The Hilltop Institute

analysis to advance the health of vulnerable populations

Continuity of Care Report

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CoC Advisory Committee Meeting

UMBC

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Presentation Goals

- Present Committee report
  - Background
  - Example continuity policies
    - Maryland
    - Other states
  - Results of analysis
  - Policy options
- Obtain Committee feedback

Background

- Life changes that affect household composition, job status, and income will affect eligibility for Medicaid and Exchange subsidies
- National estimates indicate high rates of transitions in between Medicaid and qualified health plans (QHPs) offered in the Exchange

Background continued

- This process of transitioning eligibility is referred to as churn
- National estimates project that 35% of adults <200% of the FPL will shift between Medicaid and Exchange
- Need for Maryland-specific estimates

Sources:
Hwang, A., Rosenbaum, S., & Sommers, B. (2012). Creation of State Basic Health Programs. *Health Affairs*. 31, no. 6: 1314-1320

Ingram, C., McMahon, S., & Guerra, V. (2012, April). Creating Seamless Coverage Transitions between Medicaid and the Exchanges. State Health Reform Assistance Network Issue Brief.

Continuity/Transition Plan Examples

Maryland

- Maryland Medicaid
  - Health risk assessment
  - Self-referral
- Maryland commercial market
  - Maryland insurance code
  - National Committee for Quality Assurance (NCQA) standards
  - Health plan-initiated programs

Other States with Pre-ACA Exchanges

- Utah – no continuity of care policies
- Massachusetts – receiving MCO required to provide transition plans for:
  - Pregnancy
  - Individuals with significant health care needs/complex medical conditions
  - Individuals hospitalized or receiving ongoing care at transition
  - Individuals with prior authorization

California

- Requires continuation of services from out-of-network provider, if requested, for:
  - Duration of acute condition
  - Time period necessary to complete course of treatment and arrange safe transfer for a serious chronic condition up to 12 months
  - All stages of pregnancy and immediate postpartum period

California continued

- Duration of terminal illness
- Care for infants between birth – 36 months
- Surgery or procedure authorized by relinquishing plan scheduled within 180 days of transition

Analysis of Transition/Churn Population

Volume of Churn Analysis

- Analyzed the rate of turnover in Medicaid eligibility, identifying beneficiaries who:
  - Were continuously enrolled
  - Were newly enrolled
  - Lost eligibility
  - Lost and regained eligibility

Volume of Churn Analysis continued

- Most populations have continuous eligibility
  - Children in foster care and MCHP most likely to retain coverage
  - The Primary Adult Care (PAC) program is a key exception

Identifying Sub-Populations: Methodology

- Used Medicaid claims history to identify measurable sub-populations in churn groups with:
  - Pregnancy
  - Hospitalization
  - Receiving treatment for chemo, radiation, & dialysis
  - Organ transplant
  - Ongoing care needs: durable medical equipment (DME), home health, and prescription medications for management of chronic diseases
  - Mental health and substance abuse
  - HIV/AIDS
  - Dental – will be added as a report supplement

Key Findings

- Majority of population losing coverage had none of the measured conditions, although they may have other health care needs
- Overall, the population gaining coverage more likely to have measured conditions, particularly prescriptions and hospitalizations
  - PAC more likely to use substance abuse services
  - Foster children and PAC more likely to use mental health services.
  - Chemo, radiation, dialysis, transplants, home health were rare

Cost Analysis

Cost Estimation Methodology

- Analysis conducted by actuarial firm, Optumas
- Data from Optumas database of commercial insurance and Medicaid claims
- Data from Hilltop on the prevalence of churn in the Maryland Medicaid population

Cost Estimation Methodology
continued

- Calculated ratio of the annual cost of each of individual condition to the total population health care cost
- Multiplied by churn rates
- Adjusted for out-of-network utilization and price differentials

Cost Estimation Methodology
continued

- Separate analyses conducted for:
  - Exchange to Medicaid population
  - Medicaid to Exchange population

Medicaid to Exchange

- The condition with the greatest impact is mental health, followed by DME, substance abuse, and pregnancy
- Total impact is 0.024%

Estimates of PMPM Cost and Percentage from Medicaid Coverage to Exchange, with Variable Churn Rates

	Percentage of Total Service Costs	Churn Rate	Percentage of Providers Not in Network	Reimbursement Differential for Providers Not in Network	Months of Coverage	Total Impact
Pregnant Women	14.02%	3.69%	22%	4%	6	0.0022%
Prescriptions	8.16%	7.52%	10%	13%	3	0.0017%
HIV	0.35%	11.36%	25%	31%	3	0.0008%
Mental Health	2.74%	6.78%	25%	31%	3	0.0100%
Substance Abuse	3.87%	10.05%	25%	31%	3	0.0029%
Dialysis	0.42%	9.86%	25%	31%	3	0.0008%
Chemotherapy	1.22%	5.01%	25%	31%	3	0.0012%
Radiation Therapy	0.61%	7.66%	25%	31%	3	0.0009%
Transplants	0.05%	6.13%	22%	4%	3	0.0000%
Hospitalizations	19.18%	3.42%	22%	0%	3	0.0000%
Home Health	1.09%	3.49%	40%	31%	3	0.0012%
DME	2.72%	4.79%	40%	31%	3	0.0041%
						0.024%
					Original Capitation Rate	$ 300.00
					Adjusted Capitation Rate	$ 300.07
					PMPM Impact	$ 0.07

Exchange to Medicaid

- The condition with the greatest impact is substance abuse, followed by DME, mental health, and pregnancy
- Total impact is 0.015%

Estimates of PMPM Cost and Percentage from Exchange Coverage to Medicaid, with Variable Churn Rates

	Percentage of Total Service Costs	Churn Rate	Percentage of Providers Not in Network	Reimbursement Differential for Providers Not in Network	Months of Coverage	Total Impact
Pregnant Women	18.69%	3.32%	22%	3%	6	0.0021%
Prescriptions	8.16%	6.76%	10%	10%	3	0.0014%
HIV	0.26%	10.22%	25%	25%	3	0.0004%
Mental Health	2.42%	6.10%	25%	25%	3	0.0023%
Substance Abuse	3.36%	9.05%	25%	25%	3	0.0048%
Dialysis	0.01%	8.87%	25%	25%	3	0.0000%
Chemotherapy	0.29%	4.51%	25%	25%	3	0.0002%
Radiation Therapy	0.03%	6.89%	25%	25%	3	0.0000%
Transplants	0.17%	5.52%	22%	3%	3	0.0000%
Hospitalizations	21.32%	3.08%	22%	0%	3	0.0000%
Home Health	1.09%	3.14%	40%	25%	3	0.0009%
DME	2.72%	4.31%	40%	25%	3	0.0029%
					All Combined	0.015%
					Original Capitation Rate	$ 300.00
					Adjusted Capitation Rate	$ 300.05
					PMPM Impact	$ 0.05

Continuity of Care Policy Options

Goals

- Review written and oral comments provided by Committee
- Obtain final committee feedback

Option 1: Potential Advantages

- Maintain current continuity/transition of care policies in Maryland market; no new policies
  - National NCQA guidelines currently exist, and these are well-established, vetted processes that are currently working
  - Suggestion that MHBE adopt this approach in year 1 and then revisit

Option 1: Potential Disadvantages

- Current standards not adequate and vulnerable populations need additional protections

Option 2a: Potential Advantages

- New health plan accepts prior authorization determination from relinquishing plan
  - This option could work if there are clear sets of criteria for prior authorization across health plans, but would be problematic if there is wide variation in criteria

Option 2a: Potential Disadvantages

- Many expressed concern about lack of time limitations
- Implementation would be difficult
- No current process for identifying patients for transfer of preauthorized services; patient would have to initiate
- Services could be extended longer than intended
- Difficult to honor limitations placed by relinquishing plan

Option 2b: Potential Advantages

- New health plan accepts prior authorization determinations from relinquishing plan for certain treatments for specified time period
  - Many felt this to be preferable over 2a
  - Limited time frame would prevent disruption of critical treatments and allow time for adequate review by new plan
  - Received 3 sets suggestions for limitation criteria

Option 2b: Committee Suggested Limitation Criteria

- Lesser of 60 days or previously authorized time
- Only outpatient services determined medically necessary by relinquishing health plan
- Provided in-network only
- No requirement to cover services not already in plan

Option 2b: Committee Suggested Limitation Criteria

- Lesser of 90 days or previously authorized time
- CareFirst list of services that require prior authorization could be used as a guideline (see handout)
- Pregnancy should be covered through delivery
- Question about absence of prior authorization for service in relinquishing plan, but required prior authorization in new plan

Option 2b: Potential Disadvantages

- National standards not yet developed
- Implementation would be difficult
- No current process for identifying patients for transfer of preauthorized services; patient would have to initiate

Option 3: Potential Advantages

- New health plan allows enrollees within specified courses of treatment to receive care from out-of-network providers for a specified time period.
  - NCQA has defined standards for commercial carriers on the issue
  - Process in place in commercial market and similar to Medicaid self-referral program
  - Process easily and simply explained in benefit guide/web

Option 3: Committee Suggested Limitation Criteria

- Received two sets of suggestions
  - Providers should be paid at receiving plans'
  - Time limit that provides coverage through acute episode to a max of 90 days or through delivery
  - Should only cover a limited course of treatment
  - New plan should not be required to cover services not already in plan

Option 3: Potential Disadvantages

- Out-of-network providers not contractually obligated to continue care and must be willing to accept patient through transition
- Added cost of out-of-network reimbursement rate
- May be burdensome to carriers if implemented in a manner that does not follow NCQA

Option 4: Potential Advantages

- Formal notification is provided to enrollees of their transition options
  - May be appropriate if integrated into existing health plan benefit materials
  - Navigators and assistors could potentially be used to review these with members

Option 4: Potential Disadvantages

- Notification may not be adequate to protect consumers
- Aggressive outreach to educate consumers may be needed
- May be costly and confusing if not integrated into health plan's existing benefit materials

Option 5: Potential Advantages

- Both Medicaid and QHPs conduct health risk assessments for new enrollees
  - May be an effective way of identifying individuals who need transition plans
  - Currently used by Medicaid and works well by notifying MCOs that enrollee has ongoing care needs

Option 5: Potential Disadvantages

- Concern that this is not currently in place in commercial market and no processes in place for sending, receiving, tracking, or evaluating surveys
- Would require additional resources and costs that would be borne by the payers
- Many enrollees may not require assessments and transition issues should be limited to ongoing treatment needs

Option 5: Potential Disadvantages continued

- Written materials may be difficult to understand
- Response rates would likely be low, especially if done by mail only
- No way to require members to complete surveys
- May be hindered by lack of information, such as proper addresses

Option 6: Potential Advantages

- New health plan creates transition plans for enrollees within specified courses of treatment
  - No advantages provided

Option 6: Potential Disadvantages

- New health plan would not know whether a member is within a course of treatment
- Member or provider would have to identify needs for a transition plan; no way to compel out-of-network provider to comply
- Concern that this would constitute a new benefit outside scope of EHBs
- If required, may need to rest outside of carrier and handled by navigators or assistors

Option 7: Potential Advantages

- MHBE works with others to evaluate continuity of care as it progresses
  - Many members felt that this is an appropriate role of MHBE
  - Helpful to re-evaluate as MHBE gains market experience and new federal guidance emerges

Option 7: Potential Disadvantages

- MHBE still developing IT system and some data required for such evaluation may be housed outside MHBE

Other Considerations

- Requested by committee members to note considerations beyond Committee scope in report:
  - Differences in cost-sharing between Medicaid and QHPs
  - Benefit gaps between Medicaid and essential health benefits
  - Basic Health Plan option

Next Steps

- Finalize report and submit to MHBE Board
- MHBE Board will review and make recommendations in report due to General Assembly on January 5

About The Hilltop Institute

The Hilltop Institute at UMBC is a non-partisan health research organization—with an expertise in Medicaid and in improving publicly financed health care systems—dedicated to advancing the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, objective, and innovative research and analysis.

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