NTT DATA Services

WHITE PAPER | HEALTHCARE & LIFE SCIENCES

Medicaid Managed Care Regulation: An Opportunity for States to Achieve High Performance

Utilizing data and analytics, as well as the wealth of knowledge from recent work in the public and private sectors, to operate a sustainable Medicaid program

MARCH 2019

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Executive summary

The public healthcare delivery landscape is changing drastically. Greater Medicaid managed care regulation gives state health agencies an opportunity to progress from strategy to execution, and to build a high-performing Medicaid program based on outcomes and cost effectiveness.

As the federal government continues to analyze the program, states should expect more regulations. For example, to make federal costs on Medicaid more predictable, future regulations could focus more on set spending limits and caps to generate savings in states' budgets. But it's not wise to continue to think that federal funding will remain open-ended. Currently, larger federal funds are automatically released if states spend more due to increases in enrollment or costs per enrollee. According to a Henry J. Kaiser Family Foundation report, spending in Medicaid continues to correspond with enrollment growth, and state spending tends to track overall Medicaid spending (see Figures 1 and 2).[1]

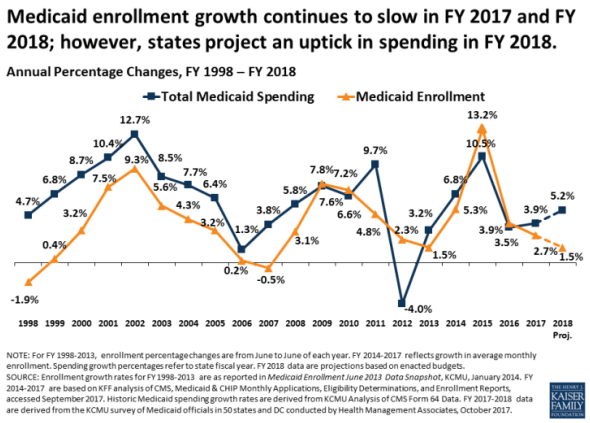

Figure 1: Medicaid enrollment and spending patterns in 2017 and 2018[1]

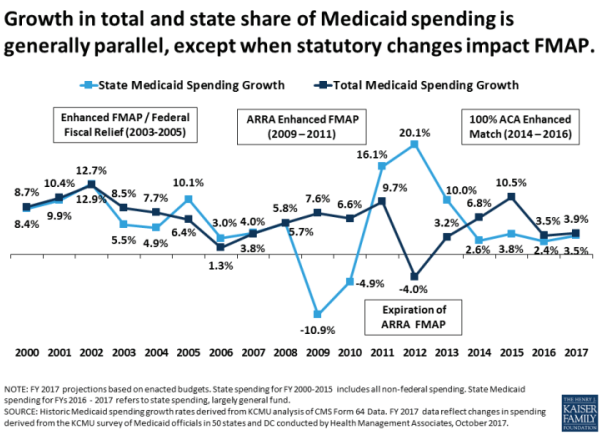

Figure 2: Medicaid spending in individual states tracks with overall Medicaid spending, except in cases of revised regulations[1]

States, however, must reassess their current Medicaid programs. They need a dynamic, learning healthcare system — one that continuously evolves and scales. A successful system will do the following:

- Create a strong program focused on outcomes
- Effectively coordinate with all stakeholders
- Accurately track and report on federally required measures
- Establish clear policies and guidance for outcomes-based reimbursement to entities
- Tackle, adopt and extend technical standards and infrastructure (for example, health information exchanges) among stakeholders
- Address challenges as they arise throughout the lifecycle of the Medicaid program

Greater regulation

Medicaid is the nation's primary public health insurance program for low-income residents. According to Medicaid.gov, more than 72 million Americans were covered as of November 2018. To provide these services states rely on managed care organizations (MCOs). These private insurers can be small non-profits or major commercial insurers. In return for managing beneficiaries' care, states pay these organizations a fixed amount per beneficiary. Preset budgets make managed care popular with states and profitable for MCOs.[2]

Now, the federal government — for the first time in over a decade — is proposing new regulations for privatized Medicaid. The goal of these so-called Mega-Rule or Final Rule regulations is to strengthen the quality of care Medicaid beneficiaries receive and to encourage managed care programs to better use their data.[3]

The impetus for the greater regulation of Medicaid managed care may be threefold:

- The need to reduce costs and improve efficiency to meet substantial budget shortfalls at both state and federal levels.
- The rapid expansion of patients into private health plans and the inadequate networks of doctors, as well as the growing demand for healthcare, stemming from the aging population and the increasing incidence of chronic lifestyle diseases.
- The greater variation across state standards for access to care, with increasing demands for improvements in the quality of healthcare services and patient care.

These sweeping updates by the Centers for Medicare & Medicaid Services (CMS) are an attempt to make managed Medicaid plans more like traditional government-run Medicaid plans. Reflecting on the significant role that managed care plays in the Medicaid program, as well as on the substantial changes to modernize it (for example, full-service MCOs transitioning to prepaid inpatient health plans [PIHPs] or prepaid ambulatory health plans [PAHPs]), regulatory structures can facilitate and support delivery system reform initiatives to improve health outcomes and the beneficiary experience while effectively managing costs.

To lower Medicaid spending, federal lawmakers could continue to adjust the program. Among the various possible options are repealing the Affordable Care Act expansion, arbitrarily reducing the federal government share of spending, reducing the scope of covered services and/or capping the amount that states receive from the federal government to operate the program.

From the federal government's perspective, funding caps could generate spending cuts and budgetary savings that would make costs more predictable. This would also help limit states' current ability to increase federal spending through open-ended federal financing by reducing the percentage — which is a relatively high proportion — of program costs the federal government covers.[4] Most states have reconfigured their health services, including some that are self-funded, to qualify for reimbursements. Healthcare provider taxes finance at least a portion of most states' Medicaid spending. The intent is to then return the taxes collected to those providers through higher Medicaid payments. This approach boosts federal Medicaid spending without committing to an increase in state spending. A capped program would reduce or eliminate these activities.[5]

These changes could put states and the recipients of their Medicaid services in serious jeopardy. Capping federal spending would add uncertainty to states' future budget planning initiatives. It would make it difficult to predict if Medicaid spending would exceed the caps and require additional state spending. States would also need to determine whether to eliminate optional services, reduce payments by cutting healthcare providers and health plans, or commit more of their own revenues to Medicaid. Or, states may figure out how to deliver outcomes-based services more efficiently to their citizens.

Building a successful Medicaid program

State health services agencies must be accountable to their citizens/constituents, no matter the burden. Given the challenges and complexities involved in ever-changing regulations, Medicaid agencies must re-examine their current system and preparedness. This is the time to look at every aspect of these programs from the standpoint of public health value creation (outcomes and cost effectiveness) for better assessment and required program course corrections. With successful reassessment and retooling, Medicaid agencies can accurately track and report on federally required measures, establish clearly interpreted policies and guidance for outcomes-based reimbursement, and be prepared to address budget challenges as they arise throughout the lifecycle of Medicaid programs for years to come.

Defining objectives

As a service provider supporting six of the 10 largest U.S. health systems, NTT DATA's Healthcare and Life Sciences team has significant insights into regional health plans. We suggest first identifying an agency's public health outcomes.

Consider the value the agency delivers from two perspectives:

1. What is the purpose of the agency? Why was it initially created? A simple way of ensuring an agency has the right purpose is to consider what the societal consequences would be if the agency ceased operations.
2. What are citizens' expectations of the agency? This is where the principles of fairness, trust and constituent satisfaction come into play.

To meet both objectives, more weight must be given to utilization as an outcome of the equation — the mission of the agency is first and foremost to provide access to healthcare and improve health status. But there's also a need to map agency objectives directly to outcomes.

It's essential to identify an agency's cost-effectiveness measures, too. An accepted standard in the healthcare industry is that the frequent use of preventive services reduces the need for high-cost interventional services, and that these services fulfill the objective of improving health outcomes overall. This is how an agency can serve citizens better — how it can improve health outcomes effectively, efficiently and in a manner that satisfies its stakeholders (who aren't only citizens but also providers).

With a wealth of knowledge available from recent work in the public and private sectors, applying these lessons learned will help agencies control mission-critical programs and administrative costs and, ultimately, progress forward on the journey to becoming high-performing agencies.

Examples of outcomes and cost effectiveness

Outcomes should focus on:

1. How to maximize utilization of preventive services — weight 35%
   Use of regular, preventive services reduces the need for interventional high-cost procedures and services. It should also contribute to lowering costs in the long run, as well as improving the population's health status. Assessing the utilization of case management (for example, prenatal and elder care) and disease management programs should be included, too.
2. How to maximize access — weight 30%
   Access to the program affects the program's effectiveness. Ensuring that the target population (particularly high-risk groups) is enrolled in Medicaid and has access to necessary services through providers improves the population's health status and reduces costs over time.

Cost effectiveness should focus on:

1. How to optimize medical spending — weight 20%
   Health services expenditures tend to be higher in inpatient and acute care services. However, preference is placed on preventive health services, because it's a more cost-effective means of improving the population's health.
2. How to capture outcomes adjusted expenditure — weight 15%
   Cost-effective agencies optimize the use of agency assets (opportunity cost of capital) and budgeted expenditures to generate the maximum level of outcomes per used resource.

Note: Effectiveness, and a focus area's given weight, determined by internal NTT DATA study.

Measuring outcomes

These Medicaid reform initiatives create a demand for data as the foundation for analysis and evaluation. Much of this data might start with the collection of base financial data for the rate development process on the basis of population covered to achieve actuarial soundness. However, for a successful Medicaid program, clinical data is also crucial for overall outcomes.

Drawing from many years of serving health plans across the country, NTT DATA has developed a series of metrics that can be used to measure how effective an organization is at achieving its dual objectives. Both dual objectives and metric weightings can be drawn from Medicare and commercial best practices.

Here are our suggested measures for tracking Medicaid program outcomes:

1. Maximize the utilization of preventative services:
   a. Preventative services utilization — 25%
   b. Emergency services utilization (inverse) — 10%
   c. Inpatient hospital utilization (inverse) — 25%
   d. Pharmaceutical services utilization — 20%
   e. Home care services utilization — 10%
   f. Nursing facility utilization — 10%

2. Maximize access:
   a. Member enrollment — 60%
   b. Number of months eligible members remained in the program per year — 40%

3. Optimize medical spending:
   a. Preventative services expenditures — 30%
   b. Emergency services expenditures (inverse) — 15%
   c. Inpatient hospital services expenditures (inverse) — 25%
   d. Home care and nursing expenditures — 15%
   e. Pharmaceutical services expenditures — 15%

These metrics then must be divided into a series of sub-metrics. The following are sample metrics and associated sub-metrics with the assumed weightings:

1. a. Preventive services utilization:
   - Clinic services beneficiaries as a percentage of total beneficiaries — 40%
   - Outpatient hospital services beneficiaries — 40%
   - Dental beneficiaries as a percentage of total beneficiaries — 20%

2. b. Number of months eligible members remained in the program per year:
   - Full-year eligible — 33%
   - Partial-year eligible (inverse) — 33%
   - Partial year months (times 12) — 33%

3. a. Preventive service expenditures:
   - Clinic services expenditures as a percentage of total expenditures — 40%
   - Outpatient hospital services expenditures as a percentage of total expenditures — 40%
   - Dental expenditures as a percentage of total expenditures — 20%

3.d. Home and nursing expenditures:
   - Home services expenditures — 50%
   - Nursing home expenditures — 50%

It will become increasingly important to capture a wide variety of data. The changing nature of the Medicaid environment now demands the ability to identify and measure outcomes, share information across stakeholders, and improve financial, clinical and operational efficiencies in the name of providing improved quality at a reduced cost. A data-driven environment underlies all these imperatives. Some studies indicate that financial, clinical and operational accuracies and efficiencies can be enabled through automated data capture and state-wide access to rich data.

Utilizing data and analytics

To mitigate the Mega-Rule risks and pressures to operate a sustainable Medicaid program, states need certain technological and operational capabilities to succeed. One of the most important requirements is to collect and mine data across stakeholders in the Medicaid program. The biggest challenge for states today is achieving better patient outcomes while also achieving predictable budget projections — the federal government has the same goal. The bill requires changes in business operations and the applications states use each day. Some provisions span all functional areas of the organization. One thing is certain: there will be an increase in demand for information.

However, states are drowning in data and ad hoc reports that don't provide insights to make business decisions. The investments made in health information exchanges (HIEs) are valuable, but these exchanges don't make a complete solution to meet the requirements. HIEs lack the robust capabilities needed to access past and real-time data to help define capitation rate settings and achieve certification with accuracy. We recommend expanding these information systems so agencies can provide the right direction to all stakeholders to achieve better health outcomes and cost effectiveness.

Finding a trusted partner to work with agencies to create a robust data warehouse and business intelligence (BI) solution, including analytics capabilities, can help. The solution will need to combine the financial, clinical and citizen data required to control costs, optimize operations and meet compliance requirements. Creating this cohesive and collaborative information environment will change how states compete for more federal Medicaid funding dollars, and it will enable them to become more agile and better prepared for creating a successful, data-driven Medicare program.

Managing the BI and analytics tool portfolio will become increasingly difficult, because the latest regulation has some undefined areas and numerous internal and external stakeholders requesting more information. To manage all requirements, states must first increase the quality of their data, and then standardize and consolidate their BI application and data analytics tool portfolio. This will help states do the following:

- Develop individual plan rates in an annual bid scenario. Because the mandate calls for exact rates to be certified, states may need to initially develop a rate range for each rate setting analysis so MCOs can be contracted at different points within the range. This could set the stage in the future for a better rate certification process based on specific demographics or type of service provided to achieve a common capitation process across MCOs.
- Separately and independently develop rates, if they differ by plan, in accordance with new rate development and certification requirements. With quality data sets, this can be avoided or evolved into a simpler process.
- Remove the burden from the actuary to develop and justify different rates to different plans and determine how to provide the detail of the build-up of the rates to demonstrate that the rates are actuarially sound to help in fixed or competitive bid scenarios.
- Provide past medical loss ratio (MLR) data for contracted plans and recommend future capitation rates if the plans report an MLR below 85%.3 Re-evaluate the underlying assumptions used in past rate settings.
- Deliver projections and indications even when base data isn't sufficiently combined with trend factors to aid the actuary in establishing capitation rates. This will be particularly helpful when historical trends fluctuate significantly; the actuary needs a solid source to consider when developing trend factors.
- Effectively establish no-cross subsidization if a reimbursement adjustment is developed in aggregate for a particular rate cell (different type of bundle).3 The actuary can easily understand the magnitude and whether the mix of services is appropriate with a budget impact analysis.

Conclusion

To keep up with the fast-evolving healthcare landscape (and its numerous regulations), states need a comprehensive and well-planned execution strategy. A dynamic, learning healthcare system that continuously evolves and scales is key. A successful system will have a strong program management function that brings together and effectively coordinates with all stakeholders; accurately tracks and reports on federally required measures; establishes clearly interpreted policies and guidance for outcomes-based reimbursement to entities; tackles, adopts and extends technical standards and infrastructure among stakeholders; and addresses challenges as they arise throughout the lifecycle of a Medicaid program.

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Kamesh's experience spans both U.S. and international healthcare, as well as life sciences. During his career, he has assisted these industries in new plan/product filings, sales and marketing launch strategies, product launches, and post-launch stabilization and performance improvement. Kamesh has helped clients set up shared service centers, transition to value-based care models and migrate to platform-based business models. He has also helped set up multi-payer/multi-patient population health services organizations, consolidating and optimizing operations to improve value-based care outcomes. Kamesh's expertise includes management consulting, end-to-end process consulting, systems integration and business process outsourcing.

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