Medicaid 2.0
Issue Brief:
NJ Purchasing Authority/Administration

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Background

State as Purchaser of Health Care Services

New Jersey's organization and oversight of its health care programs -- which have a combined cost of nearly $20B -- is spread among multiple state agencies:

- Department of the Treasury - State Health Benefits Plans ($3.8B)
- Department of Corrections – Inmate Care and Treatment ($250M)
- Department of Health – DSRIP ($166M); Early Intervention ($107M)
- Human Services – Community Mental Health Services ($367M); PAAD ($95M); and Medicaid ($15B)
- Department of Education - School Based Medicaid ($83M)

Consolidating the purchasing power of these programs could yield a substantial volume discount. Program consolidation may also yield efficiencies in care delivery as best practices become more standard across these programs.

Medicaid Managed Care - Procurement

Currently NJ Medicaid sets MCO contract operating standards and monthly capitation rates. Any health insurance carrier that meets the standards and is willing to accept the rates may participate. Alternatively, other state Medicaid program's competitively bid for MCO services. NJ has considered competitively bidding the contract and limiting the number of MCOs in the past but has not pursued the issue.

The current MCO contract requires all of its participating plans to be available to members in all 21 counties – some states bid and award these services by region. MCOs entering the NJ market have found it difficult to establish contracts statewide particularly in southern portion of the state. This difficulty may be limiting more MCOs from entering the NJ Medicaid or limiting new market entrants from being successful. This is particularly true when there is no limit on the total number of MCOs competing in the market.

Other states determine how many different MCOs their state needs to efficiently administer the program by determining their capacity for the administrative oversight of the MCOs including regulating and monitoring for contract compliance and identifying fraud, waste and abuse. Notably, NJ's MCO contract requirements for fraud waste and abuse are considered insufficient relative to the size of the MCOs medical expenditures.

Medicaid Managed Care - Cost Effectiveness

To offer some perspective on MCO managing per capita cost growth, below are the state's Medicaid MCO capitation rates for selected rate categories as well the All Inclusive Maternity rates since 2012. The Consumer Price Index for medical care for the same period was 2.75%

NJ Medicaid MCO Capitation and All Inclusive Rates							
						Growth	
	2012	2013	2014	2015	2016	2012-2016	Avg annua
Children	$ 147	$ 150	$ 152	$ 154	$ 157	7%	1.7%
Parents	$ 360	$ 381	$ 393	$ 397	$ 391	9%	2.2%
Kidcare D	$ 130	$ 139	$ 142	$ 148	$ 151	16%	4.0%
Maternity							
NE	$ 12,836	$ 13,676	$ 13,749	$ 13,133	$ 14,211	11%	2.7%
NW	$ 10,988	$ 12,328	$ 12,404	$ 12,302	$ 13,251	21%	5.1%
Central	$ 15,144	$ 14,328	$ 14,418	$ 14,853	$ 16,288	8%	1.9%
SC	$ 14,287	$ 15,076	$ 15,165	$ 15,242	$ 16,671	17%	4.2%
Southern	$ 15,652	$ 16,634	$ 16,752	$ 17,153	$ 16,657	6%	1.6%
ABD W/out	$ 1,086	$ 1,188	$ 1,246	$ 1,243	$ 1,312	21%	5.2%
Medicare							

Medicaid's Role in State Government

While it is one of largest components of the state's budget and a critical lever in the state's safety net financing, Medicaid's role in state government remains relatively small. Despite a budget of $15B that funds health care services for 20% of NJ residents, it is one of seven divisions within the Department of Human Services. As a Division the program must operate within the state's purchasing and hiring rules. These rules limit the program's ability to attract and retain top talent and inhibit the use of purchasing tactics such as best and final offer.

In other states like Ohio, Medicaid has been elevated to a cabinet level. Its prominence and the direct access to the Governor were credited with playing a key role in implementing many of their value based purchasing initiatives including bundled payments and CPC Plus. Three states – Oklahoma, Oregon and Washington - have created health care authorities that provide the program with more autonomy and flexibility to adjust to circumstances and quickly adapt to changes in the marketplace.

Problem statement

- The silo structure of health care purchasing and financing does not maximize the State's purchasing leverage.

- The current Medicaid MCO rate setting process limits the state's ability to obtain the best price for Medicaid managed care services.
- The Medicaid program's status in NJ government does not fully recognize its importance on the health care system as a whole and limits the programs ability to quickly adapt to changes in the marketplace.

Goal(s)

- Develop strategies to maximizes NJ's purchasing leverage
- Identify contract strategies to encourage MCO competition and efficiency of administration of the program
- Organize NJ Medicaid to ensure widespread and effective implementation of the State's health policies
- Incorporate enhanced program integrity measures into the MCO contract

Strategy Options (informed by other states)

- Combine purchasing of health care services under single state agency
- Restructure and competitively bid Medicaid MCO services
- Adopt a regional contracting model
- Reorganize all Medicaid programs under a Department of Medicaid
- Reorganize Medicaid as a Health Care Authority in which Medicaid would operate autonomously as a special purpose public authority similar to the Economic Development Authority or the Turnpike Authority

Research Links

Health Care Payment Learning & Action Network: Increasing Purchasing Power in Washington State. June 21, 2016.
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New Jersey DMAHS: NJ FamilyCare Report 2015. August 2016.
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https://www.oregon.gov/oha/Transformation-Center/pages/index.aspx

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https://www.tn.gov/hcfa/section/strategic-planning-and-innovation-group

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