Health New England
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# Strategies to Breakeven in a Managed Medicaid Program

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The Leadership Institute – February 17, 2017

# Market Context

- Health New England (HNE) is a ***not-for-profit health plan*** owned by Baystate Health, the leading integrated delivery system in Western Massachusetts.
- Across all lines of business, 200,000 ***members trust Health New England*** for their health insurance needs.
- HNE ***Be Healthy*** is our Managed Medicaid Product with 65,000 Members that we have operated since 2010.
- MassHealth, the Medicaid Program in Massachusetts, has a mixed model with Managed Care Organizations (MCOs) and a State-managed alternative.

# Medicaid Strategy

- Supports Mission of Baystate and HNE
- Grow Covered Lives
- Spread Fixed Costs
- Allocate Costs Disproportionately to Effect Commercial Rates
- Break Even

# Medicaid Population Profile

- HNE covers four counties in Massachusetts from inner city neighborhoods to sparsely populated rural communities.
- Our population is primarily Caucasian however includes a large Puerto Rican community and a number of recent immigrant groups.
- Massachusetts divides the population into Rating Categories (RCs) which include relatively well women and children, the disabled and an expansion population.
- Our population
  - 62.3% children, 37.7% adults
  - 58% female, 42% male
  - 17.1% disabled

# Medicaid Program Covered Services

- Comprehensive set of covered services including:
  - Medical
  - Behavioral Health
  - Pharmacy
  - DME
  - Ancillaries
  - Diagnostics

- Services not included In the Managed Medicaid Program for MCOs:**
  - Long Term Support Services
  - Hepatitis-C Medications (95% risk with the State)
  - Dental
  - Vision Hardware
  - Specialized screening for Children's Behavioral Health
  - Some Children's Behavioral health services which were court mandated.
  - Some autism treatments

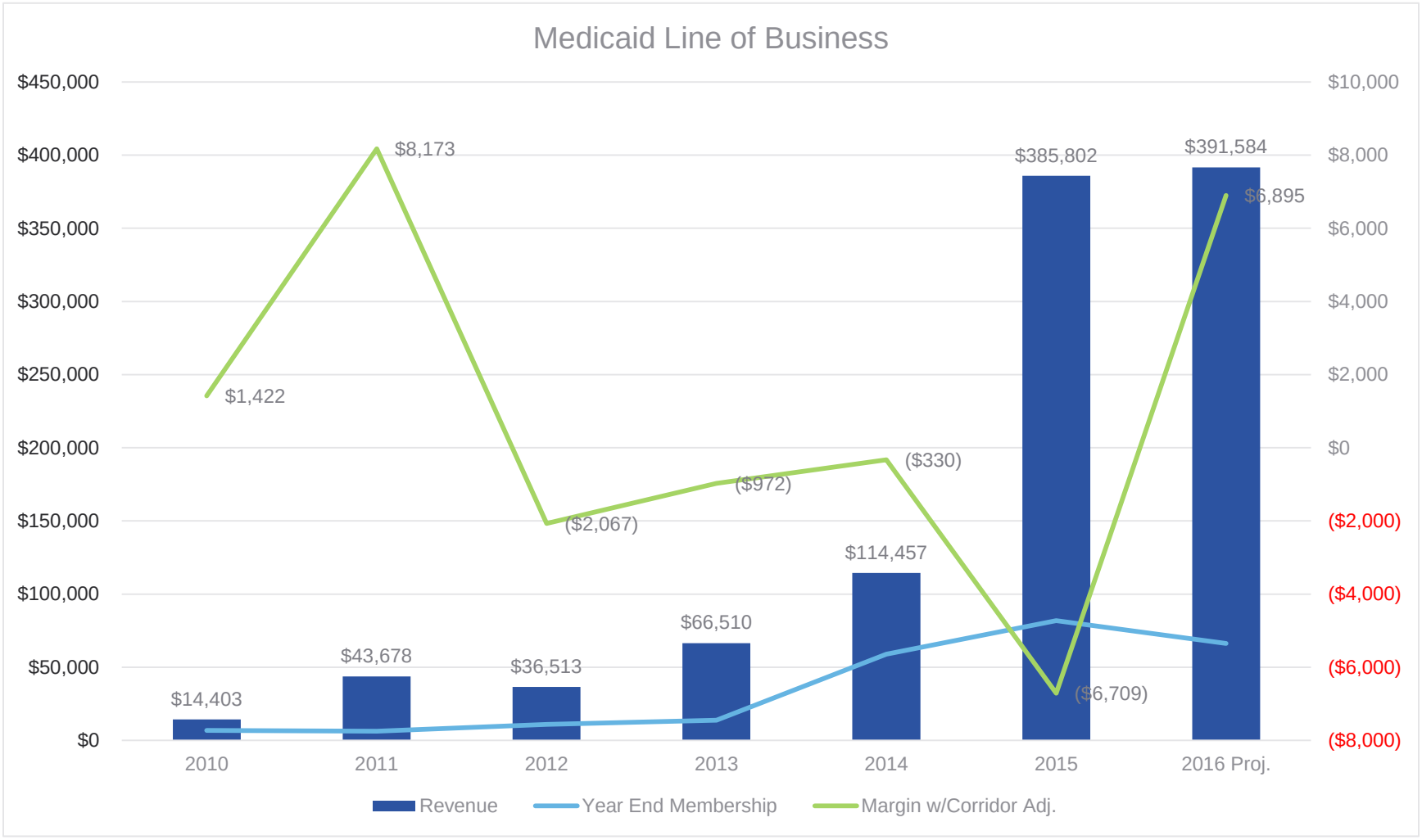


***Not included in PMPM but reimbursed by the state at cost*

# Effective Business Models

- Analyze cost and utilization trends (by age/gender and geographic region) in Medical, Behavioral Health / Substance Abuse, and Pharmacy categories to identify areas to impact.
- Ensuring that members are placed in the proper payment category – HNE uses a vendor to help qualify individuals for Social Security Disability Income and move to a higher reimbursement category.
- Continually monitor payment policies to ensure accurate payment of Medicaid coverage. Establish payment policies in the absence of any.
- Design a utilization management strategy focusing on areas with high spend and variability. For example, hiring a physical therapist to review DME requests.
- Establishing a network of providers willing to engage collaboratively with you to manage the population.  This requires reviewing cost and utilization data by practice group.
- Utilizing alternative payment methodologies to encourage efficient and high quality delivery system decisions.
- Selection and negotiation of vendors – Pharmacy and Behavioral Health

# Financial Performance



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# Financial Performance

**Medicaid Historical Reporting**

| Category | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 Proj. | 2010 to 2016 |
|---|---|---|---|---|---|---|---|---|
| **Year End Membership** | 6,893 | 6,298 | 10,885 | 13,819 | 58,873 | 81,894 | 66,280 | |
| **Revenue** | $14,403 | $43,678 | $36,513 | $66,510 | $114,457 | $385,802 | $391,584 | **$1,052,947** |
| **Margin w/Corridor Adj.** | $1,422 | $8,173 | ($2,067) | ($972) | ($330) | ($6,709) | $6,895 | **$6,412** |
| **Margin Percent** | 9.9% | 18.7% | -5.7% | -1.5% | -0.3% | -1.7% | 1.8% | **0.6%** |

# Effective Care Models

- Care management at the site of care for our most closely aligned health centers with measurable goals jointly established by the MCO and practices.
- Imbedding behavioral health in an integrated model within the primary health care setting.
- Carefully chose small incentives to encourage best health practices. For example gift cards for adolescent well care visits.
- Telehealth urgent care to impact overutilization of ED.
- Telehealth for psychiatry and diabetes education to improve underutilization of necessary care.

# Special Programs

- Green & Healthy Homes Initiative – targeting children with asthma
- 4C – Grant funded medical management program for children with complex medical conditions
- Baystate Addiction Task Force – uses recovery coaches as community health workers
- Community Health Workers – comprehensive 5 year training and implementation plan based on pilot success
- TechSpring – utilizing Baystate's tech incubator to work with developers on solutions for this unique population

# Every State is Different

- Understanding the Managed Medicaid Program in your State
  - All Managed Medicaid with health plans? Hybrid with health plans and a State-managed option? Competitive bid versus regional rates?
  - Is there a member lock-in? Auto-assignment if a person doesn't select a Managed Care Organization?
  - Are there risk protections (e.g. corridors of shared risk, carved out services)
- Understand the population at risk and reimbursement from the State for each cohort (Standard Medicaid; Disabled; Expansion Population with the ACA)
  - Do you need to participate in all segments? (margin can be different)
  - Are there differences in rates by geography?
  - How is the State risk adjusting your premium? Retrospective or Concurrent
  - Are individuals classified in the right buckets?

# Lessons Learned

- Strategies to breakeven in Medicaid are different than Commercial and Medicare. No member premium or benefit design differentiation and a challenging dynamic with provider payment rates being underfunded.
- Membership swings can happen rapidly based on network dynamics. Capital considerations need to be monitored closely.
- Integrated delivery systems can innovate with alternative payment models to bring meaningful change to the cost and quality of care, i.e. bundles.
- State rule changes for the Medicaid program have a profound impact on the margin of the business - e.g. Auto-assignment, risk corridors, etc.…
- Know your spend by subpopulation and target your interventions accordingly. For example, we do relatively well with children and the disabled. We need to target adults with chronic conditions who are not disabled.

# More Lessons Learned

- Avoid duplication of efforts with your network practices. For example, reserve plan-based care management for those members in practices without care managers or members disconnected from primary care. ***Patients trust their provider, not their health plan.***
- Measure results for ALL interventions and stop what isn't working.
- Monitor utilization and costs on a regular and continuous basis to catch concerning trends early. For example, a new specialist in your network may introduce very high cost drugs. A new surgeon may send every joint replacement to rehab. A DME vendor may go for the Cadillac version of every device. ***Monitor trends daily and stop monitoring what doesn't matter (small $).***
- Meet with provider groups regularly and share information in a collaborative approach. ***FQHC partners can have major impact.***
- Integrated behavioral health is critical to success. In the one county where providers have not integrated behavioral health we experience the highest cost trend.

# QUESTIONS?