Next Stage Health Care System Transformation: Options for New York State

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Prepared for the

Overview

- New York State can be a leader in addressing nationwide health care system challenges
  - **High cost**
  - **Inadequate access**
  - **Poor and inequitable outcomes**
- What should New York State do next?
  - **Assessment of system change options**

National and New York Challenges

- **High costs—to individuals, governments and business**
  - US per capita cost 90% higher than other high-income country median
  - NYS per capita cost 22% higher than national average
  - Driven primarily by prices not utilization
- **Inadequate access—including inequities in insurance coverage and barriers to care**
  - US: 8.7% uninsured
  - NYS: 5.7% uninsured
  - Barriers to care: geographic, provider shortages, cultural/linguistic, access to quality care
- **Poor and inequitable outcomes of care and health status**
  - US share of adults with diabetes is 54% higher than OECD average
  - NYS diabetes rate equals US average
  - Disparities in care and outcomes by income, race, geography, and immigration status

New York's Decade of Transformation

- Significant progress on access to insurance
  - 5.7% uninsured in 2017, down from 11.9% in 2010
  - Implemented Essential Plan
- Control Medicaid costs: Medicaid Redesign Team, global cap, and new plan options
- Reform delivery system: DSRIP, NYS Patient Centered Medical Homes
- Promote provider payment evolution: Value Based Payment roadmap
- Promote health information technology: SHIN-NY, All Payer Database
- Health system consolidation

Time and Place for Next Phase

- **Inflection point**
  - Selective unwinding of ACA
  - Proposed public charge rule
  - NYS DSRIP ends in 2020
  - Federal flexibility under ACA waivers
  - Concerns about consolidation
- **Diversified NYS landscape ideal to test models**
  - NYC and upstate market variation
  - Robust social service sector
  - Large immigrant community

What's Next?

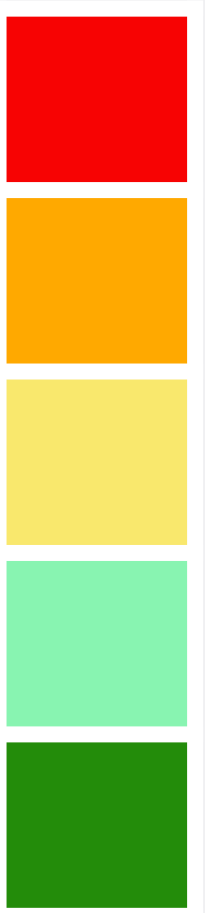
Evaluated Options for System Changes

- Focused on system changes that target cost, access, and outcomes
- Evaluated range of options drawn from states' experiences and proposed designs
- Considered options that lay groundwork for future changes

Criteria

- **Cost restraint**
  - Restraint of prices
  - Reduction in unneeded utilization
- **Increased access**
  - Access to insurance: increased coverage, reduced premiums, reduced inequity
  - Reduced barriers to care, including financial, provider scarcity
- **Improved outcomes**
  - Improved quality of care and health outcomes
  - Reduced inequity, including by income, race/ethnicity, geography, immigration status
- **Feasibility**
  - Operational feasibility: resources, federal regulatory approvals, system capacity
  - Political feasibility: acceptance by political leaders, influential stakeholders

Preliminary Assessment Scale



Negative impact/Not feasible

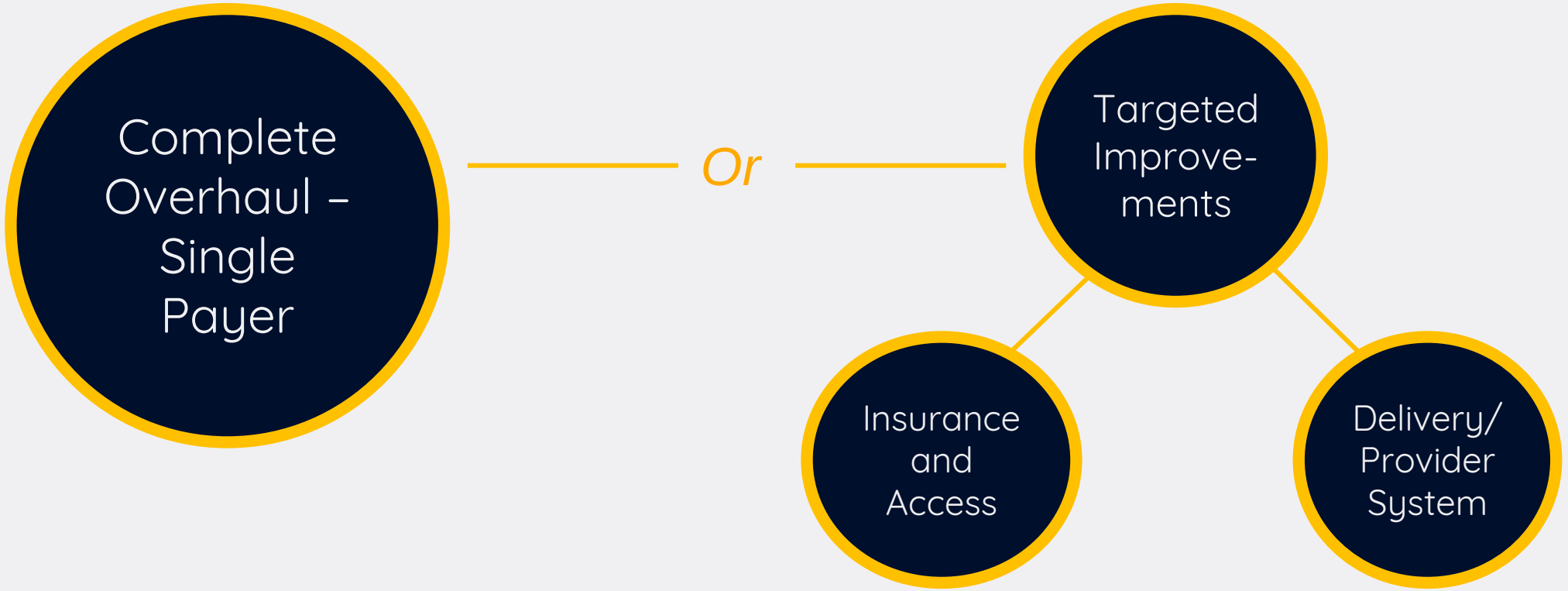
Somewhat negative impact/Feasibility unlikely

Neutral/Uncertain feasibility

Slightly positive impact/Feasibility modest

Positive impact/Feasibility likely

System Change Options



Single Payer: New York Health Act (NYHA)

- Public or quasi-public entity pays for all health care; does not define delivery system organization
- NYHA covers comprehensive benefits, excluding long term care, with no out of pocket costs
- NYHA financing
  - Federal funds now paid on behalf of and to New Yorkers for Medicaid, Medicare, ACA plans, and services for veterans
  - Current State health care funding (e.g., Medicaid)
  - New State taxes
    - Payroll tax—80% paid by employers; 20% by employees
    - Tax on non-payroll related income (e.g., capital gains, interest)

Single Payer: Assessment

Costs restrained under optimistic assumptions

- Total and per capita cost restrained **if** administrative costs significantly reduced and provider payment rates and growth lower than current average
- No control of unneeded utilization

Access may increase

- Increased access to insurance and reduced financial barriers
- Lower provider rates may reduce provider availability
- New demand may not be fully satisfied due to “congestion”

Outcomes may improve with increased access

Current feasibility is very low

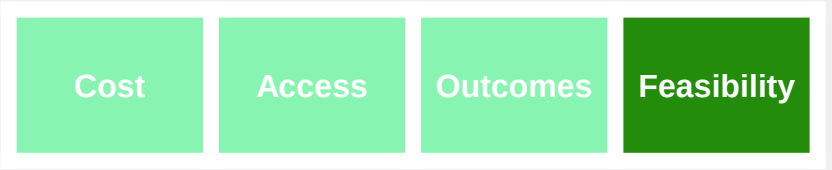
- Federal waivers not forthcoming; ERISA challenge likely
- Requires over 10 million New Yorkers to switch from private insurance
- Requires 156% tax increase (likely to adversely affect higher income groups) to shift $139 billion from individual and firm premium and direct payments to tax revenue
- Roughly 76% of State budget would be for health coverage
- Some providers will resist lower payments; objections from payers and public unions

Individual Mandate

Insurance & Access

- Establish a state mandate that individuals must have insurance
- Model penalty on ACA tax penalty or variant

Individual Mandate: Assessment



- **Costs will increase in aggregate, but will be born by affected individuals; public costs and others' premiums will decline**
  - Cost to many individuals will decline—exchange premium estimated to decline 9.9%
  - Public cost to care for uninsured will decline—estimated $411 million
- **Access will increase or be maintained**
  - Elimination of federal mandate would otherwise increase uninsured
- **Outcomes are improved or maintained**
- **Feasibility is fairly high**
  - Two states (MA and NJ) have mandates and at least 9 other states considering
  - No apparent strong stakeholder opposition
  - Operationally feasible; State can enforce through state income tax filing

Offer New Public Plan

Insurance & Access

- Create new public insurance plan (aka “public option”)
- Individuals, and perhaps groups, purchase at own expense
- Design Options:
  - Benefits: slimmed-down version of Medicaid, qualified health plan, or other
  - Eligibility: possibly limit by individual income or group size
  - Plan contracting: Managed Care Organizations (MCOs) or contract directly with providers
  - Provider payment: Medicaid or alternative rates
  - Geographic coverage: statewide or selected areas
- May provide opportunity to pilot payment reforms to test impact and feasibility

Offer New Public Plan: Assessment

Cost | Access | Outcomes | Feasibility

- **Costs may increase in aggregate, but decrease for public sector**
  - Total costs may grow with more covered
  - Public cost for uncompensated care would decline as coverage increases
  - Cost growth offset by possible downward pressure on provider rates and private plan premiums due to competition
  - Cost to individuals could be lower or higher depending on prior plan or coverage
- **Access will increase with more insured**
- **Outcomes may improve with increased coverage**
- **Feasibility uncertain**
  - Considered by 10-20 states; buy-in precedent in NYS and other jurisdictions
  - Medicaid managed care plans likely support; other plans likely oppose public plan competition
  - Providers may resist public plan rates

Expand Insurance Subsidies

Insurance & Access

- Provide full or partial state subsidy to currently ineligible individuals
  - Non-eligible immigrants
  - For those above 400% federal poverty level (FPL) with high cost premiums
- Provide greater subsidy for those with partial subsidies
  - State supplement to federal subsidy for those between 200% and 400% FPL
- Design Options:
  - For Medicaid, Essential Plan, private exchange plans and/or newly created public streamlined plan
  - Subsidy levels
  - Whether to defray both premiums and out of pocket costs

Expand Insurance Subsidies: Assessment

Costs increase due to expanded coverage

- Increase for State; decrease for individuals
- Federal funds leveraged for those between 200%-400% FPL; no match for others
- Costs depend on design; can range from $70 million to $215 million per 25,000 people covered

Access to insurance increased, including for immigrants

- Financial barriers to care for insured also decreased depending on design

Outcomes may improve with increased access

Feasibility uncertain

- Increased State spending faces competition in budget process; perhaps less so when federal funds for individuals leveraged
- Political feasibility may be affected if those with higher incomes are subsidized

Price Regulation

- State sets provider payment rates
- Design Options:
  - Scope of payers: Medicaid, public employee plans, other commercial plans and/or Medicare
  - Scope of services: hospital inpatient and outpatient, physician services, other
  - Basis of rate: relative to Medicare, average of current rates, or other
  - Set quality standards

Price Regulation: Assessment

- **Costs restrained**
  - Degree affected by rate
- **Access should be maintained, unless providers exit some markets**
- **Outcomes may improve**
  - Potential to decrease inequity
  - Potential for lower provider payments to decrease quality
- **Feasibility is low**
  - Significant resistance likely from some health care stakeholders
  - ERISA challenge likely; Medicare waiver unlikely
  - Design complications to incorporate Accountable Care Organizations, Value Based Payment
  - Precedent, but results mixed
  - If not broadly implemented, providers may exit selected markets

Enhanced Price Competition

- Implement selected maximum covered ("reference") pricing
  - Design Options:
    - Select services—focus on high cost and high cost variation services
    - Scope of payers: Medicaid, public employee plans, other commercial plans and/or Medicare
    - Set reference price rate levels: relative to Medicare, average current rates, or other
    - Set quality standards
- Transparency of provider rates for consumers and insurance plans, and out of pocket costs and bills for consumers
  - Increases leverage for patients and payers relative to large networks
- Promote administrative simplification and competition-enhancing provider/insurer contracting

Enhanced Price Competition: Assessment

Cost | Access | Outcomes | Feasibility

- **Costs would be restrained**
  - Reference pricing in California lowered costs for covered services, both through consumer selection and provider price reductions
  - Consumers may or may not make price-sensitive decisions
  - Impact of transparency uncertain
- **Access should be maintained, unless some providers exit markets**
- **Outcomes could be improved, if providers stay in market**
  - Incentives for differential services reduced
- **Feasibility is moderate**
  - Precedent for reference pricing
  - Transparency is operationally feasible; large providers may oppose
  - Contracting improvements and administrative simplification have mixed feasibility depending on design

Value Based Payment Acceleration

Delivery System

- Extend and expand NYS Value Based Payment (VBP) roadmap targets
  - Current roadmap 2020 goal: 80%-90% Medicaid managed care payments are value based and >35% include provider risk sharing
  - Design Options:
    - Magnitude of target change and duration extension
    - Continue for only Medicaid managed care or expand to public employees and/or other payers
- Require selected bundled payments
  - Design Options:
    - Scope of payers: Medicaid, public employees, other
    - Select bundles: Leverage federal models and evidence from other states
    - Set quality standards

VBP Acceleration: Assessment

- **Costs moderately restrained**
  - Evidence of cost restraint is limited
  - Taking risk is easier for large providers, but encourages consolidation which can increase costs
- **Access likely unaffected**
- **Outcomes may improve, particularly for those experiencing disparities**
  - Quality may increase with quality standards required by VBP and bundle arrangements, assuming providers stay in the market
- **Feasibility moderate for selected designs**
  - Accelerating VBP roadmap targets logistically feasible, but provider readiness and MCO acceptance are uncertain; federal waivers needed to expand payers
  - Bundled payments for selected services is feasible for Medicaid and public employee coverage

Global Provider or Geographic Budgets

Delivery System

- Allocate a hospital or multi-provider organization a fixed annual amount to care for its population
  - Pilots can test multi-payer, price competition and/or other models
- Design Options:
  - Scope of providers: all hospitals or pilot with selected hospitals/PPSs/provider collaborations
  - Scope of services: hospital inpatient and outpatient, physician services, or other
  - Scope of payers: Medicaid, public employee plans, other commercial plans and/or Medicare; can also cover uninsured
  - Population to cover: institutional attribution or geographic coverage
  - Basis for budget: historical spending, capitation accounting for relative risk, or normative rate setting and volume approach
  - Set quality standards

Global Provider or Geographic Budgets: Assessment

Costs can be restrained

- Incentives for efficiency, volume reduction, cost control
- Maryland experience: no change in spending for hospital services but decline for ambulatory spending

Access may increase with reduced provider risk of uncompensated care

Outcomes can be improved if strong quality requirements

- Potential to improve equity

Feasibility depends on design

- Mixed acceptance by some providers likely: provides flexibility to manage and transform care and simplifies administration; makes some types of growth challenging
- Medicare an important component to global budgets and federal waivers may not be feasible
- Feasibility increases if piloted in area with appropriate provider mix and concentration

Performing Provider System Next Steps

- Support select interventions to address social determinants of health
  - Support evidence-based models with positive health system return on investment
  - Support housing and social services directly; require focus on health system needs and health system partners
- Limit any future Performing Provider System (PPS) support to established, sustainable contracting and care coordination/ management structures

PPS Next Steps: Assessment

- **Costs may increase with support, but can be constrained over time**
  - Costs can be constrained to the extent coordinating care, joint contracting, and evidence-based interventions are successful
- **Access may be improved and more equitable with improvements of social determinants**
- **Outcomes may improve**
  - Coordinated care and joint contracting may improve health care quality, health outcomes, and equity
  - Successful improvement in social determinants will improve quality and equity
- **Feasibility is mixed**
  - Increased State spending faces competition in budget process
  - Lack of evidence-based interventions that address social determinants and restrain public and other costs limits impact

Behavioral Health Care Improvement

- Support evidence-based interventions to coordinate care and integrate behavioral and physical health care
  - Include evidence-based remote care where provider access is limited
- Refine Health Homes—which coordinate and manage services for those with high-needs—to better target individuals with severe mental illness
- Improve integration among NYS mental hygiene and health agencies

Behavioral Health Care Improvement: Assessment

- **Costs will rise due to increased services, but over time may be more than offset by savings in preventable care**
  - Savings may accrue to other service systems
- **Access will improve if additional services provided for those in need**
- **Outcomes may improve with effective services**
- **Feasibility is low to moderate**
  - Limited behavioral health provider capacity restrains growth
  - Increased near-term State spending faces competition in budget process
  - State organizational coordination has been a long-term challenge and not been prioritized

Do Not Pursue Options Not Currently Feasible

Do Not Pursue:	Cost	Access	Outcomes	Feasibility
Single Payer				
Expanded Insurance Subsidies for Those Earning More Than 400% of Federal Poverty Level				
Price Regulation				

Pursue Insurance and Access Improvements

	Cost	Access	Outcomes	Feasibility
Pursue:				
State Individual Mandate				
New, Low-Cost Public Plan (Targeted and Affordable)				
Explore:				
Expanded Insurance Subsidies for Non-Eligible Immigrants and Those Earning 200-400% of FPL				

Pursue Delivery System Improvements

Pursue:	Cost	Access	Outcomes	Feasibility
Reference Pricing for Select Services for State Employees				
Bundled Payments for Select Services for Medicaid and State Employee Coverage				
Social Determinants Interventions with a Proven Return on Investment				
PPS Supports for Established Care Coordination/ Management and Contracting Structures				
Better Targeting Individuals with Severe Mental Illness by Health Homes				
Evidence-based Behavioral-Physical Health Integration Models				

Explore Delivery System Improvements

Explore:	Cost	Access	Outcomes	Feasibility
Transparent Provider Rates and Out of Pocket Costs				
Administrative Simplification and Competition-Enhancing Provider/Insurer Contracting				
Geographic Global Budget Pilot for Medicaid and Uninsured, or All-Payer if Possible				

Other Challenges

- Targeted Programs (Opioids, Diabetes, Etc.)
- Prescription Drug Costs
- Long-Term Care
- Risk Adjustment
- Medicaid Rates and Primary Care Support (Impact on Access and Safety Net)
- Public Health Investments
- Provider/Workforce Availability and Practice

Conclusion

- Targeted package of insurance/access and delivery reforms is **feasible** and can:
  - **Restrain costs**
  - **Improve access**
  - **Improve outcomes and equity**
  - Lay groundwork for additional future reforms
  - Continue New York's leadership in health system transformation