Pay for Performance
Joint Medicaid Oversight Committee

Testimony by
Dr. Craig Thiele, Chief Medical Officer

May 18, 2017
Our MISSION

To make a lasting difference in our members’ lives by improving their health and well-being.

CARESOURCE

- A nonprofit health plan and national leader in Managed Care
- 27-year history of serving the low-income populations across multiple states and insurance products
- Currently serving over 1.5 million members in Kentucky, Ohio, Indiana, West Virginia
- Preparing to serve Indiana and Georgia Medicaid members in 2017

1.6M members
Medicaid Snapshot

- 1.3 million Members
- 303k Medicaid Expansion Members
- 54% Market Share
- 68% of Enrollees are Families
- 60% Voluntary Enrollment
- 44% Male
- 56% Female
- Average Age: 22.9

Confidential & Proprietary
Ohio Medicaid Pay for Performance Measures
Medicaid Quality Measures

- Adolescent Well Care Visits
- Controlling High Blood Pressure
- Prenatal Care – Timeliness of Care
- Post Partum Care
- Diabetes: HcA1c
- Follow-up After Hospitalization for Mental Illness – 7 Days
Quality Outcomes Strategy

VALUE BASED REIMBURSEMENT
Hospitals, CMHCs, FQHCs, Physicians, Nursing Homes

CAPTIVE AUDIENCES
@School, Upon Discharge, @the Doctors office, @Pharmacy (MTM), @Home

MANAGED CARE COLLABORATION
Infant Mortality, @School, HIE

ACCOUNTABILITY
Financial and Membership Assignment with the Managed Care Plans

LIFE SERVICES
Social Determinant Drivers (Food, Housing, Employment, Healthcare)

DATA
Accelerate the sharing of medical records for the purpose of improving health
CareSource Role

Alignment

Collaboration

Engagement
TRANSFORMING Care

CareSource continues to lead health care in an innovative, new direction. Care4U is a game-changing, holistic population health model. Through tailored care plans, CareSource can address the needs with the greatest impact for each individual member. The model fully integrates our commitment to Primary Care & Prevention, Care Management, Behavioral Health and Life Services, promoting health and wellness across the entire continuum of the population we serve.

CareSource continues to lead health care in an innovative, new direction.
Care4U

No matter where our members are in their stage of wellness, we have services and supports for them.

CARE MANAGEMENT
One-on-one attention to support health needs

DISEASE MANAGEMENT
Assistance managing issues like diabetes, asthma, high blood pressure or high cholesterol

TOBACCO CESSATION
Health coaching from a Certified Tobacco Treatment Specialist

WOMEN & CHILDREN’S HEALTH
Pre-pregnancy and pregnancy programs plus support for young children

BEHAVIORAL HEALTH
Mental health and substance use services and resources

WELLNESS
Online wellness tool to learn about health topics

HEALTH RISK ASSESSMENT
Clarity on personal health and wellness including physical, mental and social health
## Medicaid Opportunities

<table>
<thead>
<tr>
<th>Measure</th>
<th>Opportunity</th>
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| Adolescent Well-Care                           | • Require Well Child Check-ups for School:  
|                                                |   • Managed Care and Health Partners provide and pay for them               |
| Controlling High Blood Pressure                 | • Requires medical records and must contain both diagnosis and compliant blood pressure:  
|                                                |   • Health Information Exchange and Health Partner Coding Education and Compliance |
| Comprehensive Diabetes Care, HbA1c Poor Control >9% | • Requires lab results:  
|                                                |   • Data needed from labs, provider EHR systems                             |
| Follow-up After Hospitalization for Mental Illness – 7 Days | • Outdated Coding and Appointment Availability:  
|                                                |   • Anticipate significant improvements with Behavioral Health Carve-In     |
| Prenatal Care – Timeliness of Care              | • Infant Mortality Collaboration                                           |
| Postpartum Care                                 | • Captive Audience and Health Partner Collaboration                        |
Partnering with Health Partners
Partnersing for Success

Integration

VBR Arrangements

Triple Aim

Managed Care and Health Partners Working Together

Achieves a common platform, goals, and strategies with our Health Partners through:

- Shared Quality and Population Health Management Goals
- Shared initiatives to enhance patient/member experience
- Shared financial and savings goals
Partnering with Providers

The CareSource Clinical Practice Registry (CPR) is a feature on the CareSource Provider Portal. This registry offers providers a working list of their members and associated gaps in care.
Partnering with Providers

Coding guides are intended to assist the provider with understanding of quality measures and associated codes.
Clinical Practice Guideline fliers are shared with providers to inform and guide the care provided to CareSource members.
DATA
Connection to CliniSync

**Hospital Data:**
- ADT (admission, discharge and transfer) alerts from 149 facilities:

**CareSource:**
- Real-time feed of Emergency Room (ER) alerts to Care Management dashboard
- Pharmacy: Daily feed of discharge alerts to MTM vendor in order to complete medication reconciliation for members

**Lab Data from 3 facilities:**

**CareSource:**
- Real-time feed of lab data to Care Management dashboard
- HEDIS: Monthly lab data feed to HEDIS application

**NCQA**
- NCQA is emphasizing the importance of this type of data sharing
Connection to The Health Collaborative (THC)

2017 Target: Receive ADT (admission, discharge and transfer) alerts from 6 facilities

CareSource:

- Real-time feed of Emergency Room (ER) alerts to Care Management dashboard
- Pharmacy: Daily feed of discharge alerts to MTM vendor in order to complete medication reconciliation for members

2017 Target: Receive lab data from 7 facilities

CareSource:

- Real-time feed of lab data to Care Management dashboard
- HEDIS: Monthly lab data feed to HEDIS application
Appendix
# Medicaid Clinical Programs

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<thead>
<tr>
<th>P4P Measure</th>
<th>Programs</th>
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<tbody>
<tr>
<td>Controlling High Blood Pressure</td>
<td>• Participation in Hypertension Quality Improvement Projects (QIP)</td>
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<td>• Partner with Community HUBs</td>
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<td></td>
<td>• Provider Clinical Practice Registry – gaps in care</td>
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<tr>
<td></td>
<td>• Value Based Reimbursement</td>
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<tr>
<td>Comprehensive Diabetes Care - HbA1C</td>
<td>• Partnered with Community HUBs</td>
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<tr>
<td></td>
<td>• Partnered with Diabetes support group in Hancock County (Caughman Clinic Program)</td>
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<tr>
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<td>Prenatal and Postpartum Care:</td>
<td>- Statewide Infant Mortality Program</td>
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<tr>
<td></td>
<td>- Discharge planning</td>
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<td>- Provider evidenced based care communication</td>
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<td></td>
<td>- Provider Coding Guides</td>
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<td>Follow-Up After Hospitalization for Mental Illness – 7 Day Follow-Up</td>
<td>- Partnerships with Community Mental Health Centers</td>
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<td>- Personalized discharge planning</td>
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<td>- Imbedding staff into health partners</td>
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<td></td>
<td>- Provider Clinical Practice Registry – gaps in care</td>
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<tr>
<td></td>
<td>- Value Based Reimbursement</td>
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<tr>
<td>Adolescent Well-Care Visits</td>
<td>- School based program partnerships with The Community Learning Center and over 40 schools</td>
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## Partnering with Ohio Medicaid

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<td>Targeted initiatives coordinated with all MCPs</td>
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<tr>
<td>Childhood immunization requirements prior to the member’s 2&lt;sup&gt;nd&lt;/sup&gt; birthday</td>
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<tr>
<td>Mandatory annual preventive health visits</td>
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<td>Well-child visit requirement for participation in sports (expand sports physicals)</td>
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<td>School Based Health Clinics</td>
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<tr>
<td>CPC – Comprehensive Primary Care Initiative</td>
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<tr>
<td>Infant Mortality Initiative</td>
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NCQA is working with clinicians, system interoperability experts, NCQA-Certified EHR vendors, data analytic experts, NCQA-Certified auditors and other stakeholders to develop a clear framework using electronic clinical data.

NCQA is following three core principles to ensure that use electronic clinical data for HEDIS quality reporting will:

1. Support appropriate access to electronic health data across the entire care continuum
2. Emphasize a member-centered, team-based approach to quality health care services
3. Support a learning health system that encourages innovation

NCQA is reviewing existing administrative, hybrid and medical record HEDIS technical specifications to determine which could be re-engineered to utilize the wealth of data available in ECDS.
Electronic health record (EHR). Real-time, patient-centered records that make information available instantly and securely to authorized users. EHRs eligible for this category of ECDS reporting include any vendor certified by the NCQA Measure Certification program, the NCQA eMeasure Certification program or any system that meets the 2015 Edition Base Electronic Health Record (EHR) definition

Health information exchange (HIE)/clinical registry. HIEs and clinical registries eligible for this reporting category include state HIEs, immunization information systems (IIS), public health agency systems, regional HIEs (RHIO), Patient-Centered Data Homes™ or other registries developed for research or to support quality improvement and patient safety initiatives. Registries can be sponsored by a government agency, nonprofit organization, health care facility or private company, and decisions regarding use of the data in the registry are the responsibility of the registry’s governing committee.