THE HAWAII HEALTH AUTHORITY PROPOSAL: USING THE AFFORDABLE CARE ACT AS A STEPPING STONE TOWARD UNIVERSAL HEALTH CARE

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Hawaii’s health care system is better than most states, thanks primarily to broader coverage under our Prepaid Health Care Act, a commercial health insurance sector that is less fragmented than in most states, and our historically generous Medicaid program. However, our system is developing worsening problems, and the most obvious symptoms are runaway costs and deteriorating access to care, especially for sicker patients in our Medicaid program.

The goals of Hawaii’s health transformation effort are the “Triple Aims:”

1. Improve quality of care
2. Improve health – individual and population
3. Increase value and control unnecessary costs

Both the Health Transformation Initiative/The Hawaii Health Project (HHP) and the Hawaii Health Authority (HHA) support these goals and we agree on measures to improve care coordination, develop patient centered medical homes, and improve health information technology. However, no clear decisions have yet been made on how to deal with the problems in our Medicaid managed care program, and we are not aware of any credible plan that has been proposed to improve access to care for Medicaid patients.

**Health Transformation:**

**What is the diagnosis?**

Many issues have been raised during the health transformation process, but there does not appear to have been an attempt to weigh their relative importance or to ask how we should focus our efforts to ensure that the most important problems are addressed and that we achieve the most cost-effective health care system possible.

**Where is the waste?**

* Administrative complexity and cost?
* Unnecessary care driven by fee-for-service (FFS) for providers?
* Inappropriate demand for care by patients?

**Administrative costs:**

Administrative costs in US health care are around 35% of total health spending, compared to around 5-10% in single-payer countries. Therefore, around 25% of the US health care dollar is wasted on unnecessary administration. The use of competing insurance plans to finance health care is a key contributor to this administrative waste. Hawaii is not as bad as the rest of the US due to broader coverage from our Prepaid Health Care Act and minimal competition in the commercial market, but we still have plenty of administrative inefficiency, so let’s assume we could save 15-20% by adopting an administratively efficient system.

**Unnecessary and inappropriate care:**

This is estimated to be around 20% of US health care costs, but it is not as bad in Hawaii as shown by our lower Medicare spending, so perhaps 10-15% of our costs are due to unnecessary and inappropriate care.

**Is this due to too much care?**

1. Unnecessary care driven by fee-for-service (FFS) incentives for providers?
2. Unnecessary care NOT driven by FFS incentives (futile end-of-life care, direct to consumer ads for drugs, antibiotics for colds, physician errors, etc.)?
3. Unreasonable demands for care by patients (driven by direct-to-consumer ads, psychiatric problems)?
4. Failures in care coordination due to failures in communication?
5. Excessive tests and procedures due to fear of lawsuits?

**Or not enough care?**

1. Lack of access to cost-effective care (due to un-insurance, under-insurance, and insurance that doctor’s won’t accept), driving expensive complications, excessive ER use, and excessive hospitalizations?
2. Failures in care coordination due to lack of access?

Hawaii has a shortage of doctors in primary care and most specialties, and our emergency room use is high, especially for Medicaid, suggesting that the bigger problem is “not enough care.” Based on both Hawaii1 and U.S.2,3,4,5 data and on the experience of physicians in practice, the HHA would rank #6 first, followed by #7 and #2, especially for our Medicaid population. It appears that most of the care coordination problems in Hawaii are among Medicaid recipients, the under-insured, and the uninsured. Failures in coordination are largely attributable to lack of access to appropriate cost-effective care, obstructions to care by managed care policies, and lapses in care when patients switch plans. Our Medicaid managed care program is plagued by excessive administrative costs and burdens for providers, declining physician participation, and escalating problems with access to care for patients, especially for those in the aged, blind, disabled (ABD) category under the QExA program.1 Payment and delivery system reforms carry new administrative complexities and costs, especially for our multi-payer Medicaid program, and cannot be effective without enough physician participation to ensure adequate access to appropriate care. Medicare is a fee-for-service program, and Hawaii has the lowest per-capita Medicare spending in the country, so it appears unlikely that excessive care due to FFS incentives is a significant problem in Hawaii. Therefore, payment reforms designed to counter a supposed FFS incentive to over-treat are unlikely to improve the cost-effectiveness of health care in Hawaii.

**What Solutions (“treatment”) would work to heal our broken system?**

The Health Transformation Initiative brought in speakers from North Carolina, Vermont, and Oregon who are all involved in implementing coordinated care delivery systems, especially for Medicaid, that enable the delivery system to manage care without using competing insurance plans. However, it appears that the Hawaii Health Project Executive Committee has been reluctant to challenge our Medicaid managed care system. The Executive Committee met with MedQUEST director Ken Fink, who told us that there are only 3 kinds of Medicaid systems in the US: Traditional fee-for-service Medicaid, Medicaid managed care with competing plans (Managed Care Organizations, or MCOs), and Primary Care Case Management (PCCM) with enhanced payment for care coordination by primary care providers, without intervening MCOs.6 North Carolina has developed what is now called “enhanced PCCM” (ePCCM) with cost-effectiveness of care managed by the delivery system using patient-centered medical homes (primary care), physician-led quality improvement, and community care teams to reach out to those patients who cannot be easily managed from a doctor’s office alone. Vermont, Oregon, Connecticut, and several other states are in the process of setting up ePCCM. Oklahoma formerly used both MCO’s and PCCM in different communities, but found PCCM to be more cost-effective and eliminated MCO’s in favor of statewide PCCM.7 Managed care by competing MCO’s and ePCCM with care managed by the providers themselves are incompatible models, and *no state* is trying to do both at the same time in the same location. If they did they would encounter much higher administrative costs and a conflict between the managed care plans and the delivery system over who was responsible for managing care.

The solutions proposed so far by the Hawaii Health Project – electronic health records and health information technology, pay-for-performance, certification of “patient centered medical homes,” and care coordination projects that will generally reach only those who already have good access to care - will do little to address the bigger problems with administrative complexity and cost and lack of access for Medicaid recipients, and are likely to make these problems worse. Furthermore, pay-for-performance, pay-for outcomes, and bundled payments all carry a serious risk of unintended adverse consequences because they introduce strong incentives for doctors and hospitals to “game” diagnoses and procedure codes to increase reimbursement, and for both providers and health plans to avoid sicker, more complex patients.8,9,10

Who is going to be responsible for managing care and keeping it cost-effective – **insurance plans** or the **care delivery system**? Who can best look out for the actual health needs of individual patients – managed care plans or doctors? Who can make public health needs a priority? Are we going to have a health system that is centered on patient care needs, or on the needs of competing health insurers?

We have been shown by North Carolina that it is possible to develop a care delivery system that places patient care at the center, that enables and encourages providers to manage care at the front lines (instead of hiring bureaucrats to manage care from afar), that covers the entire Medicaid population, and does it all with low administrative costs. Vermont, Oregon, and Connecticut are committed to developing similar systems, starting with their Medicaid programs, and they are all doing it without an administrative layer of competing managed care plans. Hawaii must choose between Medicaid managed care driven by insurance plans, or ePCCM driven by caregivers focused on the health care needs of their patients and of the population. We won’t succeed by attempting to implement two incompatible models simultaneously. We believe we can learn a lot from North Carolina and other states that have implemented this model and believe addressing our Medicaid issues should be a key component in improving health care for our State. This is especially urgent with the impending expansion of Medicaid in 2014 under the Affordable Care Act.

**The Hawaii Health Authority Proposal:**

The Hawaii Health Authority has proposed a roadmap to get from our current health care situation to a universal and far more cost-effective system. (See <http://hawaii.gov/budget/hha>: “2011 Update to the 1999 Health Futures Task Force Report”) This plan would leverage the features of the Affordable Care Act (care coordination initiatives, implementation of an insurance exchange) in such as a way as to maximize federal matching funds, but it would also position Hawaii to move to a fully universal system as soon as the necessary waivers can be obtained, following the lead of Vermont. Plan administration would be contracted to a local health plan that is not investor-owned, and the system would include integrated health care delivery systems such as Kaiser and the community health centers. This proposal would be far simpler and less expensive to administer, it would greatly improve physician participation, greatly improve access to care for those financed by Medicaid, and it would save far more than the collection of measures envisioned in the Affordable Care Act or proposed so far by the Hawaii Health Project.

**Recommendations:**

1. The Hawaii Health Authority recommends an eventual goal of **Universal health care with a unified delivery system.** This is otherwise known as an “all-payer” system with a single set of comprehensive benefits, and doctors and hospitals paid the same regardless of the source of funding for a given patient, following the example of Rocky Mountain Health Plans in Colorado.11
2. This All-Payer system should include a continuous quality improvement (CQI) program with physician leadership, following the examples of Intermountain Health Care in Utah, Rocky Mountain Health Plans in Colorado, and Community Care of North Carolina.11,12,13 With CQI, the health care delivery system would control unnecessary care driven by providers, reduce futile care, reduce fraud and abuse, and ensure high quality of care without introducing perverse incentives to avoid caring for sicker, more complex patients.
3. The Hawaii Medicaid program should begin planning a transition from Medicaid managed care to an enhanced Primary Care Case Management system similar to Community Care of North Carolina and the programs being implemented in Vermont, Connecticut, and Oregon. A unified Medicaid program with physician directed CQI would be far more effective than Medicaid managed care organizations in persuading doctors to resume accepting Medicaid patients, thereby improving access. It would become a foundation for a universal system, instead of the entrenched obstacle that it has become under Medicaid managed care.
4. The Hawaii Health Connector should develop an insurance exchange designed to be as close to “all-payer” as possible, preferably with standardized comprehensive benefits and the same fees and providers (delivery system) as the unified Medicaid program above. This also follows the lead of Vermont.
5. Once this all-payer system has been established for Medicaid and the insurance exchange, it can be expanded to State and County employees and retirees, and then to the commercially insured population.

A universal “all-payer” system would be far more cost-effective than the insurance-based measures in the Affordable Care Act or proposed so far by the Hawaii Health Project, such as pay-for-performance, bundled payments, and competing “Accountable Care Organizations.” An all-payer health care delivery system would be far simpler and cheaper to administer, saving around 15-20% of health costs if fully implemented. Its large market share would ensure the participation of almost all licensed providers and all health care facilities, and would greatly reduce problems with access to care. This system would be organized around the health needs of both individual patients and the population (public health). Compared with the proposals in the Affordable Care Act, it would also be far easier to explain to physicians, businesses, and the general public.

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