Issue Brief #2:

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Date: February 12, 2010

To: Washington State Legislators
From: Wilson Strategic Communications

Re: Hospital re-basing from the perspective of sub-capitated groups

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Thank you for taking the time to engage in conversation about the risk of losing the sub-capitated provider groups which contract to provide care for Healthy Options patients. This issue briefing serves to outline our perspective, our experience and our potential solutions that have been discussed by various parties to the problem ahead of our group meeting on Friday at 3:00 pm in Cherberg 211

Background: Our groups comprise two of the three entities which contract on a sub-capitated basis to provide care to Healthy Options patients in Washington State. Northwest Physicians Network (NPN) is an independent physicians association (IPA) of about 500 doctors in Pierce and south King Counties. Highline Medical Services Organization (HMSO) is a physician hospital organization (PHO) whose members are Highline Medical Center, and about 200 physicians in south King County. Both groups contract only with Molina Healthcare for Healthy Options.

Our groups have developed significant care coordination infrastructure, providing high quality outcomes while managing costs in an efficient manner. Both groups are provided positive feedback regarding performance in this area. Our groups are set up to act as Accountable Care Organizations (ACO), and as such provide a delivery model being pursued at both the state and federal level under healthcare reform proposals.

Combined, we manage the care for approximately 28,000 Healthy Options (HO) patients. Due primarily to the impacts of hospital re-basing, each of our groups lost about $1.0 million dollars in 2009, and each is projected to lose approximately $1.7 - $2 million in 2010. Neither group can sustain these losses.

As a consequence of these losses, the current situation will lead to the dismantling of the care coordination infrastructure for more than 700 physicians developed over more than a decade by these proto-ACOs.

Policy Context: During the process of re-basing hospital rates in 2007, a number of expectations were built into the project. Based upon comments made during the original

process, the “budget neutral” aspect of re-basing appeared to apply to both the state budget, and to the groups responsible for paying the increased rates (plans and sub-capitated groups). In reality, while it may have been budget neutral for the state, the resulting policy added no new dollars to the base medical premium. Meanwhile rates for hospitals borne by the plans and sub-capitated groups increased 21% statewide, according to Molina, and 28% in our service area.

Upon Molina’s understanding of this shortfall, they participated in an effort to increase funding to cover this rate increase. The result was an increase of about $33 million to the delivery case rate (DCR) statewide. However, based upon analysis of our claims experience since re-basing, this increase only covered approximately 25% of the total cost of inpatient hospital care, leaving a significant shortfall between the state-directed increased rate, and the funding provided by the state to compensate hospitals for those services.

It is also now our understanding, based primarily upon conversations with legislative staff, that the actuarial analysis completed in advance of the re-basing project determined that there were sufficient funds available in the existing base medical premium to cover the 21% rate increase to hospitals. Based upon this analysis, funding was not provided to Molina, nor consequentially to the sub-contracted groups to pay for the increase in hospital rates.

Due to the above average hospital fee schedule increases in our service areas, this exacerbated an already untenable cost increase for NPN and HMSO. Today, our estimates suggest an 8% increase in sub-capitated premiums would have been required to compensate for the increase in hospital rates in our service areas. Accordingly, significant losses resulted.

Given the funding levels of the Healthy Options premiums, we believe an increase of 8% in sub-capitated rates would have been a challenge for the health plans to absorb. In other words, the actuarial analysis which raised rates for hospitals clearly did so at the expense of the plan and sub-capitated groups. These actions have the result of the destruction of the infrastructure of the coordinated care model on which policy makers are increasingly focusing as a primary tool for healthcare reform.

Further, what the current actuarial analysis has failed to take into account is the increased utilization per thousand members per year with the influx of thousands of new Medicaid members as a result of the loss of jobs and the downturn in Washington State’s economy. According to actuarial analysis performed by Molina, new membership on average results in utilization of 85% more services than continuing members. Unprecedented increases in utilization resulting from the H1N1 virus have resulted in significant upward cost trends, which serve to exacerbate the increase to hospital reimbursements

Consequently, future actuarial analysis must include these 2009 utilization trends, or addressing the re-basing issue alone will not be sufficient for the sustainability of the Healthy Options program.

The sub-capitated care coordination model works and would continue to be sustainable if, when the state directs major rate increases, the state also ensures and directs adequate funding to the appropriate point of patient care. Nation-wide, the challenge lies in the development of payment criteria to sub-capitated groups that create aligned incentives to control costs, ensure quality and meet the policy needs mandated by the state. In many ways, the work we all do here together is both important and innovative.

Solutions: Our interest is in finding a "win-win" solution for all parties involved: the state, hospitals, plans and sub-capitated provider groups. We believe that while pre-hospital re-basing funding was sustainable, the Healthy Options program was generally under-funded. Accordingly, we see the importance of the state increasing compensation to the hospitals for the care they provide. Funds must also be provided to support physicians and the care coordination infrastructure which is the bedrock principle of the Healthy Options program and the cornerstone of future reform.

Healthy Options is not a market-based insurance product. It is a creation of the state. Accordingly, the state must put in place rules for the operation of this program so that the policy expectations of the Legislature are met. The plans and the sub-capitated groups understand their fiduciary responsibility to ensure that the Medicaid program remains viable as it has proven to save the state dollars as compared to a straight fee for service Medicaid program.

Following are three suggested solutions to address the previous rate increase to hospitals, and to keep these proto-ACO organizations in sub-capitated arrangements.

1) **Increase the proposed safety net assessment to allow for additional services**
    - By collecting $660m with federal match, hospitals can retain approximately $500m as currently proposed and still meet federal "hold harmless" requirements
        - This expansion of the program would meet the "hold harmless" threshold of no more than 75% of dollars going to one provider, in this case the hospitals
        - This leaves $160 m for the State to distribute across the health care system, including support for patient access to medical care, an increase in physician reimbursement, or covering the plans' increasing costs from the influx of new, higher cost members.
        - We propose that approximately $66m of the remaining $160 m dollars go to plans in the form of a "Sub-Capitated Incentive Fund" for to support groups with care coordination infrastructure
    - No other state that we can find allocates 100% of matching funds to hospitals from assessment
        - Oregon's hospital assessment is specifically for patient access for care
        - In Oregon's logic, by increasing access, this eliminates the pressures of providing uncompensated care on hospitals
        - Oregon's program also provides physician reimbursement at levels 25% greater than Washington State.

This first approach is our preference as we believe this offers a "win-win" solution for all parties involved. Patients, hospitals, the state, health plans, and physicians are all in better position under this arrangement.

If that proves untenable, here are two other solutions that are worthy of consideration.

2) **Set aside 1% of the safety net assessment for the purposes of compensating sub-capitated groups for care coordination in HO**
   - Specifically, add 1% of the total fund (equal to $5.01m) in Sec. 3.3f to be directed by DSHS to NPN and HMSO for the purposes of care coordination
     - Some portion of those funds, not to exceed 10%, would be kept for administration by the department
     - It would be clear that the purpose of these dollars are to make up for a shortfall in HO funding to NPN and HMSO, which would continue and would be exacerbated after the assessment sunsets in 2013
   - There could be some qualifiers on the funds by DSHS so that those dollars could achieve outcomes desired by DSHS related to ACOs or quality outcomes for HO; either for 2010 or in future years as the State further develops its ACO's and quality improvement programs

3) **Implement the actuarial analysis created during re-basing by requiring premiums associated with the hospital rate increases for our specific service areas are passed through to sub-capitated groups responsible for the payments**
   - A budget proviso could be created this year which would address this, and there may be a few options as to how this would happen, for instance:
   - Complete an actuarial analysis by Milliman, which NPN and HMSO would pay for, to demonstrate how much of the premium should go to cover costs and care coordination in the sub-capitated model
   - Create a floor for the percentage of premium that must be passed through to sub-capitated groups that pay all of the claims, handle all of the care, and are responsible for all of the risk

Please consider this letter, the perspective offered and the solutions presented here as a good faith effort on our part to engage in a healthy dialog working towards a solution. We appreciate very much the commitment by the Washington State Hospital Association to resolve this matter, and the statement recently by email from Mr. Leo Greenawalt that "It would be absolutely devastating if we lose important physician networks." We also value highly our long standing partnership with Molina Healthcare that each of our organizations has fostered and developed over more than a decade.

A special thank you also to the agency, legislative, caucus and committee staff who have worked with us so closely on this matter.

On behalf of the 700 physicians and the 28,000 Healthy Options patients which our two groups represent, we look forward to continuing the conversation on Friday at 3:00 pm in Cherberg 211.