

Monitoring Medicaid Managed Care

Presented By:

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Agenda

- Navigant Health Care Overview
- The Importance of Monitoring – Making the Case
- The Changing Landscape of Medicaid
- Integration and Coordination



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NAVIGANT HEALTHCARE

NAVIGANT HEALTHCARE OVERVIEW



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Who is Navigant Healthcare?

- 30+ years Global Consulting Firm
- 2,500 professionals located in over 45 U.S. / Global Based Offices
- Key Health Care Practice Areas:
 - Health Care: > 500 consulting professionals and industry thought leaders
 - Payer
 - Provider
 - Performance Improvement
 - Life Sciences
- Our Clients
 - Federal and State Government Agencies
 - Health Plans
 - Health Systems and Physicians
 - Pharmacy Benefit Managers (PBMs)



Monitoring Medicaid Managed Care

MAKING THE CASE

WHY IS MONITORING IMPORTANT



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The ultimate goal of monitoring plan and program performance is to improve health outcomes in the most cost-effective manner while promoting compliance with contract requirements



Why is Monitoring Important?

Managed care is expanding

- State Medicaid agencies transitioning from FFS to Managed Care
- More than just a transfer of responsibility
- Effective contractor monitoring will be particularly critical for states moving populations with special needs to managed care

Rigorous federal reporting requirements

- Meeting these requirements becomes more challenging with expanding populations, particularly with expansion to shared savings models

Fiscal Responsibility

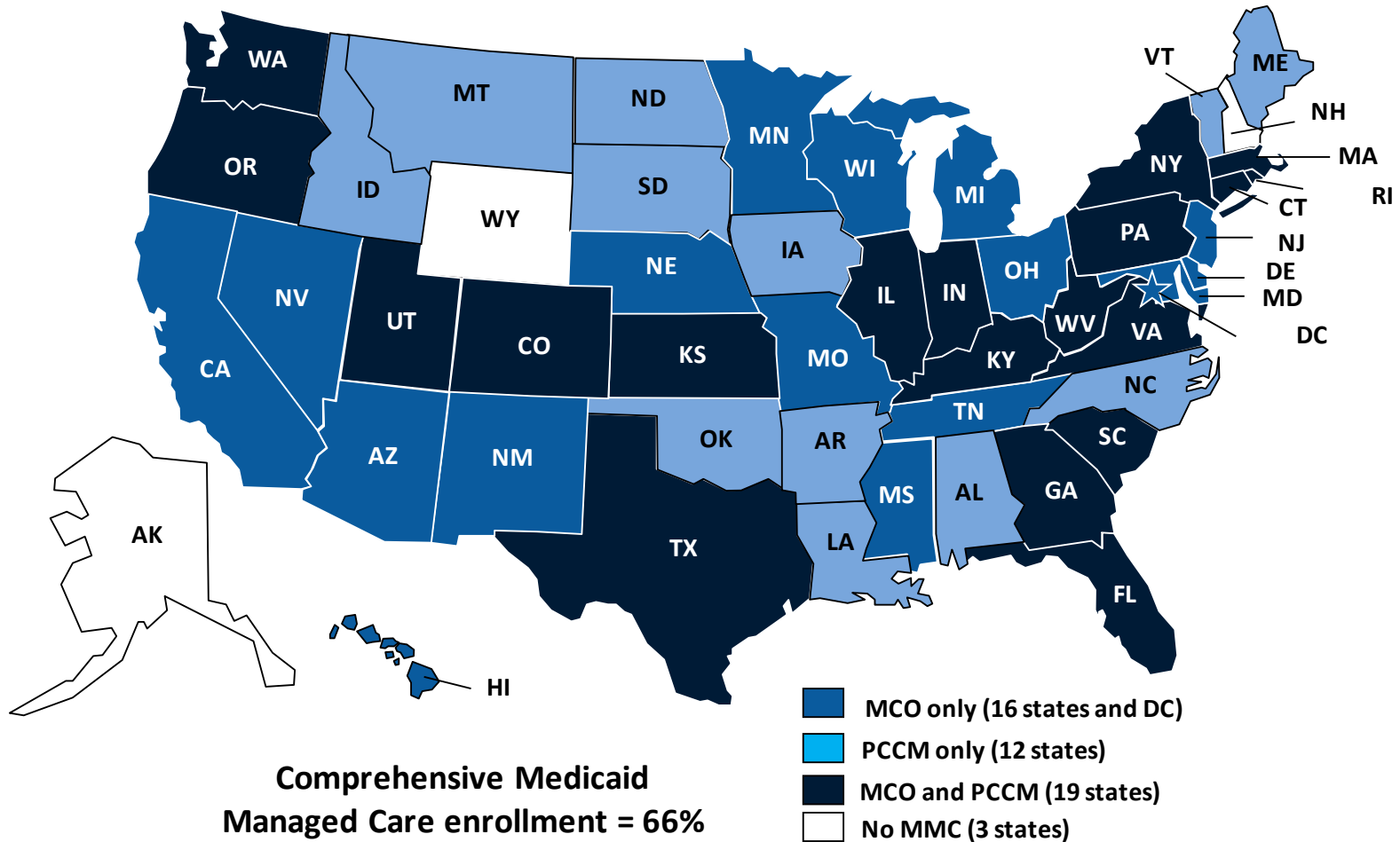
- States are increasingly under the microscope to ensure the best use of taxpayers dollars to gain the optimum return on the investment

Accountability

- Value based purchasing....driving performance improvement.



Managed Care Operating in the States, 2010



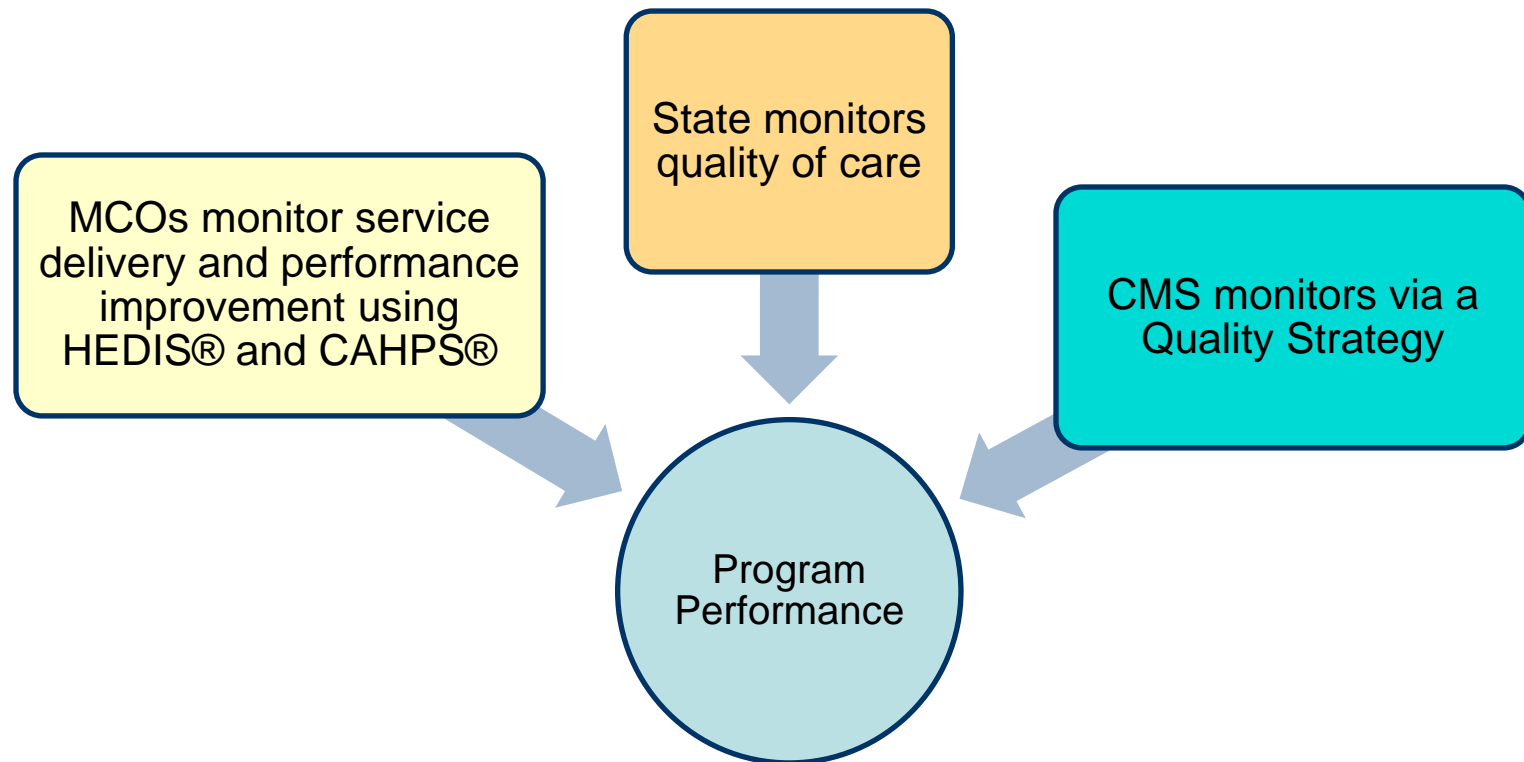
Source: Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010: A Summary
From a 50 State Survey. September 2011.



Federal Monitoring Regulations

Overview

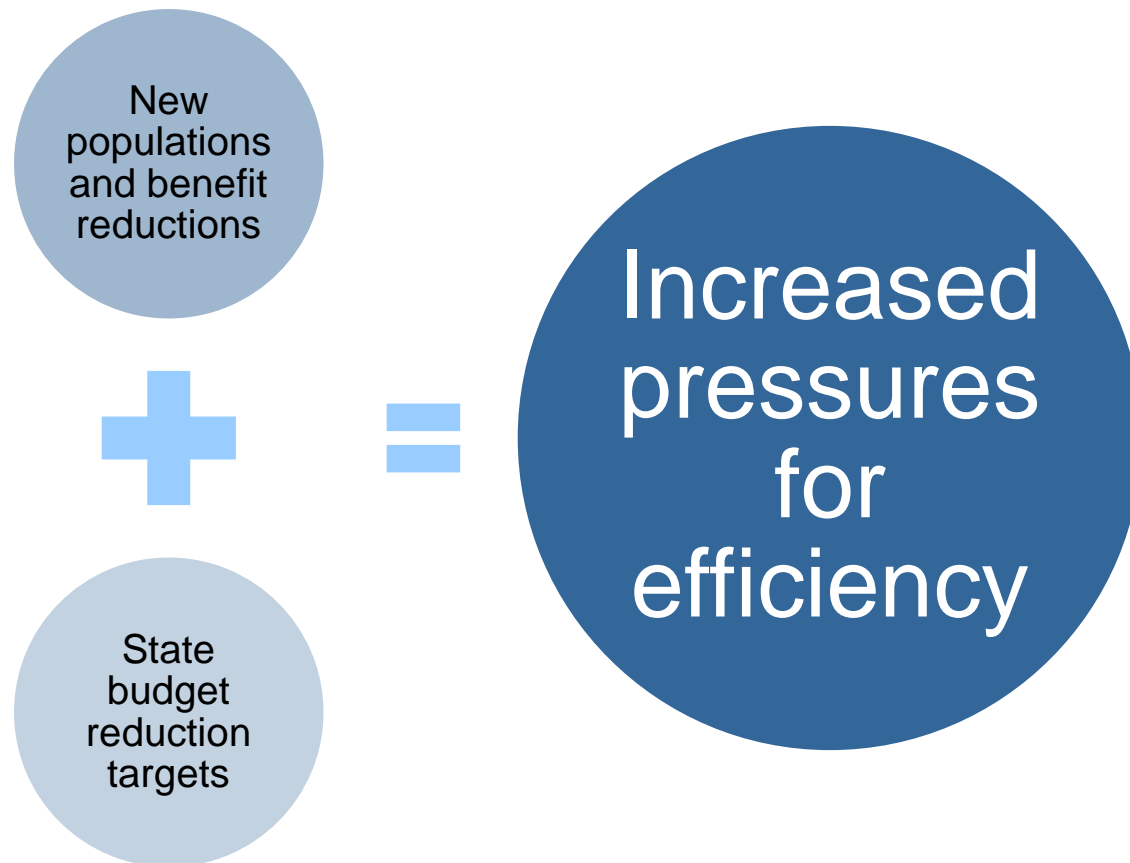
Federal rules require quality management for Medicaid managed care plans



Federal Medicaid Managed Care Regulations (42 CFR 438.200 et seq.)



Impact of the Accountable Care Act on State Medicaid Programs



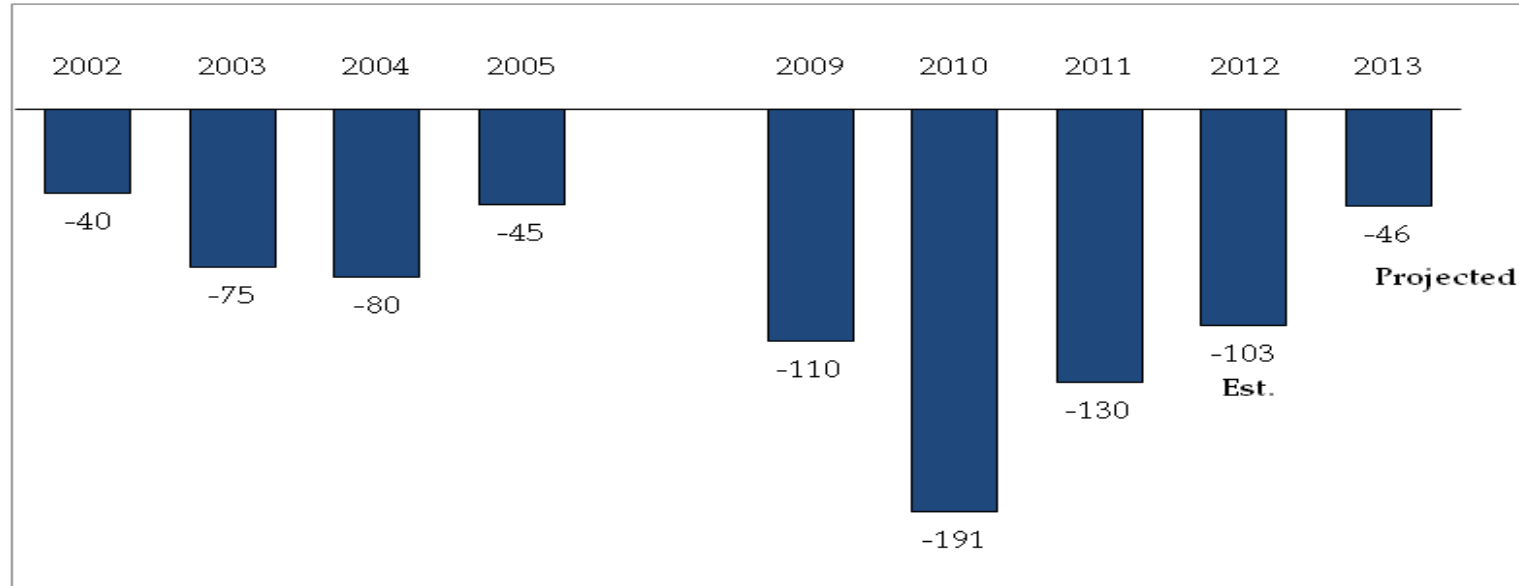
H.R. 1--111th Congress: American Recovery and Reinvestment Act of 2009. (2009)

Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010:A Summary From a 50 State Survey. September 2011..



National Themes: Available Dollars

- State budgets are stressed from the recession

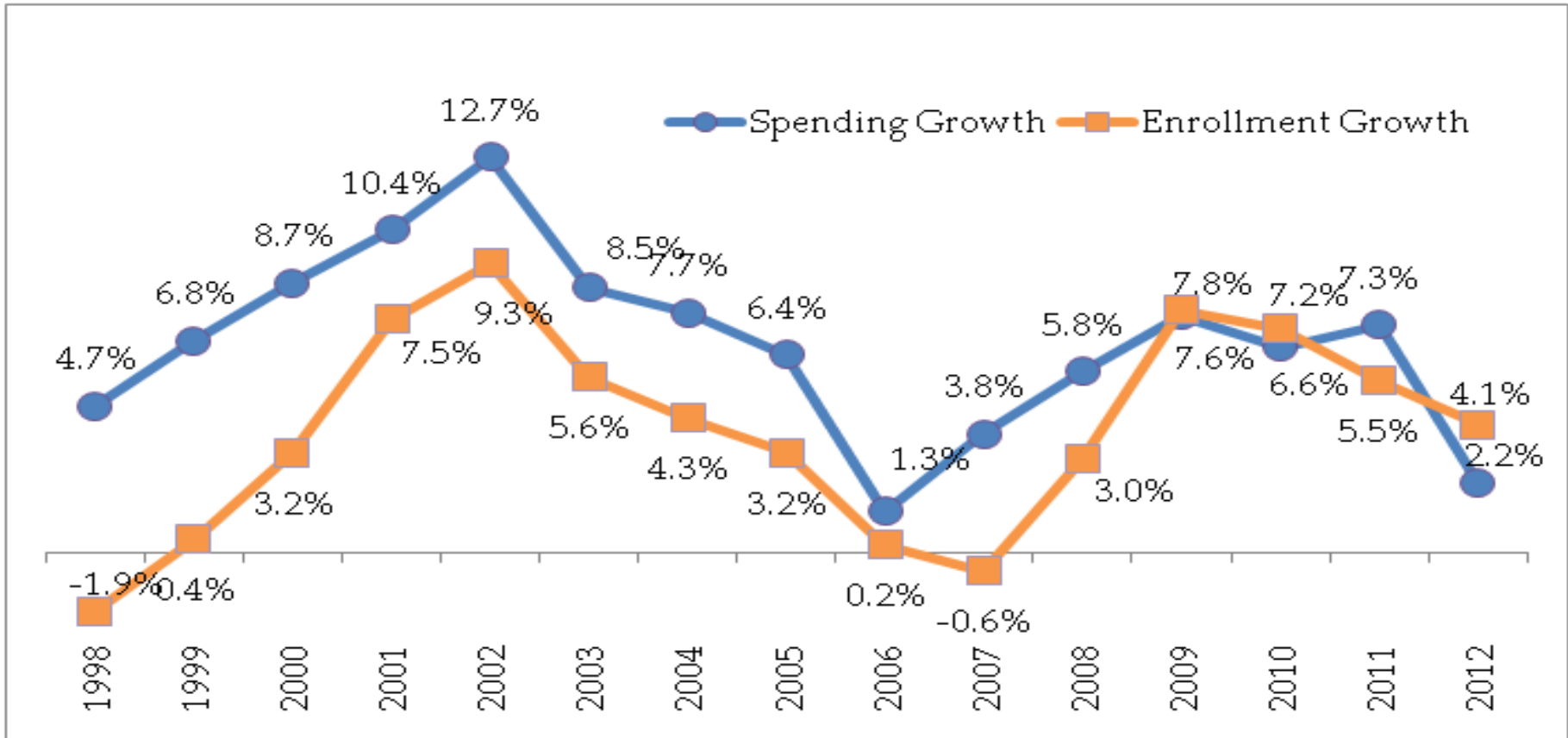


- Affordable Care Act provisions introduce new programs and requirements, including eligibility expansion

Source: Center for Budget and Policy Priorities. States Continue to Feel Recession's Impact. Revised June 2011.

National Themes: **Costs**

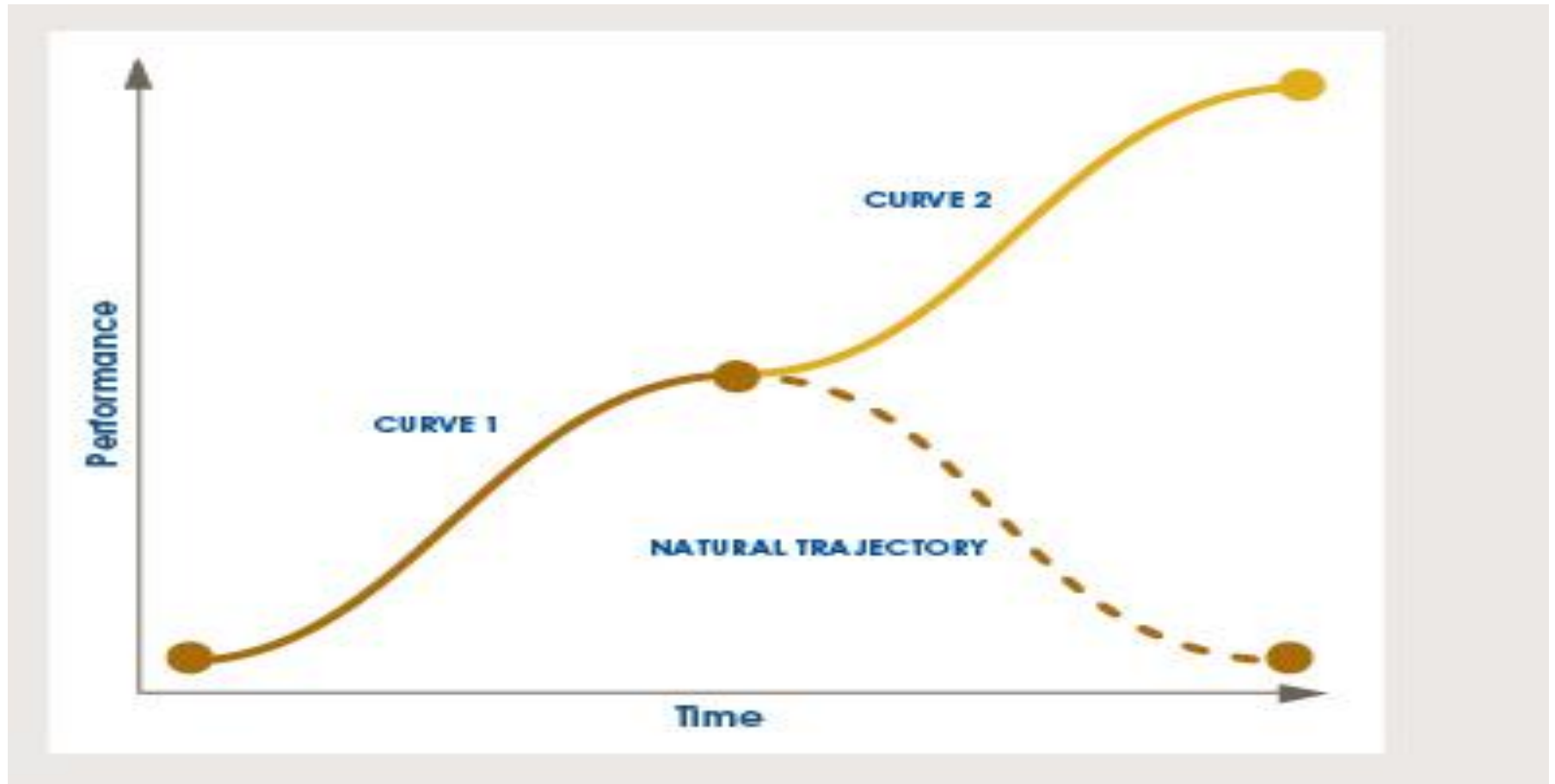
Total Medicaid Spending and Enrollment Percent Change, FY 1998 – FY 2012



Source: Smith, Gifford and Ellis. Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012. Kaiser Commission on Medicaid and the Uninsured, October 2011



National Themes: Payer & Provider Implications



Savings Opportunities

Key Drivers to Cost Savings (in billions of dollars)

1. Administrative System Inefficiency and Errors	\$100 – \$150
2. Provider Inefficiency and Errors	\$75 – \$100
3. Lack of Care Coordination	\$25 – \$50
4. Unwarranted Use	\$250 – \$325
5. Preventable Conditions and Avoidable Costs	\$25 – \$50
6. Fraud and Abuse	\$125 - \$175



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THE CHANGING LANDSCAPE OF MEDICAID: **PREPARE FOR IMPACT**

OPPORTUNITIES AND NEXT STEPS



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The Changing Landscape: **Prepare for Impact**

I. 2014 Medicaid Expansion

- Effective January 1, 2014
- ACA mandates coverage for all children and nonelderly adults with family incomes up to 133% FPL (estimated at 8 to 22 million)
- States may pursue alternative managed care designs to handle the influx of new enrollees.
 - States may enroll additional members in current contracts
 - States may need to contract with additional health plans to accommodate increase population
 - States may transition current, fee-for-service programs to risk-based managed care

H.R. 1--111th Congress: American Recovery and Reinvestment Act of 2009. (2009)



The Changing Landscape: **Prepare for Impact**

Other Federal opportunities that are changing the landscape and helping states prepare

Federal Initiatives

- EHR Incentive program
- Health Insurance Exchanges
- Payment Integrity Compliance

State Opportunities

- Real-time data
- Levers for quality improvement and monitoring
- Federal dollars

EHR Incentive Program: Administration and Compliance

➤ *State Medicaid agencies are making significant investments in their Medicaid EHR Incentive Programs and providers stand to earn billions in incentive programs if they can successfully apply, attest, and comply with program requirements.*

The Situation

- ◆ Billions \$ available to providers to promote the adoption and meaningful use of EHRs: Professionals: \$60k; Hospitals: Millions
- ◆ All states, the District, and the territories are pursuing Medicaid EHR Incentive Programs and have enhanced 90 % Federal funding match available
- ◆ 40 states have already gone live and made incentive payments requiring administrative oversight through 2021

The Challenge

- ◆ States have requested help designing, developing and administering their EHR Incentive programs
- ◆ Providers can receive incentive payments from both State (Medicaid) and Feds (Medicare) and are at risk of financial forfeiture for non-compliance with program requirements
- ◆ States must conduct audits within four months of provider payments ---includes all eligibility and meaningful use criteria
 - States will require data analytics to administer their incentive programs and interpret provider data
- ◆ States must identify all overpayments and return funds within a year to the Federal government States must identify all overpayments and return funds within a year to the Federal government



Cost Containment: **Payment Integrity Compliance**

➤ *Health Care Fraud, Waste and Abuse (FWA) is believed to be a \$70B industry and growing. Rx FWA offerings are in nascent stage.*

The Situation

- CMS imposes strict Fraud, Waste and Abuse program requirements on Medicare contractors and Medicaid State agencies
- Payers are seeking new cost containment / performance improvement strategies
- Lack of PBM oversight

The Challenge

- Retrospective not enoughprospective solutions are sought after as “cost avoidance” is more meaningful
- Market Lacks comprehensive (integrated medical/pharmacy) one-stop-shop solutions
- Payers typically have SIU units that focus predominantly on Fraud and not overpayments/abuse
- PBMs focus primarily on pharmacy fraud and overlook member and provider constituencies



Health Insurance Exchanges

➤ ***States are scrambling toward preparedness to comply with ACA Health Insurance Exchange Requirements and Market Impact (Economic Feasibility/Sustainability, Provider Access, Health Plan Participation)***

The Situation

- ◆ Exchanges continue to be one of the most pressing health care reform implementation issues for health plans, states and national policy makers
- ◆ States will continue to examine the impact of health insurance market reforms, implementation of premium payments, submission of benefit and rate information to the Exchange, and the implications for the consumer experience as they search for insurance options

The Challenge

- ◆ Significant systems integration likely required for State Agencies
 - e.g., State Agency coordination / integration re: eligibility and enrollment for better consumer experience
- ◆ Key Impact: New Processes, e.g., Qualified Health Plan (QHP) Selection:
 - Licensing
 - Certification
 - Re-certification / de-certification



Monitoring Evolution: From Compliance to Performance Improvement

Basic Monitoring – Program Inception

- Focuses primarily on policies and procedures, operations, and health plans' past performance and experience.
- Includes the readiness review and focuses on collecting baseline data for future monitoring
- Can the health plan support the program?

Compliance Monitoring - “Growing Pains”

- Focuses on contract compliance and compliance with other program requirements
- Frequency of compliance monitoring is based on priorities and past compliance

Quality and Performance Monitoring - Seasoned/Tenured Program

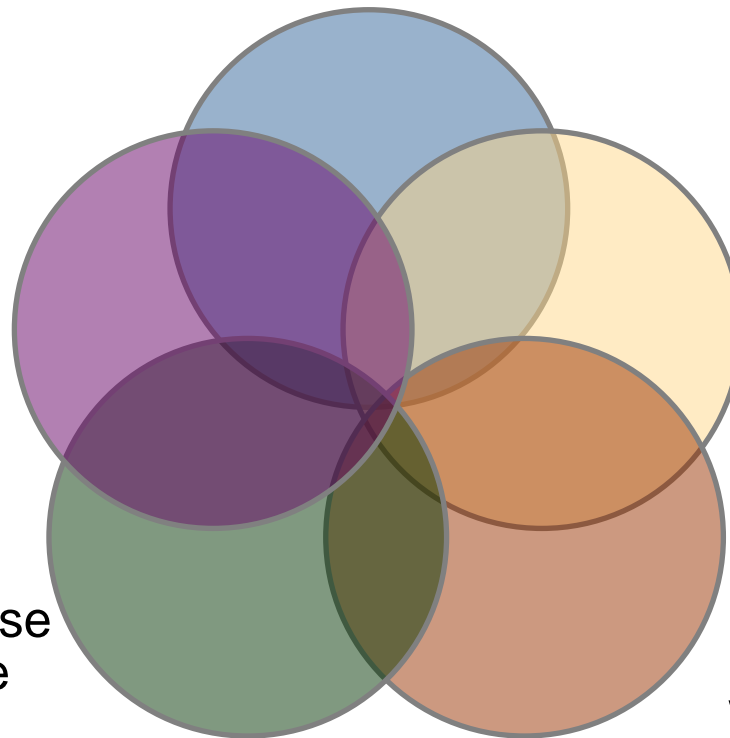
- Helps the reviewer understand how the health plan operates
- Focuses on high priority clinical areas and measures to what extent the health plan is successful in improving health outcomes



Monitoring Must-Haves

Goals: Health plans and state agencies share the same goal

Structure: Develop and maintain an appropriate organizational structure



Processes: Develop monitoring processes, policies and procedures

Tools: Develop and use tools that support the monitoring goals

People: Train health plan and state staff to work together toward the common goal

Integration and Coordination

Clinical models and payments

Technology as a driver of quality

Infrastructure to drive integration and performance improvement



Integration and Coordination: **Overview**

- States are realigning staff, data and technology to deliver “care for the whole person”
 - The *right* data, presented in the *right* manner helps clinicians *and policy makers* make the *right* decisions.
 - Using the data effectively to monitor and evaluate drives the quality and cost containment process



Integration and Coordination

Clinical Models and Payment

ACOs

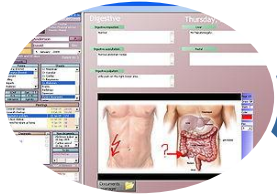
- Promote integrated, organized processes for delivering coordinated services that meet the highest quality and efficiency standards
- Designed at the macro/systems level

Patient Centered Medical Homes

- Similar goals of an ACO
- Utilize payment redesign, quality reporting requirements, data requirements and accreditation to drive performance and quality improvement at the micro/provider level

Integration and Coordination

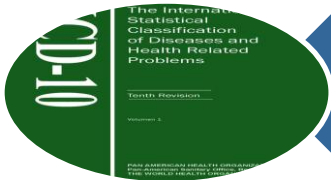
Technology as a driver of quality



EHRs: Real time collection of data used for quality monitoring and improvements



Health information exchange at the regional and state levels



Other Drivers: ICD-10; cost sharing for duals and data availability

Challenges persist: submitting and collecting valid data, making comparisons over time across providers

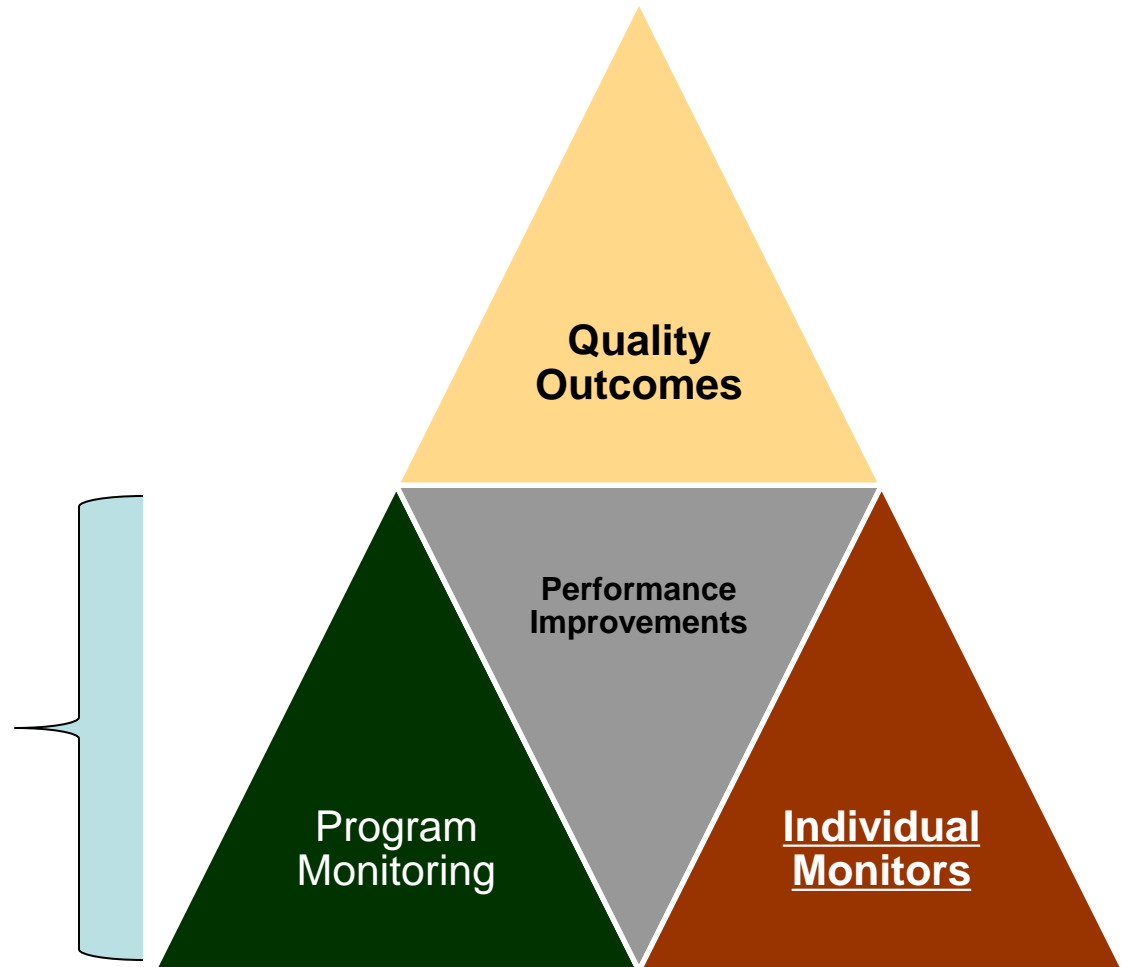
Integration and Coordination

Infrastructure that drives integration and performance improvement

Infrastructure

- Training
- Experience
- Tools

*The key is not to just have reports with numbers on them, but rather to build comprehensive plans for gathering, analyzing, disseminating, and using information **to drive performance improvement.***



Conclusion

- States must effectively monitor and plan “today” to help them best prepare for “tomorrow”
- Demand for accountability will increase
- Competition for dollars will increase

