Opportunities for Value-Based Insurance Design in Medicaid

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Art or Science?
Wine quality = 12.145 + 0.00117 winter rainfall + 0.0614 average growing season temperature - 0.00386 harvest rainfall
Reality Check

Years of Successive Revenue Shortfalls

- FY 2009: $340.9 million
- FY 2010: $780 million
- FY 2011: $106.8 million
- FY 2012: $251.3 million

States must balance budgets.
A $7 billion Medicaid Program delivers:

Overall Rank: 49

America’s Health Rankings

2012 47

THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

DEPARTMENT OF HEALTH AND HOSPITALS

march of dimes®
And yet?

= 10,000 people

Louisiana Medicaid under ACA

Year 1: 467K new enrollees

Almost 260,000 would have been newly eligible individuals that were previously uninsured

More than 20,000 would have been individuals currently eligible but not enrolled

Nearly 187,000 would have come from private insurance rolls
Our Opportunity Imperative

How can Government use its position as a payer to produce better value for the taxpayer dollars we invest?

By addressing **QUALITY** & **COST**.

- Move away from fee-for-service and invest in innovative payment models.
- Organize a healthy marketplace and hold it accountable for producing better outcomes.
- Provide transparency of healthcare costs and outcomes at the consumer level.
- Incent patients to utilize higher-value care by better aligning the incentives and organizing benefits.
Medicaid and VBID

• Medicaid is ripe for reallocation of resources to promote value, but significant barriers exist:
  – Rigid federal benefit design
  – Limits on cost sharing
  – Health literacy of enrollees
  – Political influence over policy decisions

• Medicaid can use VBID principles in program design, but must shift value proposition to providers and health plans more than enrollees.
For Medicaid, Value Must Drive More

Benefit

• States sometimes implement barriers to high-value benefits, often brought about by budget constraints and inability to manage utilization. Examples:
  • Prescription drug limits (LA @ 4)
  • Primary care physician limits (LA @ 12)

Network

• Medicaid is entitlement for recipients, not providers. States are often faced with political or other pressure to keep networks open.
• Allow program to value high—performing providers and keep others out.
• Give MCOs flexibility to manage network.
For Medicaid, Value Must Drive More

**Payment**
- Either directly, or through MCOs, states can use provider payments as tool to promote value. Examples:
  - Shared savings (either at provider or plan level)
  - DRGs
  - Bundled payments for episodes of care

**Health Plan**
- Medicaid best equipped as purchaser of high value care.
- States can structure relationships with MCO’s to reward value. Examples:
  - Preference in auto-assignment for quality performance
  - Penalties and bonus payments for hitting or missing targets

**VALUE**
Also: The Value of Coverage

- VBID requires that plans have time to recoup costs associated with opening access to high-value services.
- Some Medicaid programs might dissuade MCOs from making investment due to churn.
- With focus on improving value, states should make case to improve reenrollment processes to prevent gaps in care.

### Louisiana’s Rate of Children lost in Annual Renewal

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>22%</td>
</tr>
<tr>
<td>Now</td>
<td>1.5%</td>
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</tbody>
</table>
VBID at Macro-Policy Level
Example: 39 Week Initiative

• VBID principle: Increase barriers to low-value or overused “preference-sensitive services”.
• In Louisiana, we observed an increasing number of non-medically indicated elective inductions before the 39th week of pregnancy. Why?
  – Convenience of scheduling
  – Discomfort of final weeks of pregnancy
• DHH worked to have every birthing hospital in state pledge to end these early induction practices.
  – Some hospitals have seen up to a 60% decrease in unnecessary deliveries before 39 weeks and significant reductions in NICU admissions (as much as 20%).
  – In one example, a Lafayette hospital went from 30% elective delivery rate before the policy change to 4% by June 2012.
VBID and ACA

- The federally mandated, top-down essential health benefit package (for which there are no current regulations) would require coverage of ten benefits.
- The law gives states and insurers little flexibility to design benefit packages that focus on the needs of an individual or similar group of individuals.

Example of Frustration: 9/27 Letter from LA: No decision on EHB.
- No formal rulemaking and insufficient guidance
- Lack of information on benchmark plans
- Lack of clear definitions of service categories

No state choice, and no federal authority to make one either.
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