



# BETTER CARE FOR MEDICAID PATIENTS: WHAT IT TAKES

## Recommendations to Strengthen Utah's Waiver Proposal

A Utah Health Policy Position Paper

June 20, 2011

### SUMMARY

The Utah Department of Health has released its much anticipated [Medicaid "waiver" proposal](#), a critical step in a multi-year process to modernize the way Medicaid services are paid for and delivered in Utah by organizing providers into *accountable care organizations*.<sup>1</sup> [ACOs](#) are groups of health care providers who agree to be held accountable for improving health care quality while lowering costs. Utah's waiver proposal needs significant changes – or more in the way of detail – before we can establish whether it is an appropriate first step in the state's transition to accountable care. For now, the June 1 waiver draft places the "accountability" squarely on the beneficiary in terms of increased cost sharing, penalties for noncompliance (i.e. disenrollment) and drawing clients into private insurance via subsidies. Nothing in the waiver seems to acknowledge the need for certain services, like care coordination, health education, transportation, etc., as necessities to help patients comply with care recommendations.

On make-or-break issues like cost sharing, access to medically necessary care, quality standards, and others, the proposal fails to reflect input from stakeholders, much less lessons from other waivers.<sup>2</sup> Much as we embrace the overall intent of [State Senate Bill B180 \(Medicaid Reform\)](#), we cannot support the waiver in its current form and offer these recommendations and requests for clarification.

### COST SHARING CHANGES (PAGES 23-25 OF THE WAIVER DOCUMENT)

The waiver proposes a cost sharing schedule more similar to CHIP's Plan B, which puts Utah's proposed Medicaid cost sharing schedule off the charts compared to other states. While inappropriate use of emergency rooms is a problem, and we agree that the co-payment schedule for this is reasonable, we are concerned with other features of the proposed cost sharing schedule. An annual per family \$40 deductible can be a great hardship for clients. Add to that the co-pays for doctor visits and prescriptions, and a family could easily be priced out of access to medically necessary care. Cost sharing at this level has been shown to decrease utilization of cost-effective care, possibly undermining the goals of accountable care.<sup>3</sup> If families cannot afford the deductible and co-payments they may delay care and be forced into the emergency room, limiting the savings that can be achieved through accountable care.

#### Recommendations:

- Assess whether the proposed co-pays (*see cost sharing schedules, next page*) are consistent with the goals of the ACO, specifically the need to move traffic out of the E.R. into prevention and primary care settings.
- Create a sliding scale or tiered co-pay schedule, acknowledging that ability to pay differs by income.
- Process co-pays like the spenddown, where out of pocket spending will count toward the deductible.
- Provide cost sharing protections for people with disabilities, seniors, and others living on fixed incomes.
- Take children with special health care needs out of the waiver entirely: these families have unusual non-medical expenses needed to address their medical conditions. Also, a medical home demonstration pilot project is already underway: this should be a given chance to work for these children.
- Giving MCOs flexibility to vary co-pays to reward certain health behaviors could place persons with chronic conditions and extensive medical needs at an inherent disadvantage. Under the proposed scheme, nothing stops the plans from using the co-pay structure to draw healthier clients to their Medicaid product, effectively cherry picking. Changes in cost sharing should guard against this scenario.

**Waiver Proposal and Current Cost Sharing Comparison Chart**

Proposal Benefits (Per Plan Year)	Proposal Co-Payment	Current Utah Traditional Disability/Seniors/Kids/Pregnant	Current Utah Non-Traditional Adults (Parents)
OUT OF POCKET MAXIMUM	5% Of annual gross income	* Pharmacy \$15 per month Inpatient \$220 per year Physician and Outpatient \$100 per year combined	\$500 per calendar year per person
<b>MEDICAL BENEFITS</b>			
Deductible	\$40/Family, annually	None	None
Well Child Exams	\$0	None	None
Immunizations	\$0	None	None
Doctor Visits	\$5	*Outpatient - \$3 co-pay Office visit - \$3 co-pay per visit - <i>No copay for preventative care or immunizations</i>	Outpatient - \$3 co-pay Office visit - \$3 co-pay per visit - <i>No copay for preventative care or immunizations</i>
Specialist Visits	\$5	Not specified	Not specified
Emergency Room	\$15 per visit for an emergency and \$25 per visit for non-emergency	No copay. \$6 co-pay for non-emergency use of the ER.	No copay. \$6 co-pay for non-emergency use of the ER.
Ambulance	5% of approved amount after deductible	Not specified	Not specified
Urgent Care Center	\$5	Not specified	Not specified
Ambulatory Surgical & Outpatient Hospital	5% of approved after deductible		
Inpatient Hospital Services	\$220 after deductible	\$220 co-pay yearly for non-emergency stays	\$220 co-pay each non-emergency stay

Lab and X-Ray	\$0 for minor diagnostic tests and x-rays; 5% of approved amount after deductible for major diagnostic tests and x-rays	No copay	No copay
Surgeon	5% of approved amount	Not specified	Not specified
Anesthesiologist	5% of approved amount	Not specified	Not specified
Prescriptions -Preferred Generic -Preferred Brand Names -Non-Preferred Drugs	\$5 5% of amount 10% of amount	*\$3 co-pay per prescription limited to \$15 monthly <i>Limited over-the-counter drug coverage</i>	*\$3 co-pay per prescription limited to \$15 monthly <i>Limited over-the-counter drug coverage</i>
Physical Therapy	\$5	No copay	\$3 co-pay - limited to a combined 10 visits per year
Chiropractic Visits	5% of approved amount after deductible	Not specified	Not specified
Home Health and Hospice Care	5% of approved amount after deductible	Not specified	Not specified
Medical Supplies and Equipment	5% of approved amount after deductible	\$0	\$0
Diabetes Education	\$0	Not specified	Not specified
Vision Screening	\$5	Optometrist – No copay for annual eye exam Ophthalmologist - \$3.00 co-pay for annual eye exam Glasses not covered	Annual coverage limited to \$30.00 for a medically necessary eye exam <i>Glasses not covered</i>
Hearing Screening	\$5		

### Relevant Links

The waiver proposal can be found here: <http://health.utah.gov/medicaid/stplan/1115%20Waivers.htm>  
Utah Medicaid's current co-pay schedules can be found here: <http://health.utah.gov/umb/forms/pdf/adultcomp.pdf>;  
Kaiser Foundation's recent survey of 50 states shows co-pays of all 50 states: <http://www.kff.org/medicaid/upload/8130.pdf>.)

## RATIONING OF MEDICAID BENEFITS (P. 25)

The waiver proposes that for years when Medicaid spending per member exceeds general fund growth targets, benefits would be reduced on a pre-determined schedule. The state references the Oregon Medicaid program, which implements service reductions from a prioritized list of services. The 5% average savings over the life of the Oregon waiver is more the result of their shift to managed care and capitated payment methodologies and less the results of any rationing scheme. In fact, Oregon's priority list has had limited usefulness as a cost-containment tool. Rather, it has painstakingly evolved to achieve a delicate alignment with evidence-based medicine. Its Health Services Commission is guided by medical expertise to minimize wasteful expenditures and ensure access to all medically necessary care. Even disability advocates in Oregon will say that no one, not even medically fragile newborns, has gone without life sustaining care they needed. Persons with chronic conditions or disabilities are assigned to an Exceptional Needs Care Coordinator (ENCC), "angels in the system," who help clients get the care they need, above and below the priority line.<sup>4</sup>

Utah's proposal, by contrast, seems to replicate the myths or early mistakes of the Oregon Health Plan: Rationing for the sake of rationing, without a process for consulting clinical guidelines. If the proposed rationing process is anything like the mostly arbitrary process Utah has used in recent years to decide which "optional services" should be covered, then it has no place in an accountable care environment, much less in a ethical society.

### Recommendations:

- We could possibly support a priority list, but only if the process for determining what is on that list is aligned with evidence-based medicine and continuously solicits consumer input. This list must also be updated continuously to reflect changes in medical research and technology.<sup>5</sup>
- Create a Health Benefits Commission (HBC) comprised of expertise from the private and public sectors to define a minimum level of coverage that individuals must have. The HBC should also establish standards and processes for minimizing wasteful procedures.
- Create (something akin to Oregon's) Exceptional Needs Care Coordinators (ENCC), which coordinate care between medically fragile consumers and the new ACOs.
- Create safeguards and exceptions for persons eligible for Medicare or those with exceptionally high medical expenses but with income over the poverty level (the Medically Needy Program).
- Create transparent and extensive review process of the list.

## DISENROLLMENT OF ENROLLEES BY AN ACO (PG. 32 AND 36)

Section C, the enrollment portion of the waiver, outlines criteria for an ACO to disenroll an enrollee under certain circumstances. The stipulation that *An ACO can request reassignment of an enrollee if the enrollee doesn't follow medical advice or doesn't keep a good relationship with his/her doctor*" is much too vague and can lead to abuses impacting the most vulnerable Medicaid clients, causing a potentially costly breakdown in their continuum of care.

**Recommendations:** While the state understandably wants Medicaid clients to be responsible for their health and the relationship they form with providers, the following safeguards are needed to protect clients:

- An ACO may not request disenrollment because of a change in health status or because the enrollee's utilization of medical or social services, diminished mental capacity, or uncooperative behavior is related to his or her special needs.
- All disenrollment requests by an ACO should be subject to a thorough review process by the state.
- The disenrollment survey option should be checked as a quality measurement tool.
- No one can argue with saving \$6 million by switching to e-mail communication with clients; however over-reliance on electronic communications could become a barrier for immigrants and others, possibly resulting in disenrollment.<sup>6</sup> In the transition to more electronic forms of communication, ensure

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linguistically and culturally appropriate communications with patients whose primary language is not English or who may not be comfortable or capable of using electronic modes of communication.

## **CLIENT WELLNESS INCENTIVES (P. 22)**

The waiver proposal is generally responsive to advocates' concerns regarding the use of client incentives, in particular the need to have carrots (positive rewards) and no sticks (punishments). Beyond that, however, the proposal is precariously vague. A stick to an advocate may look like a carrot to stakeholders or state officials.

A few months ago, CMS released guidance to states for the new Affordable Care Act prevention grants: the guidance applies hard lessons from state healthy incentives initiatives. For example, this guidance cautions against proposals that reduce benefits for non-compliance with prescribed treatment or participation in wellness incentives.<sup>7</sup>

### **Recommendations:**

- The state plans to apply for the ACA prevention grant. This grant should be used to structure and support the evaluation component of the new competitive approach to client wellness incentives that has been proposed for the new ACO arrangements.
- While we want patients to become more accountable for healthcare outcomes tied to lifestyle choices, there are many instances when care needed has nothing to do with lifestyle choices and that need to be taken into consideration.<sup>8</sup>
- As a constructive alternative to allowing ACOs to do differential copays for unspecified healthy behaviors, a risky proposition, structure the default enrollment process to reward those ACOs that are achieving positive outcomes on the wellness front.
- On the list of client incentives replace limited cash incentives with vouchers for “non-covered” services such as dental care.
- Specify how enrollees with disabilities will participate in incentive programs.

## **THE MEDICAL HOME MODEL OF CARE AND CARE COORDINATION (P. 1)**

The waiver says that medical homes will be at the core of the ACO but fails to explain what services it will provide. It might help to start, as so many communities have before us, with a clear definition of medical home.

### **Recommendations:**

- This definition should emphasize patient-centered medical homes.<sup>9</sup>
- ACO contracts should support enhanced payments for medical homes that utilize chronic disease case-managers or require Medicaid ACOs to place case managers in large volume medical home sites.
- The waiver calls for mandatory enrollment of dual eligibles (eligible for but provides no indication how the ACO will work with Medicare in order to provide specialized care that meets the unique needs of this vulnerable population, which is significantly more likely to experience poor health outcomes.
- It excludes services like mental health and long term care and it is unclear whether there will be any care coordination provided to beneficiaries and if so who will do it – the plan or the providers. Providing care coordination across the full spectrum of services – preventive, acute, behavioral, and long-term care – is essential for the state to achieve its goal of reducing the rate of Medicaid expenditures by focusing on patient outcomes and quality of care.

- The waiver does not specify whether a care coordination payment will be built into the capitated payments. These fees are typically used to encourage providers to function as medical homes. Beyond money, medical homes also need other types of support, like health information technology exchanges.

## ACO QUALITY STANDARDS (PP. 26-29)

The expectation that *all ACOs must meet quality of care and access standards monitored by external, and nationally recognized, professional entities whose entire focus is monitoring the quality of medical care services* may be unrealistic given that quality standards for ACOs are very much under development. We can applaud the use of intermediate quality measures, but the waiver should specify how the quality monitoring process will interface with national quality measures for ACOs once these are finalized.<sup>10</sup>

Most importantly, quality measurements need to be linked to patient experience and health outcomes. Patient experience is an excellent indicator of how well care is being delivered and correlates with improved patient adherence, health outcomes, and clinician satisfaction. While we support the Department's proposed use of the CAHPS survey to capture patient experience, we also recommend that it consider other tools to assess experience of care across the continuum of ACO providers and settings. For instance, a tool to capture caregiver experience can be used for those patients with cognitive impairments that prevent them from talking about their own experience. Caregiver experience can also provide insights into areas patients themselves may be reticent to discuss. Regardless of the survey tool used it should be developed in a culturally and linguistically appropriate manner and at a literacy level no higher than 5th grade.

### Recommendations:

- The survey should be translated into languages other than English spoken by at least 5% of ACO members.
- For ACO members who speak languages for which materials are not translated, the ACO should provide oral communication of this information using trained interpreters.
- ACOs should be required to examine patient experience data by age race, ethnicity, gender, preferred language and disability status. This will enable targeted intervention for specific populations and will help ACOs reduce and eliminate health disparities.
- While an annual [CAHPS \(Consumer Assessment of Healthcare Providers and Systems\)](#) survey will provide useful data, to truly achieve patient-centered care, real-time feedback from patients to providers is also essential. There are many approaches and tools already being used effectively to accomplish this: office-based questionnaires, patient/family advisory councils, informal focus groups, and tools like "How's Your Health."<sup>11</sup>
- The health outcomes measures should focus on those measures that are both meaningful for patients and can demonstrate quick monetary savings, including:
  1. Potentially preventable initial hospital admissions, especially for patients with chronic conditions;
  2. Potentially preventable emergency room visits, readmissions, and preventable hospital complications.

## USING MEDICAID TO SUBSIDIZE PREMIUMS IN THE PRIVATE MARKET (P. 4)

The waiver proposes to give Medicaid eligible individuals the option to use Medicaid dollars to subsidize their portion of the premium for employer-sponsored insurance, if available. The Congressional Budget Office decided it was more cost effective (for all payers, including the taxpayer) to cover low-income individuals, defined as having household income less than 133% of poverty level, in Medicaid rather than in the ESI (employer sponsored insurance) or private market with subsidies.<sup>12</sup> Utah has yet to consider the reasons for this, and this

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may be why deductibles of up to \$2,500 are permitted in this option – quite a stretch even from the new \$40 deductible proposed for enrollees that stay in regular Medicaid.

In addition, there is no reason to suppose Utah’s Health Insurance Exchange, with its bewildering choice of 142 plans, will serve the Medicaid population at all adequately. With navigator functions still under construction even for current participants, who will help the otherwise Medicaid eligible select the right plan? At a recent health reform task force meeting, Norm Thurston (policy lead on state health reform) said the state has no interest in facilitating enrollment into public programs from the state’s current or future Exchange;<sup>13</sup> this being the case, why is it okay to facilitate movement from Medicaid into the Exchange or private market?

**Recommendations:**

- Eliminate this provision entirely.
- The exchange subsidy option, if it sticks at all, should have the same Medicaid cost sharing protections: 5% of income.
- Create a clear and understandable disclosure process for Medicaid consumers who may elect this option (again, if it sticks), explaining that the cost sharing could be much higher on the private market.
- Adults should be able to opt out at any time, just like the kids.

## **WAIVER FINANCING & COST CONTAINMENT GOALS (PP. 50-51)**

Although many states have utilized a per member per month risk based or capitated payment system similar to that proposed in the waiver, the results vary greatly from state to state. What is consistent through state Medicaid payment reforms is that success greatly hinges on complicated changes in care delivery systems, *many of which are years in the making.*

Pennsylvania’s HealthChoices is estimated to have yielded overall Medicaid savings of \$5.0 to \$5.9 billion (\$2.9 billion to \$3.3 billion in State funds) when compared to fee-for-service over the past 11 years (CY2000 – CY2010).<sup>14</sup> But the success of Pennsylvania’s Medicaid reforms can be attributed to several factors, including measures to ensure access to cost-effective care and care management for consumers with special needs. These are the critical features that Utah must include in its reforms to have any hope of success. Meaningful cost containment will not come from strict rate setting alone and much less from rationing schemes. Rather it will come from a systematic, research-driven effort to minimize wasteful procedures and manage care effectively.

**Recommendations:**

- Ensure that per member/per month spending growth targets are realistic and in line with the needs of the Medicaid population and need for a fair reimbursement schedule for providers.
- The state should follow the lead of states like Pennsylvania by carefully setting the rates and adjusting them when necessary.

## **CONCLUSION**

In short, we have serious concerns about the waiver as currently proposed and think it could give ACOs a bad name. The waiver’s emphasis on cost containment is entirely appropriate, but this needs to be balanced with a commitment to quality improvement and better health outcomes for enrollees. There are real ACO proposals and strategies out in the states, but this is not one of them – or not yet. Through a careful synthesis and integration of Utah stakeholder input and expertise,<sup>15</sup> we are confident that this waiver can set the right direction for Utah’s transition to accountable care.

## ACKNOWLEDGEMENTS

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## ENDNOTES

<sup>1</sup> Department of Health (2011). Utah Medicaid Payment and Service Delivery Reform Proposal.

<http://health.utah.gov/medicaid/stplan/1115%20Waivers.htm>.

<sup>2</sup> The input generated over the comment period was so meaningful that UHPP decided to synthesize it for the MCAC (the state Medicaid Advisory Committee) so they could rate the importance of each recommendation.

[http://www.healthpolicyproject.org/Publications\\_files/Medicaid/MedicaidWaiverRecommendationsForMCACratingsFINAL6-17-11.pdf](http://www.healthpolicyproject.org/Publications_files/Medicaid/MedicaidWaiverRecommendationsForMCACratingsFINAL6-17-11.pdf). UHPP hosted several meetings with Medicaid officials, wherein the officials provided some re-assurance on many issues of concern, including the use of a priority list, quality standards, and cost sharing.

[http://www.healthpolicyproject.org/Publications\\_files/Medicaid/UMP/UMPWaiverDiscussionPart2WithHales.pdf](http://www.healthpolicyproject.org/Publications_files/Medicaid/UMP/UMPWaiverDiscussionPart2WithHales.pdf). UHPP prefers to see this re-assurance reflected in the waiver itself.

<sup>3</sup> Center on Budget and Policy Priorities (2005). The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings.

<http://www.cbpp.org/files/5-31-05health2.pdf>.

<sup>4</sup> UHPP (2011). June 6, 2011 Phone Interview with Oregon disability and health policy advocates.

<sup>5</sup> Centers for Medicare and Medicaid Services (1995). Evaluation of the Oregon Medicaid Reform Demonstration.

[http://www.cms.gov/DemonstrProjectsEvalRepts/downloads/Oregon\\_Summary.pdf](http://www.cms.gov/DemonstrProjectsEvalRepts/downloads/Oregon_Summary.pdf)

<sup>6</sup> Midvale City (2011). Emailed comments on Recommendations for Waiver Synthesis.

[http://www.healthpolicyproject.org/Publications\\_files/Medicaid/MedicaidWaiverRecommendationsForMCACratingsFINAL6-17-11.pdf](http://www.healthpolicyproject.org/Publications_files/Medicaid/MedicaidWaiverRecommendationsForMCACratingsFINAL6-17-11.pdf).

<sup>7</sup> Thomson Reuters. *Guidance Document on Preparing a Solicitation for Section 4108 of the Patient Protection and Affordability Act: Incentives for Prevention of Chronic Diseases in Medicaid*. February 3, 2011. <http://www.cms.gov/MIPCD/Downloads/CMSMedicaidIncentivesGuidance.pdf>

<sup>8</sup> Utah Medical Association (2011). Written Comments on Waiver Proposal.

<sup>9</sup> This definition can be found here: [American Academy of Family Physicians' definition/standard of PCMHs](http://www.nationalpartnership.org/site/DocServer/Yardstick_Update_DLN_Electronic_Letterhead_Version.pdf?docID=6521). Also see Campaign for Better Care's yardstick for medical homes:

[http://www.nationalpartnership.org/site/DocServer/Yardstick\\_Update\\_DLN\\_Electronic\\_Letterhead\\_Version.pdf?docID=6521](http://www.nationalpartnership.org/site/DocServer/Yardstick_Update_DLN_Electronic_Letterhead_Version.pdf?docID=6521).

<sup>10</sup> Campaign for Better Care (June 2011). Comments on Proposed Rule for Medicare Shared Savings Program/ACOs.

[http://www.communitycatalyst.org/doc\\_store/publications/FINALACOcommentletterJune6\\_11.pdf](http://www.communitycatalyst.org/doc_store/publications/FINALACOcommentletterJune6_11.pdf). Once this proposed rule or standard for Medicare ACOs is finalized it, along with expert commentary on it, should be a starting point for an ACO standard for Utah.

<sup>11</sup> For details see Campaign for Better Care (2011), Comments on ACO Regulations.

[http://www.communitycatalyst.org/doc\\_store/publications/FINALACOcommentletterJune6\\_11.pdf](http://www.communitycatalyst.org/doc_store/publications/FINALACOcommentletterJune6_11.pdf)

<sup>12</sup> Congressional Budget Office (2009). Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act.

[http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus\\_letter.pdf](http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf).

<sup>13</sup> Minutes of Health System Reform Task Force (May 18, 2011). <http://le.utah.gov/asp/interim/Commit.asp?Year=2011&Com=TSKHSR>.

<sup>14</sup> Lewin Group (2009). Medicaid Managed Care Cost Savings — A Synthesis of 24 Studies. Washington, DC.

<sup>15</sup> UHPP (2011). Highlights from Meetings with Medicaid Waiver Stakeholders.

[http://www.healthpolicyproject.org/Publications\\_files/Medicaid/Reform/MedicaidReformStakeholdersMeetingHighlightsFINAL5-13-11.pdf](http://www.healthpolicyproject.org/Publications_files/Medicaid/Reform/MedicaidReformStakeholdersMeetingHighlightsFINAL5-13-11.pdf).

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