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Interview with Mark Hoyt

By Kurt Wrobel

With his recent retirement, we thought it would be a good opportunity to interview Mark Hoyt of Mercer's Government Human Services Consulting (GHSC) practice about his career and experience consulting with state Medicaid programs. In total, Mark spent 32 years with Mercer, largely focused on helping states become more efficient purchasers of Medicaid and Children's Health Insurance Program (CHIP) health services. In addition to consulting with over 30 states, Mark played a leading role in establishing and leading Mercer's government practice.

Given your experience in working among the first Medicaid managed care programs, how would you say the programs have changed over time?

In the early 1990s, if a state implemented managed care contracting, it typically only applied it to Aid to Families with Dependent Children (AFDC). This eligibility group had large numbers of women and children with health care risk characteristics more similar to employer group coverage than to the other parts of the Medicaid risk profile. Many times, maternity was carved out and reimbursed using a case rate that included all prenatal care through two months post-partum. Because eligibility and enrollment of pregnant women to a health plan was somewhat unpredictable, the accuracy of a capitation rate was likely to be called into question. Some plans also claimed they would be selected against due to the high quality of

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the providers and hospitals in their network. So the maternity case rate acted like an early form of risk adjustment for the AFDC population, which later became Temporary Assistance to Needy Families (TANF) after welfare reform. By the time the Sixth Omnibus Budget Reconciliation Act (SOBRA) passed and created the option of covering pregnant women up to 185 percent of the Federal Poverty Limit (FPL), the use of the maternity case rate was almost universal.

By the late 1990s and early 2000s, many states were beginning to introduce managed care principles to their behavioral health programs. Medicaid provides a much richer set of behavioral health benefits than the private sector. Building actuarially sound capitation rates for these benefits can be extremely challenging for a number of reasons.

Long-term care (LTC) is the third leg of the Medicaid stool. Managed care has been late in applying to LTC for a number of reasons: high costs per person, a much smaller number of people, a much higher probability that the Medicaid benefits will need to be coordinated with Medicare (for the "dual" eligibles), and a wide variation in the use of home and community based services (HCBS). During the last three years, the Centers for Medicare and Medicaid Services (CMS) has made a concerted effort to improve the coordination and integration of Medicaid and Medicare, which has led to a sharp increase in demonstration grants that will fund the introduction of managed care to LTC.

What features of the programs proved to be among the most successful?

For a managed care program to be successful, there needed to be a viable partnership between the state and its health plans. That's still true today. Even 20 years ago, there were several states that issued contracts totaling more than $1 billion, which means that there would always be intense debate from both sides regarding whether the payment proposed matched the risk assumed. The contracts were quite long and complicated.

States did not have the greatest reputation as business partners, so many of the larger commercial plans had significant reservations about entering this market. Successful states adopted a number of different approaches to build integrity and increase trust from their member plans:

- They hired staff that would focus on the managed care plans; a chief of managed care, a medical director who understood managed care operations, and eventually entire teams would be paired with one or more health plans to follow all aspects of their Medicaid operations.

- They established a regular schedule of meetings with the plans to foster open communications about their issues.

- They raised the bar on their procurement and contracting methodologies, to put them more in line with better business practices. States had to treat plans equally and fairly. It was important to keep the promises they made and not make threats that they did not intend to keep.

For example, I worked with a state that was doing a competitive procurement. All of the rules of engagement had been established clearly from the beginning. One of the bidding plans was an incumbent plan centered on a state university hospital and a medical school. They had successfully served Medicaid in the state for seven years and were presumed by many to be a lock for an award, due to their experience and close ties to state government. But they did not have a winning proposal when the final scores were tallied, and the state dropped them, which sent shockwaves throughout the system. After that, there was no question that Medicaid program said what it meant and meant what it said. It did not matter who you were.

Like politics, all health care is local. Collaborative states listened closely to plans' concerns and looked at the risks they were being asked to take on in a given geographic area. This often led to different risk mitigation solutions, such as reinsurance, risk corridors, possible carve-outs, or new rate cells for HIV/AIDS.

As actuaries, one of the most important components of our success is our ability to access information to make accurate forecasts into the future. How have you seen the amount and quality of data change over time?

In the beginning, there was no managed care data. Actuaries used fee-for-service data and made assumptions about how the delivery of care would change under the new contracts. Currently, a number of states have high-quality encounter data and audited financial reports from their plans. Getting from point A to point B took many years in most states. During the wonder years, we often used all three data sources for rate setting and applied credibility weights. Rate setting in the second through the fourth or fifth years was not usually an exact science. It has vastly improved now.

With the passage of health care reform, we are just beginning to see substantial changes that will have significant impact on how we finance and regulate health insurance. As you look into the future, what are the most important changes that will occur in our Medicaid program?

Assuming the Affordable Care Act (ACA) remains the law of the land, we will see rapid growth in Medicaid enrollment to as many as 75 million persons within just a few years, making it by far the largest health benefit program in the country. This will put even more fiscal pressure on states, who must balance their budgets each year. The ACA calls for the establishment of exchanges to help people find coverage. States can build their own exchange or allow the federal government to handle it. For those states that put up their own exchange, I see Medicaid playing a central role, far greater than the department of insurance (DOI). The DOI has no experience dealing with large complicated programs on a granular level. Medicaid's used to collecting data on millions of recipients, running procurements, setting rates, managing contracts. With the new Medicaid income eligibility line being raised far above 100 percent of the FPL, we'll see many people bounce in and out of Medicaid eligibility. In my mind, it only makes sense for the state to create a single (huge) database that would stand behind Medicaid, the exchange, the premium subsidies (which go up to 400 percent of FPL)—all of it.

Risk adjustment methodologies have been and will continue to be an important part of how we adjust for different expected costs among populations. How would you describe the evolution among these methodologies, and do you expect significant changes in the future?

Risk adjustment rose in popularity for two primary reasons: the enrollment of sicker population groups into managed care programs and the improvements in the quality of data. Typically its introduction in a state was fairly bumpy. Even with a few trial runs, there often were surprises and then complaints from the plans whose rates were reduced. This was often due to variations in the quality and quantity of the encounter data between plans. Some plans did a much better job than others of recording all diagnoses and conditions. If the risk adjustment tool took into account the secondary conditions, these plans scored higher. To mitigate some of these problems, some states put boundaries around how much the factors could vary between plans and how much they could increase or decline in a six- or 12-month period. Including pharmacy data helped resolve some of the fluctuations. Several high-quality tools are currently available. If a state has good data and has been applying risk adjustment for two or three years, risk adjustment will likely become a mainstay of the rate-setting process that helps better match payment with risk.

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As you think about the key institutions and programs that are the foundation of our health care payment system (Medicare, Medicaid, employers), how do you see them interacting in the future?

Medicare will always be around, but what it will look like probably depends a lot on the November elections. CMS has a significant number of demonstrations underway that involve persons enrolled in both Medicaid and Medicare. I expect the results of the demos will be evaluated and used to chart a course for the future coordination of the two programs.

The number of people receiving health care coverage through their employer has been declining steadily for years. I see nothing in the ACA that would reverse this trend. If anything, my guess is that the trend will accelerate, since the penalties for not complying with the mandate appear to be a lot less than the cost of coverage. So, my crystal ball predicts that Medicare will continue to grow at about its current pace. Employer coverage will continue to decline, while Medicaid will grow rapidly and assume an ever-increasing role in the nation's health care system.

As you look back on your career, what would you say was your most satisfying accomplishment?

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My greatest joy came from playing a significant role in establishing the GHSC group as a premier specialty line of business within Mercer. I had the thrill of watching it grow from a handful of people to more than 170 people in four offices when I retired. In the 1980s, we were viewed as this strange band of weirdos consulting to states about how to take care of poor moms and kids, the aged and disabled, and the mentally ill. I was the GHSC national practice leader for 15 years and loved every minute of it. When I joined the Fortune 400 company I worked for, I never dreamt I'd lead a group devoted to assisting so many in our society who live out on the margins, in the shadows, without a voice, with gaining access to high-quality health care. I loved consulting, but this aspect of the job meant so much more to me.

In addition to your consulting work, you also saw tremendous growth in your practice. What were the keys to this success?

Passion. We decided from the very start that due to the complexity of these programs, their uniqueness as a line of business, and the dollars involved, if you were going to join us, you needed to be "all-in." You had to drink the Kool-Aid, be committed to working exclusively for these clients. I'm convinced this was a key to our success.

Strong teams. These were jumbo consulting assignments that simply could not be served adequately by two or three individuals. Although we began by doing basic actuarial work, I was convinced we needed to expand our skill sets much more broadly, so that we could cover all aspects (within reason) of managed care contracting. Eventually we hired accountants, pharmacists, psychologists, nurses, lawyers, people with skills in informatics (data), MBAs, former Medicaid directors, former CMS staff, some state staff from behavioral health, developmental disability, and LTC programs, and, yes, more actuaries. This diversification greatly strengthened our ability to solve client problems.

For students and recently credentialed actuaries, do you have any specific advice on where they should focus their careers? How can more experienced actuaries increase their profile in Medicaid policymaking?

Where they should focus will ultimately have to be their decision, of course. But before they decide, I suggest making sure they understand the depth and breadth of public programs. The managed care rate setting process for these programs provides exceptional levels of challenge and opportunity for health

In his retirement, Mark has contributed to MACPAC as one of their 17 commissioners while also spending time with his family and engaging his cycling passion.

care actuaries. The demand for competent actuaries is high. In addition, because our industry and actuaries have been more focused on the commercial market, the supply for actuaries in this health specialty has been low.

For those looking to become more familiar with the basics of Medicaid, I highly recommend reading the Medicaid and CHIP Payment & Access Commission (MACPAC) reports, especially the first two. The website also provides a lot of other useful information. The website can be accessed at *www.macpac.gov*.

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