



PBGH
PACIFIC BUSINESS
GROUP ON HEALTH



California Health Care Foundation

The Business Case for Expanded Coverage

The Evidence

October 2018

Introduction

In the ongoing public policy debate about publicly-financed health care coverage for uninsured and low-income people, there has been little attention paid to its implications for employers. To address this issue, the Pacific Business Group on Health (PBGH) conducted a literature review and convened a panel of experts to assess the evidence on the effect that coverage expansion, or reduction, can have on employers. The objective was to determine whether there is a "business case" for expanded coverage, i.e., quantifiable benefits to employers.

The purpose of the report is to summarize the existing evidence that can inform employers' discussions and positions as they consider whether and how to engage on these important issues at the Federal and state level.

"The Business Case for Expanded Coverage" was supported by a grant from the California Health Care Foundation.

In this paper, we consider four ways in which changes in coverage can affect the health of employees and their overall health care costs:



We conclude that the evidence affirms that coverage expansion does create favorable impacts for employers by reducing uncompensated care in hospitals and potential attendant cost-shift, reducing avoidable utilization and costs associated with deferred care, improving the health of new workers and the potential workforce, and contributing to system-wide improvements in the delivery of care.

Employers may be concerned that expanding publicly-financed coverage via Medicaid or the exchanges will need to be financed in some way, e.g., through additional taxes, reduced spending for other government services, or higher government deficits. Since the financing options are uncertain and the impacts are difficult to quantify, they could not be included in this analysis.

The expert panel that provided input on the framing and supporting evidence for the business case for expanded coverage include:

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The experts' involvement in this project does not mean that they necessarily support the conclusions stated in this paper. Any summary statements and conclusions are solely attributable to PBGH.



1. Is there a cost shift?

Expanded coverage may result in reductions in prices charged to commercially-insured patients. The hypothesis is that hospitals (and perhaps physicians) will change the prices charged to commercially-insured patients in response to changes in the proportion of uninsured non-paying patients vs. Medicare, Medicaid and commercially-insured patients.

It is widely recognized that hospital prices for commercially-insured patients are higher than the amounts paid to hospitals for Medicare, Medicaid and uninsured patients.¹ This is generally known among economists as "price discrimination," i.e., different prices charged to different payers, and it is common in many industries. Some hospitals have claimed that they must charge these higher prices to offset the losses from non-commercially insured patients. This has led to a widely-held belief that hospitals raise their commercial prices when the proportion of other patients

increases, (or if the payments from Medicare and Medicaid are reduced). This has become known as "cost-shifting," i.e., a change in commercial prices due to changes in revenue from other sources.

The evidence regarding the degree of "cost-shifting" by hospitals is complicated. Based on interviews with retired hospital chief financial officers (CFOs), there is good evidence that hospitals "cost-shift" to offset the losses from uncompensated care as well as low Medicaid and Medicare payment levels and bad debt. Academic research, however has not found strong evidence of significant cost-shifting.²

Much of the academic research on "cost shifting" has focused on the effect on commercial prices from reductions in hospital payments by Medicare and Medicaid (the same dynamics are relevant to the impact of coverage reductions, which in effect lower the hospitals' revenue by increasing the amount of uncompensated care).³⁻⁶ Other researchers have examined the effects of coverage reductions on uncompensated care by hospitals, and the resulting impact on commercial prices.⁷⁻⁹

Has the increase in coverage in recent years resulted in less uncompensated care?

The uncompensated care burden in hospitals fell sharply in Medicaid expansion states between 2013 and 2015, from 3.9 percent to 2.3 percent of operating costs. The largest reductions in uncompensated care were found for hospitals in expansion states that care for the highest proportion of low-income and uninsured patients.¹⁰

A related study examined the correlation between uncompensated care and the number of uninsured, and it concluded that "using actual dollars, for every decrease of 100 uninsured persons between 2013 and 2015, uncompensated hospital care costs dropped \$67,295."¹¹

What is the effect of expanded coverage and reduced uncompensated care on private sector premiums?

One study conducted before the ACA estimated that the effect in California would be less than 2 percent (of private-payer patient revenue to cost ratio).¹² A similar study estimated the effect nationally to be just under 2 percent of private health insurance costs.¹³

What has been the impact of shortfalls in Medicare and Medicaid payments on prices charged to private payers?

A thorough analysis conducted in 2011 of the evidence concluded that "as a whole, the evidence does not support the notion that cost shifting is both large and pervasive. Instead, it reveals that cost shifting can occur but may not always do so."²

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- 1 American Hospital Association. "Trendwatch Chartbook 2016 – Chapter 4: Trends in Hospital Financing." Accessed at: <https://www.aha.org/system/files/research/reports/tw/chartbook/2016/chapter4.pdf>
 - 2 Frakt AB. "How Much Do Hospitals Cost Shift?" *The Milbank Quarterly*, Vol. 89, No. 1, 2011 (pp. 90–130). Accessed at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160596/>.
 - 3 Frakt AB. "Hospitals Don't Shift Costs from Medicare or Medicaid to Private Insurers", *JAMA Forum*, January 4, 2017. <https://newsatjama.jama.com/2017/01/04/jama-forum-hospitals-dont-shift-costs-from-medicare-or-medicaid-to-private-insurers/>
 - 4 White C. "Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates," *Health Affairs*, Vol. 32, No. 5, May 2013. Accessed at: <https://doi.org/10.1377/hlthaff.2012.0332>
 - 5 Fox W and Pickering J. "Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid and Commercial Payers", Milliman, December 2008. Accessed at: us.milliman.com/insight/research/health/pdfs/Hospital-and-physician-cost-shift/
 - 6 Proebsting D. "Why hospital cost shifting is no longer a viable strategy", Milliman, June 2010. Accessed at: www.milliman.com/uploadedFiles/insight/healthreform/why-hospital-cost-shifting.pdf
 - 7 Weissman JS, Cohen MA and Reich A. "Weakening the Affordable Care Act will boost hospitals' financial burden", *Stat News*, October 11, 2017. Accessed at: <https://www.statnews.com/2017/10/11/affordable-care-act-hospitals/>
 - 8 Weissman JS. "The Trouble with Uncompensated Hospital Care", *N Engl J Med*. 2005; 352:1171–1173 (March 24, 2005). Accessed at: <http://www.nejm.org/doi/full/10.1056/NEJMp048280>
 - 9 Harbage P and Nichols LM. "A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System", New America Foundation Health Policy Program, Issue Brief #3, December 2006. Accessed at https://www.researchgate.net/publication/237592468_a_premium_price_the_hidden_costs_all_californians_pay_in_our_fragmented_health_care_system
 - 10 Dranove D, Garthwaite C and Ody C. "The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal," *The Commonwealth Fund*, May 2017. Accessed at: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2017/may/dranove_aca_medicaid_expansion_hospital_uncomp_care_ib.pdf
 - 11 Op cit., Weissman JS, October 11, 2017.
 - 12 Kessler DP, "Cost Shifting in California Hospitals: What is the Effect on Private Payers?" California Foundation for Commerce & Education, June 6, 2007. Accessed at: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.127.1959&rep=rep1&type=pdf>

What has been the impact of reduced Medicare payments for certain hospitals in recent years?

A recent study found that that "hospitals that faced net payment reductions from HRRP [the ACA's Hospital Readmission Reduction Program] and HVBP [the ACA's Hospital Value-based Purchasing Program] were able to negotiate 1.5 percent higher average private payments," which is "equivalent to about a 56-cent increase in private payments for a \$1 decrease in public payments."¹⁴ These results should be viewed with some skepticism, however, since the estimated impact is so much higher than in previous studies. Furthermore, some experts have raised methodological concerns about this study, pointing out that other factors may have contributed to the observed price changes.¹⁵

What is the "real-world" evidence for cost shifting?

Based on interviews with retired hospital CFOs, there is strong evidence that cost-shifting occurs. Hospital pricing strategies are affected by many factors, but there is general agreement that any increase in the proportion of uninsured patients puts upward pressure on prices for commercially-insured patients. This happens through contract negotiations with health plans, and it often takes effect over many years, thus making it difficult to isolate a "cost-shift" action in traditional academic studies. CFOs also point out that the willingness and ability to negotiate commercial prices aggressively varies by hospital, depending on their financial situation and competitive environment.

Does the ability to raise prices for privately-insured patients vary among hospitals?

Generally, hospitals with relatively high market power are considered to be in a better position to raise prices. The most recent analysis found "significant heterogeneity by payer mix, where cost-shifting is largest for hospitals with higher shares of private insurance patients," which is a reasonable proxy for market power.¹⁶

A recent study affirmed a greater rate of price increases in highly consolidated markets, including those where hospitals had acquired physician practices or employed physicians through foundation models. Such price changes would tend to increase the differential between commercial and Medicare and Medicaid payments.¹⁷

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- 13 Hadley J, Holahan J, Coughlin T, et al. "Covering the Uninsured in 2008: Current Costs, Sources of Payment and Incremental Costs". *Health Affairs*. 27, no. 5 (2008): w399–w415. Accessed at: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.27.5.w399>
- 14 Darden M, McCarthy I and Barrette E. "Hospital Pricing and Public Payments", NBER Working Paper 24304, February 2018. Accessed at: <http://www.nber.org/papers/w24304>.
- 15 Frakt AB. "A New Study Finds Cost Shifting, But I'm Skeptical". Blog post at the Incidental Economist. Accessed at: <https://theincidentaleconomist.com/wordpress/a-new-study-finds-cost-shifting-but-im-skeptical/>
- 16 Darden et al., op. cit.
- 17 "Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums," Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health University of California, Berkeley, March 26, 2018. Accessed at: http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf

Summary

There is a widely-held belief that hospitals raise their commercial prices when the number of uninsured patients increases, commonly referred to as **"cost-shifting."**

The evidence regarding the degree of "cost-shifting" by hospitals is complicated. Hospital executives and industry experts generally say that cost-shifting occurs, although academic research has not found strong evidence of significant cost-shifting.

The degree of cost-shifting is affected by local market conditions. Hospitals in consolidated markets often are able to use their market power to raise prices more than hospitals in competitive markets.



2. Will there be a reduction in pent-up demand?

Employers may benefit from expanding health insurance coverage for the uninsured due to reductions in health care use and spending when they do obtain access to coverage. If people do not have access to preventive health care services or primary and specialty care, they may be prone to defer services for treatable conditions, resulting in a higher state of acuity or complexity due to comorbidities that accrue due to the lack of treatment.

Is there evidence of pent-up demand among newly covered or newly insured?

In one longitudinal study of new Medicare beneficiaries, researchers determined that near-elderly adults who were uninsured required more intensive and costlier care in the Medicare program after the age of 65 than previously insured adults who were otherwise similar at ages 59 to 60.¹⁸ This was especially true for chronic medical conditions such as cardiovascular disease and diabetes that are otherwise amenable to early intervention.

For what types of service does pent-up demand affect utilization?

Analysis of claims data by the Society of Actuaries indicated that newly insured individuals were more likely to use preference-sensitive treatments, such as musculoskeletal disease.¹⁹

Insurance expansion in Massachusetts was associated with increased rates of discretionary surgery—defined as elective, preference-sensitive procedures (e.g., joint replacement and back surgery)—and a concurrent decrease in rates of nondiscretionary surgery (e.g., cancer surgery and hip fracture repair).²⁰

Analysis of 6.7 million prescription drug users pre- and post-ACA implementation showed that in reducing financial barriers to care, patients had increased treatment rates and reduced out-of-pocket spending, particularly for people with chronic conditions. Uninsured people who gained access to private coverage filled, on average, 28 percent more prescriptions and had 29 percent less out-of-pocket spending per prescription. Those who gained Medicaid coverage had larger increases in fill rates (79 percent) and reductions in out-of-pocket spending per prescription (58 percent). People with chronic conditions who gained coverage saw larger decreases in out-of-pocket spending compared to those who did not have at least one condition.²¹

Allowing for a relatively small sample size, one analysis showed that the rate of visits to office-based providers fell significantly below that of continuously enrolled adults when those individuals lost Medicaid coverage. Office visit use returned to a level comparable to the control group only several months after reenrollment. The authors suggest that longer uninsurance spells are associated with more volatile patterns of health care use, even though their analysis did not show a statistical increase in emergency department (ED) use.²²

18 McWilliams JM, Meara E, Zaslavsky AM, et al. "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *N Engl J Med*. 2007; 357; 143-53. Accessed at: <https://www.nejm.org/doi/full/10.1056/nejmsa067712>

19 Owen R, and Maeng D. "Indications of Pent-up Demand New ACA enrollee use of preference-sensitive services," Society of Actuaries, April 2015. Accessed at: <https://www.soa.org/Files/Research/Projects/2015-pent-up-demand.pdf>

20 Ellimoottil C, Miller S, Ayanian JZ, et al. "Effect of Insurance Expansion on Utilization of Inpatient Surgery," *JAMA Surg*. 2014;149(8):829-836. Accessed at: <https://jamanetwork.com/journals/jamasurgery/fullarticle/1885707>

21 Mulcahy AW, Eibner C and Finegold K. "Gaining Coverage Through Medicaid or Private Insurance Increased Prescription Use and Lowered Out-Of-Pocket Spending," *Health Affairs*, August 17, 2016. Accessed at: <http://content.healthaffairs.org/content/early/2016/08/16/hlthaff.2016.0091>

Does the increased rate of utilization taper off after an initial period of pent-up demand, and is there evidence of greater efficiency in resource use (e.g., primary care instead of ED visits)?

In a study of new and continuing Medicaid enrollees in Minnesota, utilization declined over time, as measured by the volume of office visits, ED visits, and coding for new patient visits and diagnostic procedures, while new prescriptions increased over time.²³

In a study of three Southern states (AK, KY, TX) with high baseline uninsured rates, the Medicaid expansions took more than one year to mature, suggesting that preliminary studies likely underestimate the longer-term impacts of Medicaid expansion. By the end of 2015, data showed increases in preventive care, outpatient office visits, annual checkups, and chronic disease care, as well as decreased reliance on the ED. Moreover, adults in expansion states reported significant improvements in self-reported quality of care and health, including increased glucose screening rates in the general population and increased glucose monitoring among patients with diabetes—measures of population health.²⁴

Is it reasonable to expect that the tapering off of pent-up demand should be sustained over time?

A study of Medicaid claims spanning nine expansion states indicated that claims costs did increase over time—even after adjusting or normalizing for age and sex. While inpatient claims declined fairly quickly as a share of total claims costs, the share of professional and outpatient claims was consistent over time and prescription drug spending as a share of total claims costs increased significantly.²⁵

Note: There may be different population cohorts to consider, such as individuals that lose eligibility from parental coverage or who are entering the workforce for the first time, whose behavior and medical needs are different from individuals who are unemployed, but not Medicaid-eligible, or who cannot afford health coverage.

What is the impact of churn (enrollment/disenrollment) from turnover in the individual/family and small group insurance segment or as a result of income or job status changes on eligibility for Medicaid or ACA Marketplace plans?

The income, expenses, and other family circumstances of low-income individuals can impact eligibility for and affordability of various health coverage options. There have been numerous proposals to facilitate continuous coverage or to reduce administrative burden associated with application and enrollment processes that would potentially mitigate the disruptions in health care due to enrollment churn stemming from eligibility changes for Medicaid or income support to purchase ACA Marketplace plans. There is limited data on the amount of churn that has actually occurred or its impact on utilization and costs.

22 Roberts ET, and Pollack CE. "Does Churning in Medicaid Affect Health Care Use?" *Med Care*. 2016 May; 54(5): 483–489. Accessed at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548183/pdf/nihms895715.pdf>

23 Fertig AR, Carlin CS, Ode S et al. "Pent-Up Health Care Demand Among New Medicaid Enrollees after the ACA," Medica Research Institute, March 1, 2016. Accessed at: http://shadac.org/sites/default/files/publications/PentUPD_FertigMNHSR%202016.pdf

24 Sommers BD, Blendon RJ, Orav J, et al. "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *JAMA Intern Med*. 2016;176(10):1501–1509. Accessed at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420>

25 "Profile of the Medicaid Expansion Population: Demographics, Enrollment, and Utilization," Avalere Health, January 2018. Accessed at: <http://go.avalere.com/acton/attachment/12909/f-0517/1/-/-/-/-/avalere%20Medicaid%20Expansion%20Analysis.pdf>

Summary

New employees who previously had coverage are less likely to have increased utilization (aka "pent-up demand") during their first year on the job.

Continuous coverage tends to avoid pent-up demand for chronic medical conditions such as cardiovascular disease and diabetes that are amenable to early intervention and management, as well as "preference-sensitive" procedures such as joint replacement and back surgery.



3. Will employers see productivity gains attributable to a healthy working-age adult population?

Health coverage is associated with improved health outcomes and worker productivity. In addition to the direct effects of coverage on the reduced absenteeism and greater productivity of working adults, broader coverage may improve the health status of the working-age population and increase the number of years spent employed. Thus, greater levels of coverage may increase the pool of available workers and potential future productivity.

How does coverage among workers impact productivity?

Using MEPS data in a 2016 analysis, researchers found that workers with insurance missed significantly fewer workdays than uninsured workers.²⁶

An analysis of manufacturing plants found that workers offered health insurance had greater productivity.²⁷

If data indicates increases in preventive care, outpatient office visits, annual checkups, and chronic disease care, as well as decreased reliance on the ED and improved prescription drug adherence for chronic conditions, there should be a corresponding effect on workers' absentee rates and productivity.²⁸⁻²⁹ Seminal research on chronic disease impact on worker productivity by Goetzel and a systematic review of medication adherence documented significant economic costs, including lost days at work, associated with chronic disease and poor medication adherence.³⁰⁻³¹

Does broad coverage improve the health status of the working-age population?

In an analysis of Michigan's Medicaid expansion plan, half of expansion enrollees reported that their physical health improved in the first year of coverage. This study also found that 55 percent of out-of-work enrollees said coverage made them better able to look for a job.³²

There is growing evidence about the impact of Medicaid expansion on health care access and quality.^{33,34} Although longitudinal health outcomes data are limited at this time, there are indications of increased rates of diagnosis of chronic conditions and improvements in various clinical quality indicators such as blood pressure screening and diabetes management.³⁵⁻³⁷

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- 26 Dizoli A and Pinheiro R. "Health insurance as a productive factor," *Labour Economics*, 2016.
- 27 Nguyen S and Zawacki A. "Health Insurance and Productivity: Evidence from the Manufacturing Sector," U.S. Census Bureau Center for Economic Studies, September 2009.
- 28 Sommers B, Op. cit.
- 29 Mulcahy AW, Op. cit.
- 30 Goetzel R, Hawkins K, Ozminkowski R, et al. "The Health and Productivity Cost Burden of the "Top 10" Physical and Mental Health Conditions Affecting Six Large U.S. Employers in 1999," *J Occup Environ Med*. 2003, 45:5-14.
- 31 Cutler RL, Fernandez-Llimos F, Frommer M, et al. "Economic impact of medication non-adherence by disease groups: a systematic review. *BMJ Open*. 2018;8:e016982. doi:10.1136/bmjopen-2017-016982.
- 32 Tipirneni R, Goold SD and Ayanian JZ. "Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan," *JAMA Intern Med*. 2018;178(4):564-567 <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2664514?resultClick=1>
- 33 Simon K, Soni A and Cawley J. The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the 2014 ACA Medicaid Expansions (Working Paper 22265, National Bureau of Economic Research, May 2016). Accessed at: <http://www.nber.org/papers/w22265>
- 34 Sommers BD, Gunja MZ, Finegold K, et al. "Changes in Self-Reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act," *The Journal of the American Medical Association*. 314 no. 4 (July 2015): 366-374. Accessed at: <https://jamanetwork.com/journals/jama/fullarticle/2411283>
- 35 Wherry LR and Miller S. "Early Coverage, Access, Utilization, and Health Effects Associated with the Affordable Care Act Medicaid Expansions: A Quasi-experimental Study," *Annals of Internal Medicine*, April 2016.
- 36 Medicaid Expansion Impacts on Insurance Coverage and Access to Care, Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. ASPE Issue Brief, July 18, 2017.
- 37 Sommers BD, Gawande AA and Baicker K. "Health Insurance Coverage and Health – What the Research Evidence Tells Us," *N Engl J Med*, 377;6, August 10, 2017. Accessed at: <https://www.nejm.org/doi/pdf/10.1056/NEJMs1706645>
- 38 Stewart JM. "The impact of health status on the duration of unemployment spells and the implications for studies of the impact of unemployment on health status," *Journal of Health Economics*, September 2001.
- 39 Courtemanche C, Marton J, Ukert B, et al. "Early Effects of the Affordable Care Act on Health Care Access, Risky Health Behaviors, and Self-Assessed Health," Cato Institute, Research Briefs in Economic Policy No. 108, April 11, 2018. Accessed online, <https://www.cato.org/publications/research-briefs-economic-policy/early-effects-affordable-care-act-health-care-access>, April 16, 2018.

Is health status of a working-age population associated with labor productivity? Are changes in health status of a particular community associated with increased labor productivity among workers in that community?

Individuals with impaired health have longer periods of unemployment, resulting in a health status difference between the employed and unemployed populations.³⁸

One recent study suggests the effects of the ACA on risky health behaviors (smoking, alcohol consumption, and body mass index) and self-assessed health were modest (although the time frame for the study may not have been long enough to detect improvements).³⁹

Summary

Workers with insurance miss significantly fewer workdays and have higher productivity than uninsured workers.

Medicaid expansion enrollees who were unemployed but looking for work reported that enrollment made it easier to look for work, and employed expansion enrollees reported that enrollment made it easier to continue working.



4. Greater impact of delivery system reforms by ensuring a broad coverage base

A population with higher levels of coverage may facilitate greater adoption and impact of payment and delivery system reforms that transform practice patterns. Many delivery system reforms depend on active patient engagement in consistent, high-value care; patients who lack insurance may forego care until the need is emergent. In addition, while a payment reform that applies to a small proportion of the provider's patient panel can drive some change, broader coverage allows for payment reforms that apply to a larger portion of a provider's panel and revenue, potentially enabling more systematic practice transformation rather than small-scale workarounds for only a portion of patients.

Is there an association between the adoption, success, or sustainability of a delivery system change and the payer or coverage status of the patient panel affected?

Have the states that expanded Medicaid coverage under the ACA undertaken payment and delivery system changes in their Medicaid programs?

Analysis of the New York City Health & Hospitals safety net system identified areas of synergy in the ACA's coverage and delivery system reforms, such as through more consistent use of high-value services (e.g., mental health visits) and relatively lower use of high-cost avoidable services (e.g., ED visits).⁴⁰

There have been significant innovations in provider payment and care models under Medicaid in recent years. Both expansion states and non-expansion states have implemented these innovations, but the approaches are more ambitious and impactful in the states that expanded Medicaid. Much of this was accomplished under the State Innovation Model (SIM) initiative. Examples of the innovations include comprehensive primary care (CPC and CPC+), health homes, integrated care models, episode-based payments, population-based payments, and care for beneficiaries with complex care needs and high costs. There has been an explicit effort to integrate Medicaid and Medicare service delivery and payment models, and many states are working to align their models with those used by commercial payers.^{41,42}

The Delivery System Reform Incentive Payment (DSRIP) program is a mechanism under CMS's Section 1115 Waiver authority that has been used to support hospitals and other providers to improve care for Medicaid beneficiaries. Eight states have used DSRIP waivers, and one of the initial goals was to transform their delivery systems to improve quality and reduce costs for the general population.^{43,44} An evaluation of the DSRIP program in California found that the participating hospitals achieved nearly all of their project milestones and made improvements in key quality and cost measures such as access to appointments, smoking cessation, blood pressure control, mammography screening, and pediatric asthma care.⁴⁵

40 Ziring JP, Tatem KS, Newton-Dame R, et al. "Coverage Expansion and Delivery System Reform in the Safety Net: Two Sides of the Same Coin," *NEJM Catalyst*, October 2017.

41 Centers for Medicare and Medicaid Services, "Medicaid and CHIP: Strengthening Coverage, Improving Health", January 2017. Accessed online at <https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf>

42 Bailit Health, "The Role of State Medicaid Programs in Improving the Value of the Health Care System", National Association of Medicaid Directors, March 22, 2016. Accessed online at http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf

43 Schoenberg M, et al. "State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools", National Academy for State Health Policy, March 2015. Accessed online at <https://www.macpac.gov/wp-content/uploads/2015/06/State-Experiences-Designing-DSRIP-Pools.pdf>

44 Bachrach D, Bernstein W, Augenstein J, et al. "Implementing New York's DSRIP Program: Implications for Medicaid Payment and Delivery System Reform," The Commonwealth Fund, April 2016. Accessed online at http://www.commonwealthfund.org/~media/files/publications/fund-report/2016/apr/1871_bachrach_implementing_new_york_dsrip_v4.pdf?la=en

45 Pourat N, Meng Y, Leibowitz A, et al. Final Evaluation Report of California's Delivery System Reform Incentive Payment (DSRIP) Program. Los Angeles, CA: UCLA Center for Health Policy Research, February 2016. Accessed online at www.dhcs.ca.gov/provgovpart/Documents/DSRIPFinalEval.pdf

Is there evidence that the portion of a provider's revenue or patient panel linked to a payment reform has an impact on the degree of practice transformation that follows (e.g., smaller portions lead to small workarounds or practice changes only for covered patients, while larger portions lead to more widespread changes in practice patterns for the whole patient panel)?

Research on the effect of pay-for-performance programs has produced a wide range of conclusions about the amount of incentive required to induce behavior change, potential unintended consequences of selective focus on what is being measured, or provider avoidance of high-risk patients. Evidence on the design of payment reform impacting care redesign has tended to be more anecdotal or gray research from industry conferences or implementation consultants.

Specific payment and care redesign models like the primary care medical home or the Comprehensive Primary Care+ program may have a more direct impact in supporting primary care capacity to the benefit of newly insured individuals with unmet needs.

Summary

Higher levels of coverage have stimulated innovative value-based payment and care models, led to greater alignment of public and private payer strategies, and facilitated greater adoption and impact of payment and delivery system reforms.



For more information

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