


MEDICAID MANAGED CARE

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HEALTHCARE STRATEGIES

My Background

- Started in the Arizona Governor's Office of Strategic Planning and Budgeting
- Worked for a Medicaid consulting firm, Engquist, Pelrine, and Powel (EP&P Consulting), for ten years helping states reform their Medicaid programs
- District of Columbia Department of Health Care Finance: Policy Director 3 years and Medicaid Director 2 years
- Ohio: Director of the Department of Medicaid
- Board member and Vice-President of the National Association of Medicaid Directors (NAMD)
- Founding Partner of Speire Healthcare Strategies, LLC

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Ohio Medicaid Overview

- Total Estimated Medicaid Enrollment: 3.06 million as of September 2017
  - Managed Care: 2.6 million (83%)
  - Fee-for-Service: 511,792 (17%)
- SFY 2017 Medicaid Budget: $27.1 billion (All Funds)
- SFY 2017 Medicaid Actual: $25.6 billion (All Funds)
  - SFY 2017 Managed Care Budget: $15.5 billion (All Funds)
  - SFY 2017 Managed Care Actual: $14.4 billion (All Funds)

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Improving Health Outcomes

- Incentives can be placed in the contract to improve health outcomes.
  - Pay for performance (P4P
  - Value based purchasing (VBP)

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Pay for Performance

- Can be tied to various measurements
- Most common is tying P4P to HEDIS measures, for example:
  - Childhood Immunizations
  - Adolescent Immunizations
  - Lead Screening
  - Controlling High Blood Pressure

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Pay for Performance (continued)

- Can be accomplished through either a withhold or a bonus payment
  - For example if a capitation payment is $100 PMPM and the P4P withhold is 3% the plan is paid $97 PMPM and the $3 is only paid to the plan if they hit the incentive targets
- Plans can use the P4P dollars to incentivize providers
- Can also be accomplished by changing the auto-assignment algorithm
  - Ohio ties hospital readmissions to the auto-assignment algorithm
  - Aligns the quality incentives of the plans and hospitals to encourage them to work together

Value Based Purchasing

- Many state Medicaid programs, Medicare, and private sector health insurance plans are moving from paying providers on a FFS basis to a value based purchasing model
- Under the FFS providers are incentivized to provide more services to generate more revenues
- In a value base purchasing model providers are incentivized to reduce costs by sharing in the savings with the health plans
- Many state Medicaid programs are putting value based purchasing requirements in their managed care contracts
- Ohio implemented Episodic payments and Patient Centered Medical Homes through it MCOs

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Timing of Improvements

- All improvements take time
  - At least 2 years
  - More often and more realistic is 3 or more years
- Reasons for timeframe
  - Providers have to adjust to the new incentives
  - Measurement is on an annual basis
  - Need a base year

Legislative Oversight

- Necessary but there needs to be a balance
- Set big picture direction
- Medicaid agency needs to be able to deal with issues as they arise
  - Often cannot wait for a change in law
- Mandates increase cost
  - The more requirements or limitations placed on managed care plans the greater the reduction in savings

Legislative Oversight (continued)

Budget development

- Legislature needs to understand
  - Caseload estimates
  - Capitation rate development
- Legislative staff needs to learn managed care
- May need outside help

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Timing of Managed Care Implementation

- RFP Development
- RFP release and MCO response
  - Need to give MCOs ample time to put together their proposals
  - Often changes due to questions
- Expect procurement challenges and possibly lawsuits
- Plans need ample time be ready for go live
  - State must complete readiness reviews
  - IT system coordination and integration
  - Providers need time to work with plans
    - Contracts
    - Billing testing

QUESTIONS

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