against Kaiser points to a massive fraud problem in Medicare" – LA Times Aug 4, 2021

- ". . allegations that the giant health plan systematically defrauded Medicare by overstating the severity of its patients' medical conditions."
- "It's industry-wide and it's of major proportions"
- "In 2013 alone, according to an audit by the GAO, Medicare overpaid Medicare Advantage providers $14.1 billion, primarily because of 'unsupported diagnoses'."
- ". . almost 10% of the payments to Medicare Advantage organizations were improper. Given that Medicare Advantage providers were paid about $290 billion last year, that means some $30 billion a year may be going astray."

Similar whistleblower lawsuits are pending or have been settled against Medicare Advantage plans run by:

- Signa
- Anthem
- Sutter
- United Health Group
- Humana
- Aetna

AND, Administrative cost can be hidden

- In 2011, after passage of the Affordable Care Act,
- Obama administration negotiated with the health insurance industry and agreed to classify “medical management” as health care, not administration, in calculating “Medical Loss Ratio.”
- “Medical management” includes anything plans do with a stated goal of assuring appropriate utilization, controlling cost, and/or improving quality of care.
- Includes administrative cost of payment reforms with these stated goals.
- All that matters is the stated goal – not the actual outcome. In fact, almost all recent innovations in “medical management” are having the opposite effect of the stated goals.

Medicaid Managed Care

3 Federally Recognized forms of Medicaid

- Original – “Unmanaged Fee-for-Service” (FFS)
- Managed Care Organizations (MCOs) –
  - 1115 waivers to contract Medicaid to private HMO health insurance plans
  - Goals: budgetary predictability, control cost, improve care coordination and quality, enable more flexible benefits, network management, and payment schemes
- Primary Care Case Management (PCCM), or “Managed Fee-for-Service”
  - State retains insurance risk
  - Extra payment to primary care doctors for care coordination
  - 1950 waivers - Interdisciplinary community programs for high-risk patients, intensive case management
  - Behavioral health support

Adoption of Medicaid Managed Care

- 11 states retain Medicaid as a fee-for-service program with the state bearing risk.
- 40 states contract at least AFDC and GA to MCOs
  - Many, including HI, have also included Aged Blind Disabled
- A few states (Oklahoma, North Carolina, Connecticut) have implemented Primary Care Case Management (PCCM) instead of MCOs.

Head-to-head comparisons:

- FFS to MCOs – increases cost, reduces MD participation & access
- FFS to PCCM – NC and OK - improved MD participation and reduced ER and hospital costs
- MCO to PCCM – OK and CT, CT reduced total cost 14% after 6 yr

Medicaid Managed Care - Outcomes

- Medicaid MCOs are very profitable –
  - $1.1B in 2013, increasing to $3.9B in 2015
  - More profit from higher-risk groups -
    - $7 per member for AFDC & GA (kids, mothers, working age adults)
    - $20 per member for ABD (aged, blind, disabled)
    - $90 per member for dual eligible (Medicare and Medicaid)
- “Ghost” physician networks – half of doctors listed in plan directories not available for appointments
- Cloudy accounting -
  - Some mix Medicaid MCO financial data with commercial plan financials
  - Gaming of “Medical Loss Ratio” (MLR)
  - Difficult for states to obtain information to effectively regulate plans or hold them accountable
  - MCOs are often a financial “black box”

Hawaii's Medicaid Experience – Managed Care Organizations (MCO's)

- Converted FFS Medicaid to MCO's - 1994, 2009
- Increased administrative hassles (and cost)
- Declining MD participation
- Worsening access problems
- Accelerated cost increase – 3% > US average 2001-2014 (most recent data)
- Worst for mental illness – 4 yr after Medicaid managed care, > half of psychiatrists dropped out, psychiatric ER and hospital costs increased 30%!!

Kaiser State Health Facts FY '90-'10, Hawaii Health Information Corp 06-26-13

Connecticut Medicaid – Replaced MCOs with PCCM in 2012

- Prior to 2012: Full-risk Medicaid Managed Care Organizations – Costs rose 45% 2008-2012.
- 2012: Eliminated Managed Care Organizations, took back insurance risk and self-insured Medicaid, enhanced funding and support for primary care (ePCCM)
  - Contracted necessary administration to Administrative Services Only (ASO) on non-risk basis, by former local managed care plan.
- 2018: MD acceptance of Medicaid up, ER usage down 25% and hospital admissions and re-admissions down 6%.
- 6 years later, per member Medicaid costs14% lower than in 2012: $706 pmpm in 2012 to $610 pmpm in 2018
- 2020: Medicaid admin costs now 2.8%, including ASO
  - compared to 15-40% for Medicaid MCOs, 12.5% for CT commercial plans

Oklahoma Medicaid – direct comparison study of MCOs with PCCM (in 2009)

- *Concurrently, OHCA issued its first report card comparing SoonerCare Choice (PCCM) with "Plus" (MCO).*
  https://www.cga.ct.gov/2009/rpt/2009-R-0216.htm

  - *The capitation was 16% higher than what these services would have cost on a fee-for-service basis.*
  - *Found the two to be similar in terms of performance and quality, leading the state to question the wisdom of paying the MCOs more.*

How are FFS or PCCM more cost-effective than Medicaid Managed Care

Focus on reducing administrative cost

- Pay independent physicians with a simplified, standardized fee-for-service fee schedule, regulated by the state.
  - Use collective negotiation to keep fee scale reasonable for all.
  - Would cost less than 2% of the healthcare dollar to administer.
- Pool hospital funds from all payers in proportion to the hospital needs of each plan's population, and pay hospitals with global operating budgets.
  - Eliminates cost-shifting among plans and "chargemaster" games
  - Eliminates billing and collections, ~15% of a hospital's budget
- Pay for capital expenditures with a separate fund allocated according to community need.
- Keep Kaiser as integrated hospital-physician group, paid with global operating budget for both hospital and physician group
  - eliminates closed-panel membership and insurance functions.

Capitation vs Budgets

- Capitation conveys insurance risk –
  - fixed payment per person with obligation to cover specified services over specified period of time
  - Opportunity to keep unspent earnings (profit) and risk of loss if more spent than capitated payment
  - Incentive to restrict care, “cherry pick” and ”lemon drop”
  - Requires risk adjustment (with increased administrative cost) to supposedly counter incentive to “cherry pick” and ”lemon drop.”
  - Risk adjustment leads to gaming of diagnoses and documentation to beat risk adjustment formulas.
- Global operating budgets do not convey risk –
  - Based on cost of operations, not opportunity for profit or loss
  - Can be adjusted with changing circumstances
  - No retained earnings – surplus goes to next year’s operating budget, losses covered by supplemental appropriations

Price controls for Pharma

- Medicare:
  - Pass national bill to allow Medicare to negotiate prices for drugs and durable medical equipment
- Medicaid:
  - Re-join interstate consortium to negotiate drug prices for Medicaid instead of having Managed Care Plans negotiate drug prices through Pharmacy Benefits Managers.
- Eliminate Pharmacy Benefits Managers
  - Every middle-man takes a cut, and they game the system.

Eliminate fiscal intermediaries for state-funded health benefits

- State pays providers of care directly, with no fiscal intermediaries
- State retains insurance risk and covers ups and downs of care costs year to year from reserve fund
- Necessary administration contracted to Administrative Services Only contractor(s) on non-risk basis:
  - Claims processing
  - Credentialing
  - Administrative support for care coordination programs
  - Quality improvement program administration
  - Customer service
- Community-based care coordination programs funded with non-risk global operating budgets

Care Coordination without full-risk health plans, HMOs, and ACOs

- Fund Care Coordination services directly by state on non-risk basis
- Community-based services for high-risk and special needs patients
- Collaborative Care Model for Psychiatric Consultation to Primary Care. Could also be used for many other specialty consults.
- Quality Improvement based on professional motivation to improve patient care, not Pay-for-Performance
- Example of Connecticut Medicaid

Goal is a universal system covering everyone

- Single-Payer most cost-effective
- "All-Payer" (Maryland) is a compromise allowing multiple payers, but with a single care delivery system
  - everyone has same benefits,
  - same provider network, and
  - providers are paid the same regardless of the source of funding for any individual patient.
  - Allows health plans to exist, but strips them of competitive insurance business model.
  - 90% of cost advantages of single-payer

Everybody In, Nobody Out!

- We won't get cost-effective health care from health plans whose business model rewards:
  - denial of care
  - avoidance of covering or paying for the sick
  - unnecessary micromanagement of care
- Single-payer or all-payer:
  - Universal coverage
  - Remove barriers to care in the most cost-effective settings
  - Keep administration simple and overhead costs low
  - Eliminate micromanagement of doctors by insurance companies
  - Stop sabotaging the expertise of doctors and driving them out of practice

Questions?

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Health plans game Medical Loss Ratio

THE AFFORDABLE CARE ACT AND MEDICAL LOSS RATIOS: NO IMPACT IN FIRST THREE YEARS

Benjamin Day, David U. Himmelstein, Michael Broder, and Steffie Woolhandler
Int. J. Health Svcs. Jan 2015

- The Patient Protection and Affordable Care Act (ACA) set limits on insurers' overhead, mandating a medical loss ratio (MLR) of at least 80 percent in the individual and small-group markets and 85 percent in the large-group market starting in 2011. In implementing the law, the Obama administration introduced new rules that changed (and inflated) how insurers calculate MLRs, distorting time trends. We used insurers' filings with the U.S. Securities and Exchange Commission to calculate the largest insurers' MLRs before and after the ACA regulations took effect, using a constant definition of MLR. MLRs averaged 83.04 percent in the three years before reform and 83.05 percent in the three years after reform. We conclude that the ACA had no impact on insurance industry overhead spending.