CHI SNAC LABS 2016

Food for Thought

Updates from the Safety Net Advisory Committee (SNAC)

Supply and Demand

Eligibility and Provider Pay Affect Health Coverage Enrollment

JANUARY 27, 2016

Introduction

January's meeting of the Safety Net Advisory Committee Learning Lab (SNAC Lab) focused on supply and demand obstacles to wider use of public insurance coverage programs.

On the demand side, the SNAC Lab audience heard new estimates of the Colorado population that is eligible but not enrolled (EBNE) for health coverage benefits.

On the supply side, the group heard about research that showed limited effects of an increase in reimbursement in enticing providers to see more Medicaid clients.

Primary Themes

- Colorado's EBNE rate for public coverage has dropped despite an expansion of Medicaid eligibility.
- Nearly three-quarters of Coloradans who are eligible for tax credits to buy private insurance did not take advantage of the benefit in 2014.
- A bump in pay for primary care providers led to an estimated three additional Medicaid appointments per month for each provider.

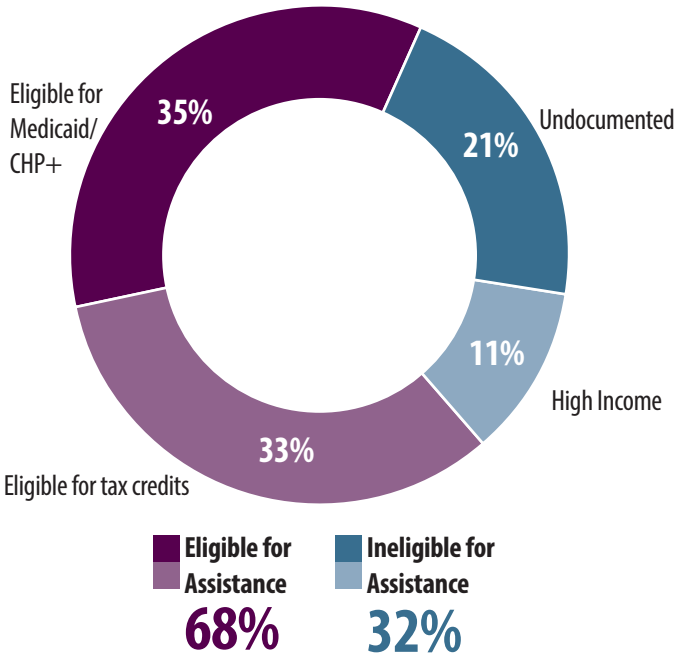
Background: Demand Side

Emily Johnson, a policy analyst for the Colorado Health Institute (CHI), shared findings from her research into the EBNE population.

Colorado's EBNE rate for public coverage — chiefly Medicaid — has dropped since 2012, but many people still are not taking advantage of their coverage benefits. More than two-thirds of the uninsured are eligible for some sort of coverage benefit. (See Figure 1.)

Nearly 136,000 Colorado adults, or an estimated 26 percent of the 530,000 eligible for Medicaid, did not enroll in 2014 and instead remained uninsured. This accounted for nearly a third of the state's uninsured adults.

Figure 1. Majority of Colorado's Remaining Uninsured Qualify for Government-Sponsored or Subsidized Coverage, 2014



Children fared better.

Only five percent of the 520,000 kids eligible for Medicaid were not enrolled. Still, about 62 percent of Colorado's uninsured children qualify for a public insurance public program but have not been enrolled.

CHI also analyzed uninsured Coloradans who were eligible for advanced premium tax credits (APTCs) to

subsidize private coverage bought on the exchange. The Affordable Care Act makes these credits available to people who earn less than 400 percent of the federal poverty level ($95,400 for a family of four in 2014).

The EBNE rate for residents eligible for tax credits was higher than those for the public insurance programs. About 73 percent of the estimated 240,000 adults eligible for a tax credit remained uninsured and did not take the benefit. (See Figure 2.)

And almost half the 17,000 children eligible for a tax credit remained uninsured.

Finally, CHI developed a new statistical model to estimate the number of uninsured undocumented immigrants in the state who are not eligible for public insurance or tax credits. An estimated 112,000 people fall into this category — roughly 21 percent of the uninsured in 2014.

In general, people in the EBNE population were more likely to be young, Hispanic, and lack a high school diploma than the overall population. (See Figure 3.)

The SNAC Lab Discussion: Demand Side

The remaining uninsured will be difficult to reach, according to people who attended the SNAC Lab.

As noted above, an estimated 21 percent of the uninsured are undocumented and therefore ineligible for Medicaid, Medicare or tax credits.

Other uninsured people have not yet learned about the coverage assistance programs available to them. Some others politically oppose the ACA and have refused to sign up. Others pointed out that affordability of private insurance is a growing problem, even with the benefit of the tax credit and cost-sharing reductions for some customers.

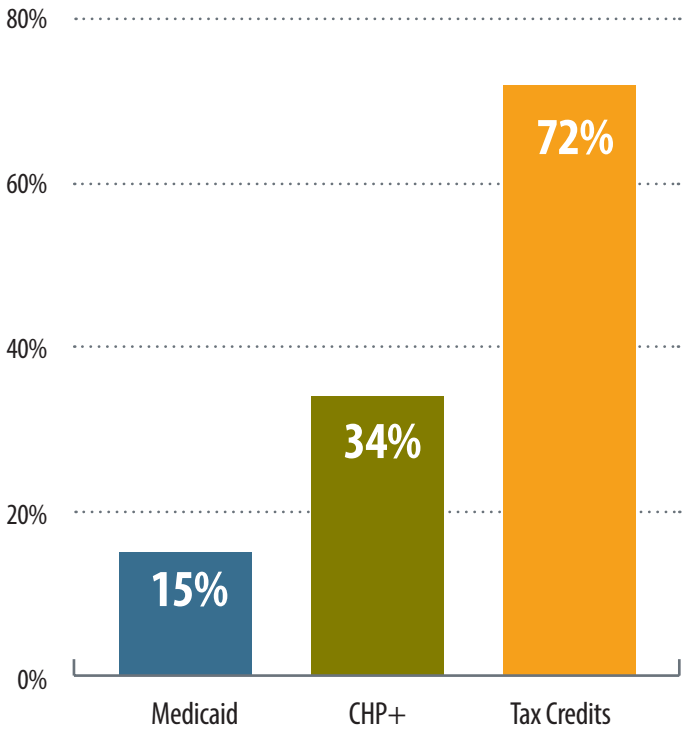
Insurance is a middle class concept, and some people have not signed up because the idea is foreign to them.

Outreach groups are using motivational interviewing to get the uninsured "from no to yes," a SNAC Lab attendee said.

Some providers are taking the initiative to spread the word to their patients.

Doctors Care Clinic in Littleton worked with the Tri-County Health Department to operate a Medicaid sign-up site at the clinic. It provided health coverage navigation to all of its patients and found that 80 percent of them were eligible for Medicaid.

Figure 2. EBNE Rates by Government Assistance Program, All Ages



Most people sign up for benefits at a clinic or some other type of medical site, according to a representative from the Department of Health Care Policy and Financing, the state agency that manages the Medicaid program. It's likely that many of the remaining uninsured have not used medical services in the past few years.

Background: Supply Side

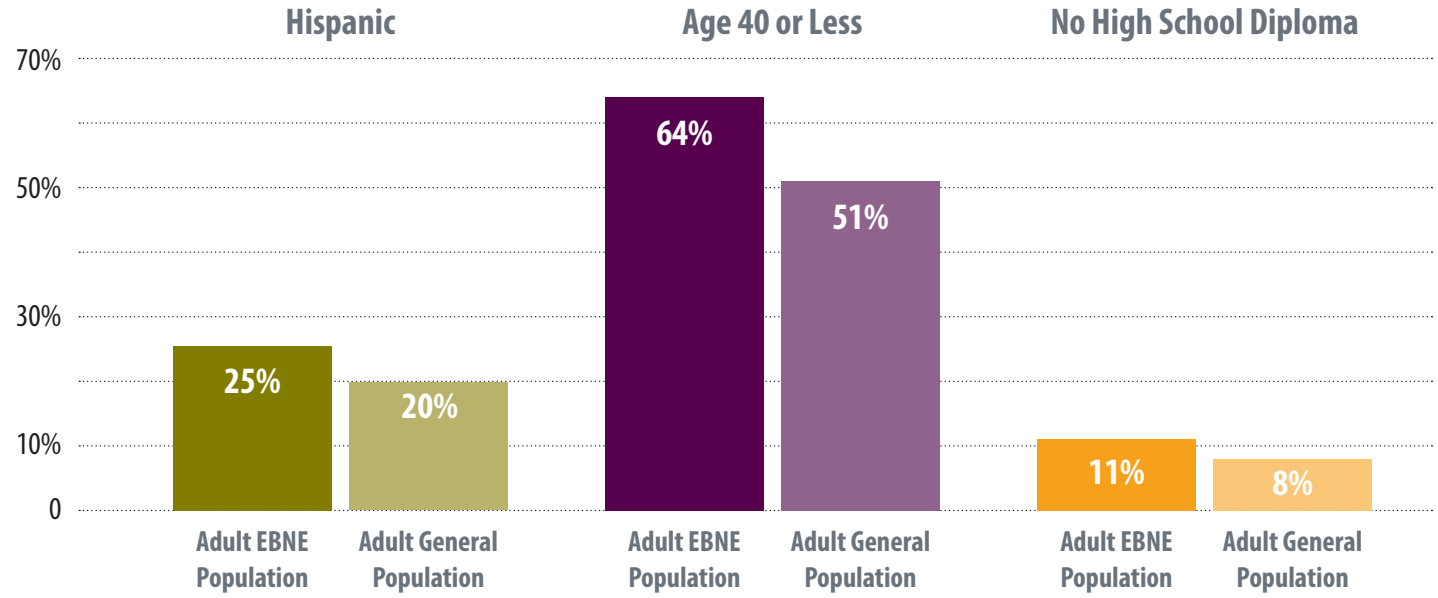
Providers in Colorado have received extra payments for treating Medicaid patients since enactment of the ACA. This so-called "provider bump" was intended to induce more providers to accept an anticipated surge in Medicaid clients.

The federal government payed for the provider bump initially, and the Colorado legislature chose to finance it last year. But this year, legislators are debating whether the state can afford to continue paying for the bump.

Dr. Mark Gritz of the University of Colorado School of Medicine is studying the degree to which the bump has induced providers to see more Medicaid clients.

His initial findings show a small effect, and they point

Figure 3. Characteristics of the Adult Eligible But Not Enrolled (EBNE) Population



to some barriers and possible policy changes to attract more providers to Medicaid.

Gritz compiled data on the effects of the provider bump from January 2013 through June 2014, when it was 100 percent federally funded.

"Short story: There seems to be a small impact on provider behavior," Gritz said.

He found an average of 3.18 more "bump-eligible" visits per month per provider. That translates to 11,000 to 13,000 bump-eligible visits each month by Colorado Medicaid clients.

The additional visits did not seem to affect Medicaid clients' access to care. Gritz studied four access to care measures:

- Emergency room visits for conditions that could have been prevented with adequate access to primary care.
- Adult access to preventive care.
- Children's and adolescents' access to primary care providers.
- Continuity of care.

None of those measures changed remarkably during the course of the study.

But Medicaid was undergoing a large expansion at the time, and there was a concern that access to care would decline. It's noteworthy that access held steady, Gritz said.

Gritz also built a model to study individual provider behavior in light of the bump. He found the additional 3.18 Medicaid visits per month came from both providers who already accept Medicaid and expanded their caseload as well as providers who previously did not take Medicaid.

11,000 TO 13,000

Estimated extra monthly Medicaid visits as a result of a bump in provider pay.

Gritz also identified a barrier to enticing providers to participate. Providers had to file paperwork to attest that they qualified for the bump. States could offer higher payments only to providers who had attested. This requirement made the bump harder to implement.

When the Colorado legislature chose to fund the bump from January 2015 through June 2016, it removed the requirement that providers file attestation paperwork.

The next step for Gritz is to study an additional year of data and see what effect, if any, there was from dropping the attestation requirement.

The SNAC Lab Discussion: Supply Side

In general, the SNAC Lab audience was not surprised that the provider bump did not change access to care, especially as seen through avoidable emergency room visits.

When other states expanded Medicaid, they saw surges in emergency room visits, because that was always the place where many uninsured people knew they could get care.

The provider bump was designed to change provider behavior, not patient behavior, one doctor in the audience said. However, in the first year, the bump payments came in at the end of the year, and it was difficult for many providers to figure out why they had received a check. This defeated the purpose of giving providers a financial incentive to see more Medicaid patients, because they did not connect their actions to the payment.

So what would it take to make a bigger change in provider behavior? "Immediate gratification," one audience member answered.

Others, though, were skeptical that even an improved bump program would do much to attract more providers to Medicaid.

The bigger hurdles have not changed, members of the audience said:

- Medicaid reimbursement rates often are lower than other coverage, even with the provider bump.
- Medicaid clients can be a difficult population to treat because of chronic health problems, and it's difficult to arrange referrals to specialists who will accept Medicaid.
- The administrative burdens of Medicaid are hard for small providers to overcome.

Conclusion

The past three years have been a time of rapid change for health care coverage. Colorado has greatly expanded its public insurance coverage and reached a greater percentage of the Eligible But Not Enrolled population. At the same time, Medicaid clients' access to care has not changed, but it's a good sign that access to care did not get worse during the eligibility expansion.

On the other hand, nearly three of four Coloradans who are eligible for tax credits to buy private insurance are not taking advantage of the benefit. And a bump in reimbursement for primary care providers has had only a small effect on the willingness of providers to take Medicaid clients.

And finally, a fifth of Colorado's remaining uninsured are ineligible for any kind of public coverage benefits because of their immigration status.

Organizations Represented at the January 27, 2016, SNAC Lab

- Beacon Health
- Caring for Colorado
- Children's Hospital Colorado
- ClinicNET
- Colorado Access
- Colorado Association for School-Based Health Care
- Colorado Behavioral Healthcare Council
- Colorado Coalition for the Medically Underserved
- Colorado Community Health Alliance
- Colorado Consumer Health Initiative
- Colorado Department of Health Care Policy and Financing
- Colorado Department of Public Health and Environment
- Colorado Hospital Association
- Colorado Rural Health Center
- Commonwealth Fund
- Covering Kids and Families
- Delta Dental Foundation
- Denver Regional Council of Governments
- Jefferson Center for Mental Health
- Kaiser Permanente
- Mile High Health Alliance
- North Colorado Health Alliance
- Rose Community Foundation
- SET Family Clinics
- Steadman Group
- University of Colorado School of Medicine

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