



BLUEPRINT FOR
A NEW OHIO

GOV. JOHN R. KASICH'S FISCAL YEARS 2016-2017 BUDGET

Ohio Department of Medicaid

Joint Medicaid Oversight Committee

March 19, 2015

John McCarthy, Medicaid Director



Today's Topics

- Payment Reform
- Care Management
- Quality Strategy
- Managed Care Performance Measures and Pay for Performance (P4P)
- Capitation Methodology and Cost Drivers



Managed Care Payment Reform

The MCP Provider Agreement (Appendix Q) spells out the expectations of the plans to . . .

- Improve the delivery of health care including:
 - Quality
 - Efficiency
 - Safety
 - “Patient-centeredness”
 - Coordination
 - Outcomes

- And to implement payment strategies that tie payment to value and/or the reduction of waste.



Managed Care Payment Reform

Managed Care Plans were required to develop a strategy that makes 20% of all aggregate net payments to providers value-oriented by 2020.

- Three Primary Areas of Focus:
 - Value-Oriented Payments
 - Market Competition and Consumerism
 - Transparency



Managed Care Payment Reform

Value-Oriented Payment, Market Competition and Consumerism

- Examples of strategies outlined in the contract:
 - Paying providers differently according to performance (and reinforced with benefit design).
 - Design approaches to payments that cut waste while not diminishing quality.
 - Design payments to encourage adherence to clinical guidelines. At minimum, plans must address policies to discourage elective deliveries before 30 weeks.



Managed Care Payment Reform

Value-Oriented Payment, Market Competition and Consumerism

- Payment strategies to reduce unwarranted price variation, such as reference pricing or value pricing
 - Analysis of price variation among network providers by procedure/service types
 - Launch pilot of value pricing programs
 - Encourage member value-based pricing information
 - Center of excellence pricing
 - Rebalance payment between primary and specialty care



Managed Care Payment Reform

Transparency

- Plans must develop a strategy to report the comparative performance of providers using nationally recognized measures of hospital and physician performance.
- At minimum, plans must make information available to members regarding:
 - Provider background, quality performance, patient experience, volume, efficiency, price of service, cultural competency factor and cost of services
 - Quality, efficiency and price comparison of providers for all service in markets where the MCP operates
 - Plans shall submit quarterly progress reports on progress on payment reform strategies, and transparency requirements



Managed Care Plan (MCP) Care Management

What makes a high performance care management system?

- Patient and family centeredness
- Proactive, planned and comprehensive
- Promotes self-care and independence
- Emphasizes cross-continuum and system collaboration and relationships
- Merges clinical and non-clinical domains



Managed Care Plan (MCP) Contract Requirements

MCPs' care management programs must:

- Coordinate and monitor care for beneficiaries whose needs span the continuum of care
- Recognize that beneficiaries' needs vary and require individualized interventions
- Achieve integrated and coordinated care; improve clinical, functional, psychosocial, and financial outcomes; and increase quality of life and satisfaction
- Emulate characteristics of a high performing care management system



Managed Care Plan (MCP) Contract Requirements

Key care management components:

- *Identify eligible beneficiaries* – Predictive modeling, IP census, self/provider/UM referrals
- *Conduct a comprehensive assessment* – Physical, behavioral and psychosocial needs
- *Assign to a risk stratification level* – Low, medium, complex, high
- *Develop an individualized care plan* – Prioritized goals, interventions, and outcomes; includes input from the beneficiary, family and providers



Managed Care Plan (MCP) Contract Requirements

Assign a care manager to lead an multi-disciplinary team and:

- Establish a trusted relationship with the beneficiary
- Engage the beneficiary in the care planning process
- Develop planned communication with the beneficiary
- Help to obtain necessary care and critical community supports; coordinates care for the member with the primary care provider, specialists, etc; collaborates with other care managers to avoid gaps/duplications in services
- Conduct a care gap analysis between recommended care and actual care received
- Implement, monitor and update the care plan



Managed Care Plan (MCP) Contract Requirements

- Enrollment in care management within 90 days of identifying need.
- Continuously evaluate beneficiary's ongoing need for care management
 - Goal of graduating from care management or transitioning to another level; moving on continuum from dependence to independence
- Apply evidence-based guidelines or best practices when developing and implementing interventions
- Maintain a care management system that integrates data with other MCP systems and facilitates information sharing in an effective and efficient manner



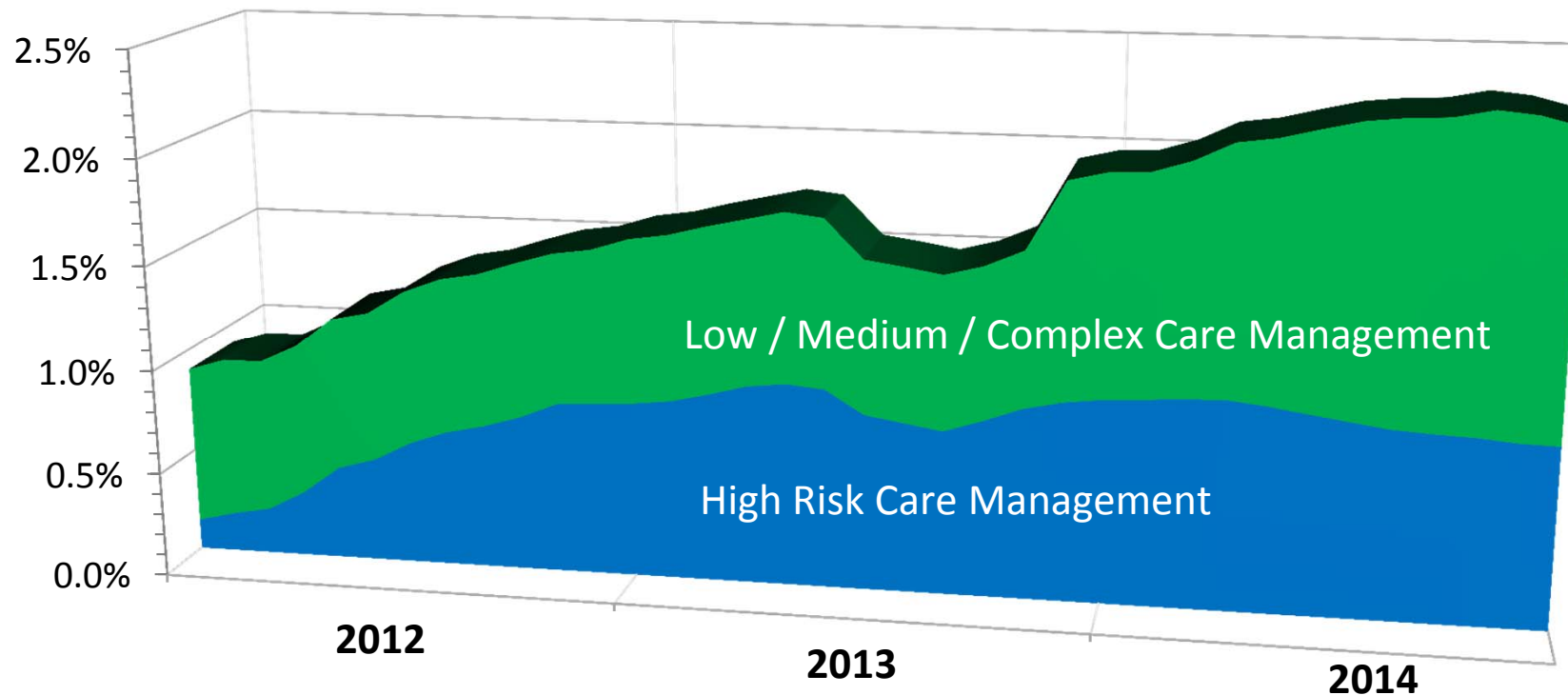
Care Management Redesign: 1/1/2012

- Provide higher need beneficiaries with a hands-on, comprehensive, and coordinated approach to care.
- Move toward field-based care management; embrace a blended social/medical model for care management; much more active approach to care management
- Features of the high risk care management program
 - *Added the use of a multi-disciplinary team to monitor and coordinate care*
 - *Addressed clinical and non-clinical needs to ensure holistic, comprehensive approach to care management*
 - *An aggressive strategy for effective and comprehensive management of transitions of care*
 - *Promoted a staffing ratio of (1 FTE:25 beneficiaries) that allows plan to interact with beneficiaries at an increased level of intensity*
 - *More contact with the consumer; minimum one face-to-face visit each quarter.*
- Extended high risk care management to at least 1% of overall population.



Percent of Medicaid Managed Care Beneficiaries in Care Management by Risk Stratification Level

Monthly Rates Between 2012-2014

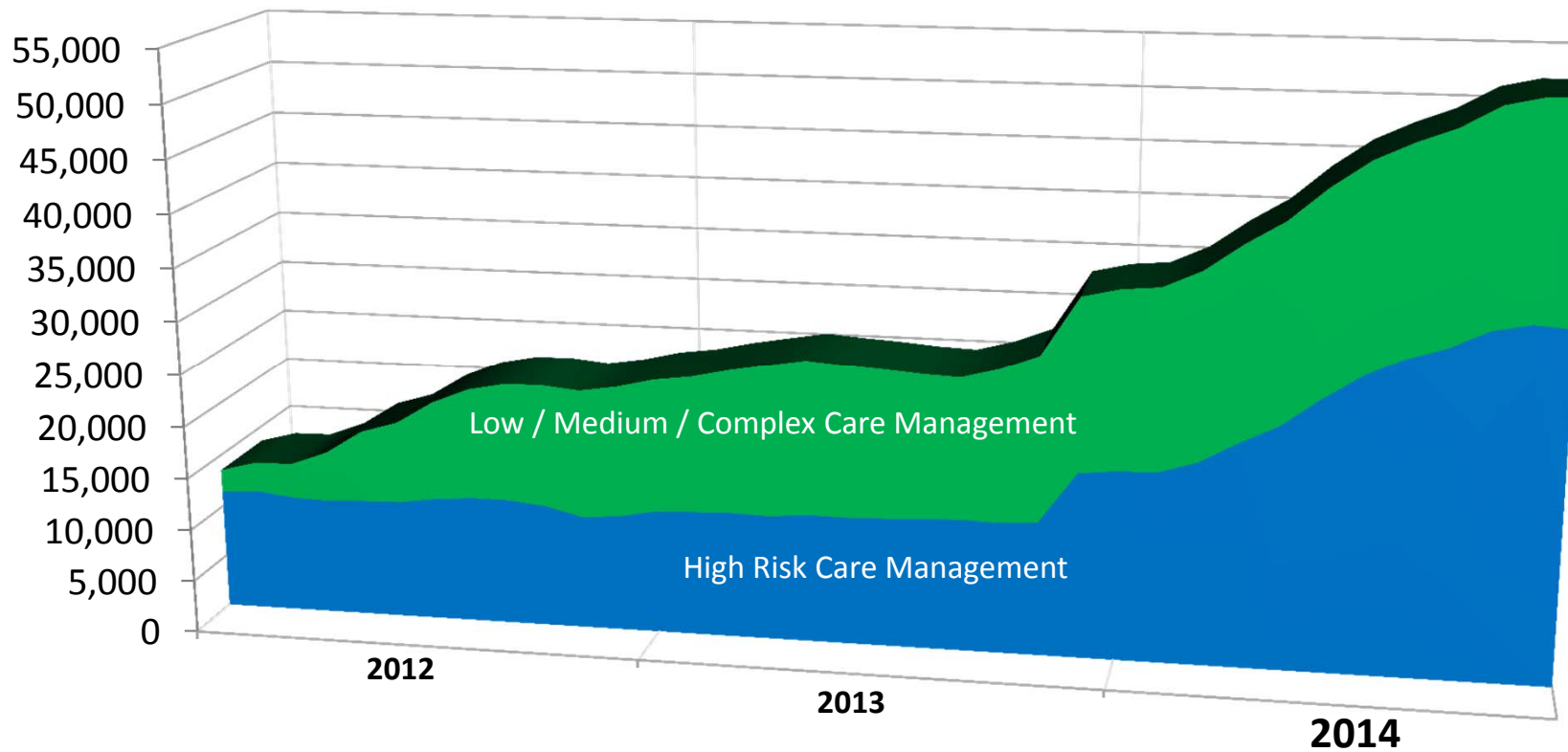


Illustrates the number of beneficiaries in high risk care management on a monthly basis.



Medicaid Managed Care Beneficiaries in Care Management by Risk Stratification Level

Per Month Between 2012-2014



Illustrates the number of beneficiaries in high risk care management on a monthly basis.



Monitoring Managed Care Plan Performance

Care Management Program Evaluation Measures (semi-annual)

1) Care Management of High Risk Members

- Minimum performance standard: 1%
- Monetary penalty for non-compliance

2) ER Utilization Rate, Inpatient Hospitalization Rate, & Overall Medical Costs of Members in High Risk Care Management

- Minimum performance standard: Decrease from baseline to measurement period
- Monetary penalty for non-compliance



Monitoring Managed Care Plan Performance

High risk care management staffing ratio (semi-annual)

- Minimum performance standard: 1 FTE to 25 beneficiaries (or .040)
- Monetary penalty for non-compliance

Evaluation of MCPs' approach to care management by Health Services Advisory Group (annually)

- Determine MCP compliance with contract requirements; identify strengths and areas requiring attention; highlight opportunities to enhance the program

Review of care management program descriptions, materials, and strategies



Highlighting Care Management Performance

Health Services Advisory Group (HSAG) evaluations of MCP approach to high risk care management:

- Conducted on an annual basis from 2012 to 2014
- Methodology – care management file reviews, staff interviews, and policy and procedure review
- Focus areas: consumer identification, assessment, care planning, beneficiary interaction, transitions of care, care manager & care management team
- Slight improvement from year to year
- Strengths: Identifying/targeting beneficiaries appropriately for high risk care management; timely completion of comprehensive assessments; assignment of care managers;
- Getting Better: Adopting an integrated approach to care management; developing individualized care plans
- Areas for improvement: Beneficiary engagement; meaningful collaboration and interaction with providers in care planning processes; and transitions of care/discharge planning
- Next review – tentatively scheduled for winter 2015



Transforming the Care Management Strategy

What's to come:

- Move to a population-level health management approach and expand the MCPs' care management efforts beyond the "1%"
- Synchronize MCP care management efforts with ODM/OHT efforts (SIM, PCMH)
- Align the care management with the entity best poised to connect with the beneficiary and influence behavior change
 - Plan-level or Practice-level
- Better support existing community-based care management models.



Ohio Medicaid Quality Strategy

Aims of strategy:

- Better Care:
 - Improve overall quality by making health care more patient-centered, reliable, accessible, and safe.
- Healthy People/Healthy Communities:
 - Improve the health of the Medicaid population by supporting proven interventions to address behavioral, social, and environmental determinants of health.
- Practice Best Evidence Medicine:
 - Facilitate the implementation of best clinical practices to Medicaid providers through collaboration and improvement science approaches.



Ohio Medicaid Quality Strategy

Priorities of strategy:

- Make Care Safer
- Improve Care Coordination
- Promote Evidence-Based Prevention and Treatment Practices
- Support Person and Family Centered Care
- Ensure Effective and Efficient Administration



Ohio Medicaid Quality Strategy

Focus Areas of strategy:

1. High Risk Pregnancy / Premature Births
2. Behavioral Health
3. Cardiovascular Disease
4. Diabetes
5. Asthma
6. Upper Respiratory Infections
7. Access
8. Consumer Satisfaction



2014 Medicaid P4P and Performance Measures

MCP Performance Measures:

- 25 Measures aligned with Medicaid's Quality Strategy
- Measurement Year: **Calendar Year 2013**
- Data Source: MCP self-reported audited HEDIS
- Standard
 - Based on last year's NCQA national Medicaid percentiles
 - Minimum Performance Standard = **25th Percentile**



2014 MCP Performance Measures

Access

- Children and Adolescents' Access to Primary Care Practitioners – 12-24 mos.
- Children and Adolescents' Access to Primary Care Practitioners – 25 mos.-6 yrs.
- Children and Adolescents' Access to Primary Care Practitioners – 7-11 yrs.
- Children and Adolescents' Access to Primary Care Practitioners – 12-19 yrs.
- Adults Access to Preventative/Ambulatory Health Services, Total

Clinical Quality

- Follow-Up Care After Hospitalization for Mental illness, 7-day Follow-Up
- Follow-Up Care for Children Prescribed ADHD Medication, Initiation
- Initiation and Engagement of AOD Dependence Treatment, Engagement
- Adolescent Well-Care Visits
- Percent of Live Births Weighing Less than 2,500 grams
- Prenatal and Postpartum Care – Timeliness of Prenatal Care
- Prenatal and Postpartum Care – Postpartum Care
- Frequency of Ongoing Prenatal Care
- Use of Appropriate Medications for People with Asthma
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life



2014 MCP Performance Measures

Clinical Quality (continued)

- Annual Number of Pediatric Asthma Emergency Department Visits
- Appropriate Treatment for Children with Upper Respiratory Infection
- Well-Child Visits in the First 15 Months of Life
- Comprehensive Diabetes Care: HbA1c control (<8.0%)
- Comprehensive Diabetes Care: BP control (<140/90 mm Hg)
- Comprehensive Diabetes Care: Eye exam (retinal) performed
- Comprehensive Diabetes Care: LDL-C screening
- Controlling High Blood Pressure
- Cholesterol Management for Cardiovascular Patients: LDL-C screening
- Cholesterol Management for Cardiovascular Patients: LDL-C control <100 mg/dL
- Persistence of Beta-Blocker Treatment after a Heart Attack

Consumer Satisfaction Survey

- General Child Rating of Health Plan (CAHPS Health Plan Survey)
- Adult Rating of Health Plan (CAHPS Health Plan Survey)



2014 Medicaid P4P and Performance Measures

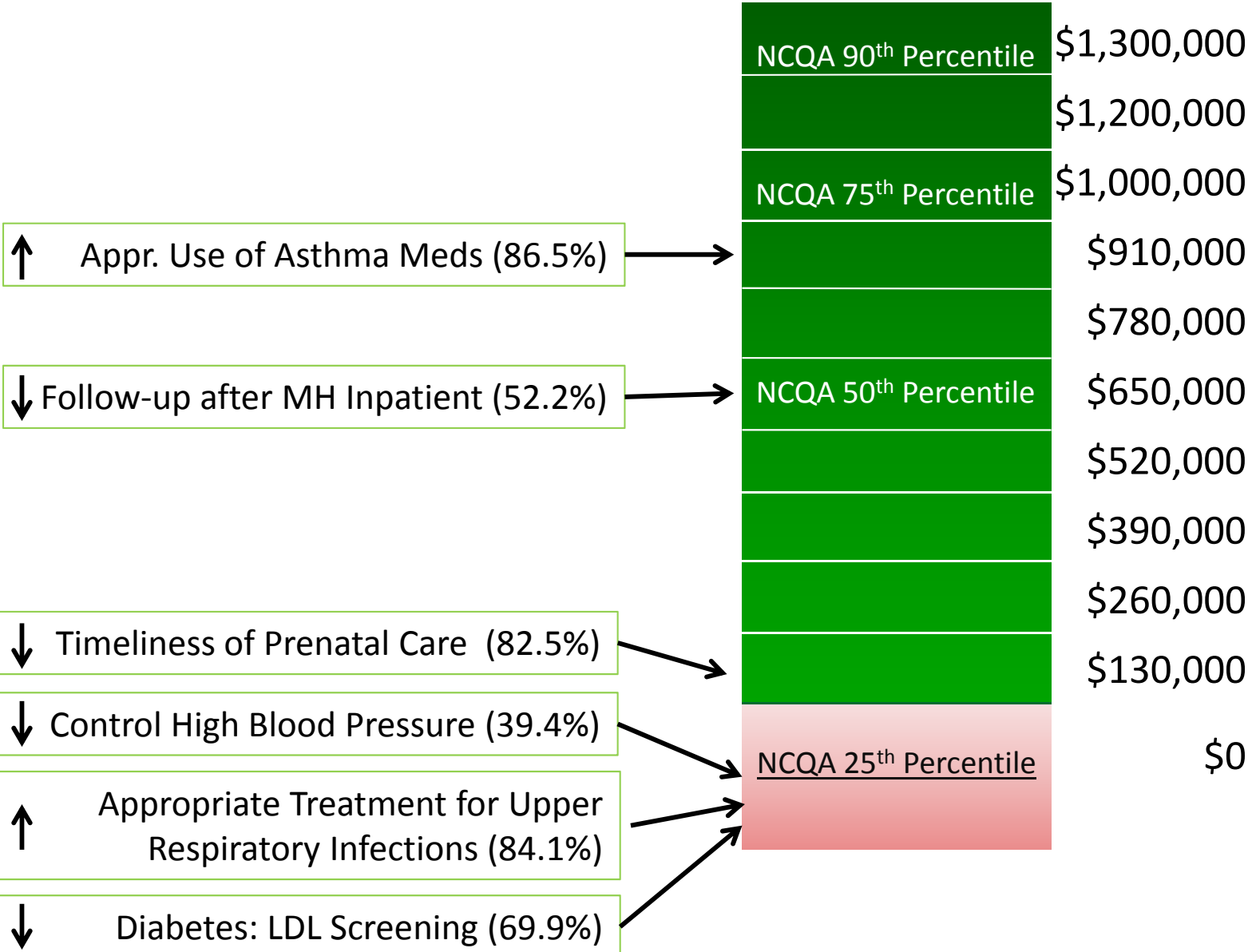
Pay for Performance (P4P):

- Based on results of six designated Clinical Performance Measures
- Method: *Higher Performance = Higher Pay*
 - Amount: 1% of premium
 - Standards:
 - Bonus starts above **25th percentile**
 - 1% awarded if at or above **90th percentile**



2014 P4P: Buckeye

<u>Trend/Measure (Performance Rate)</u>	<u>Performance Levels</u>	<u>Bonus/Measure</u>
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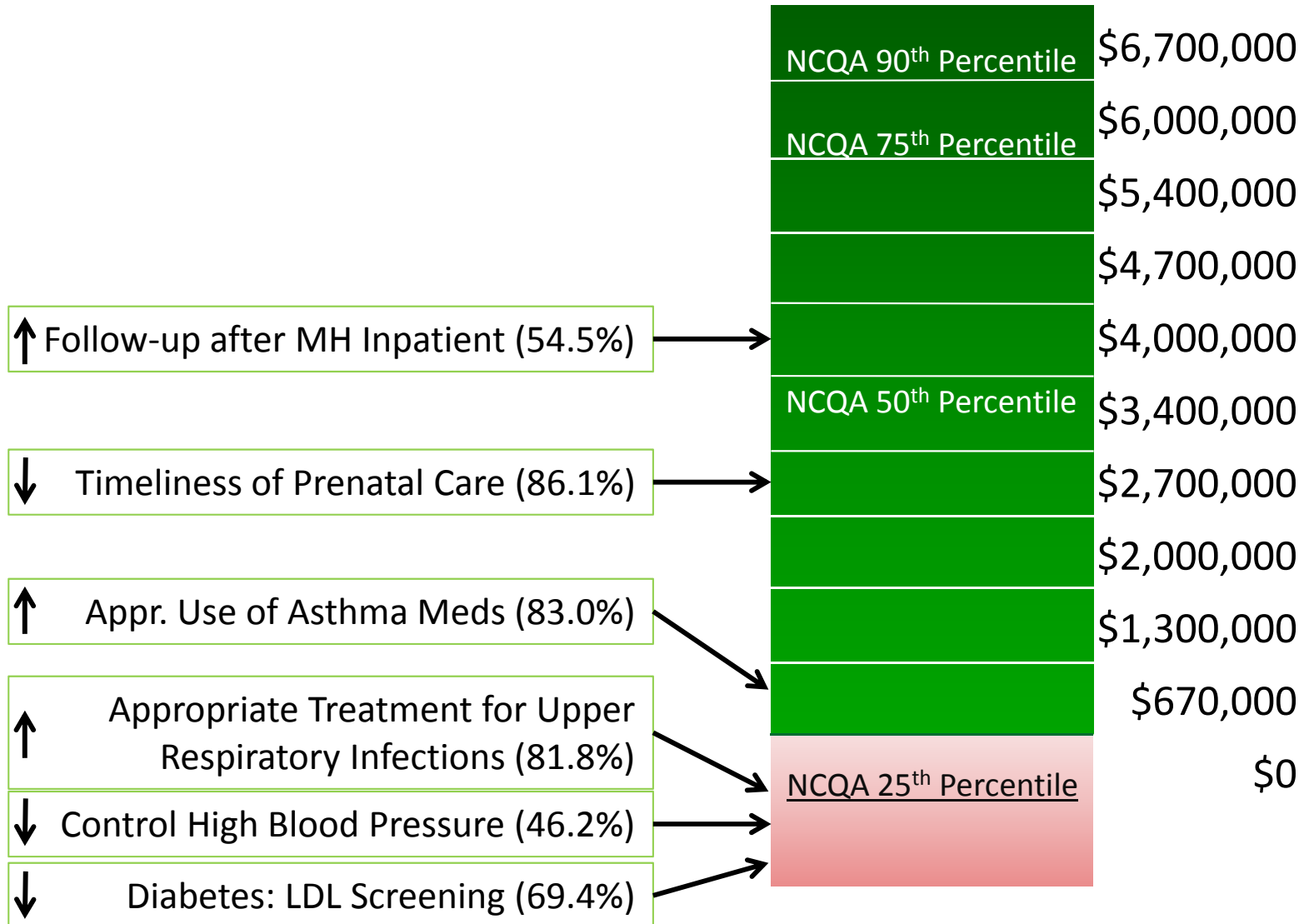


In Total,
Buckeye was
awarded
\$1.6 million
(22%) of \$7.6
million possible



2014 P4P: CareSource

<u>Trend/Measure (Performance Rate)</u>	<u>Performance Levels</u>	<u>Bonus/Measure</u>
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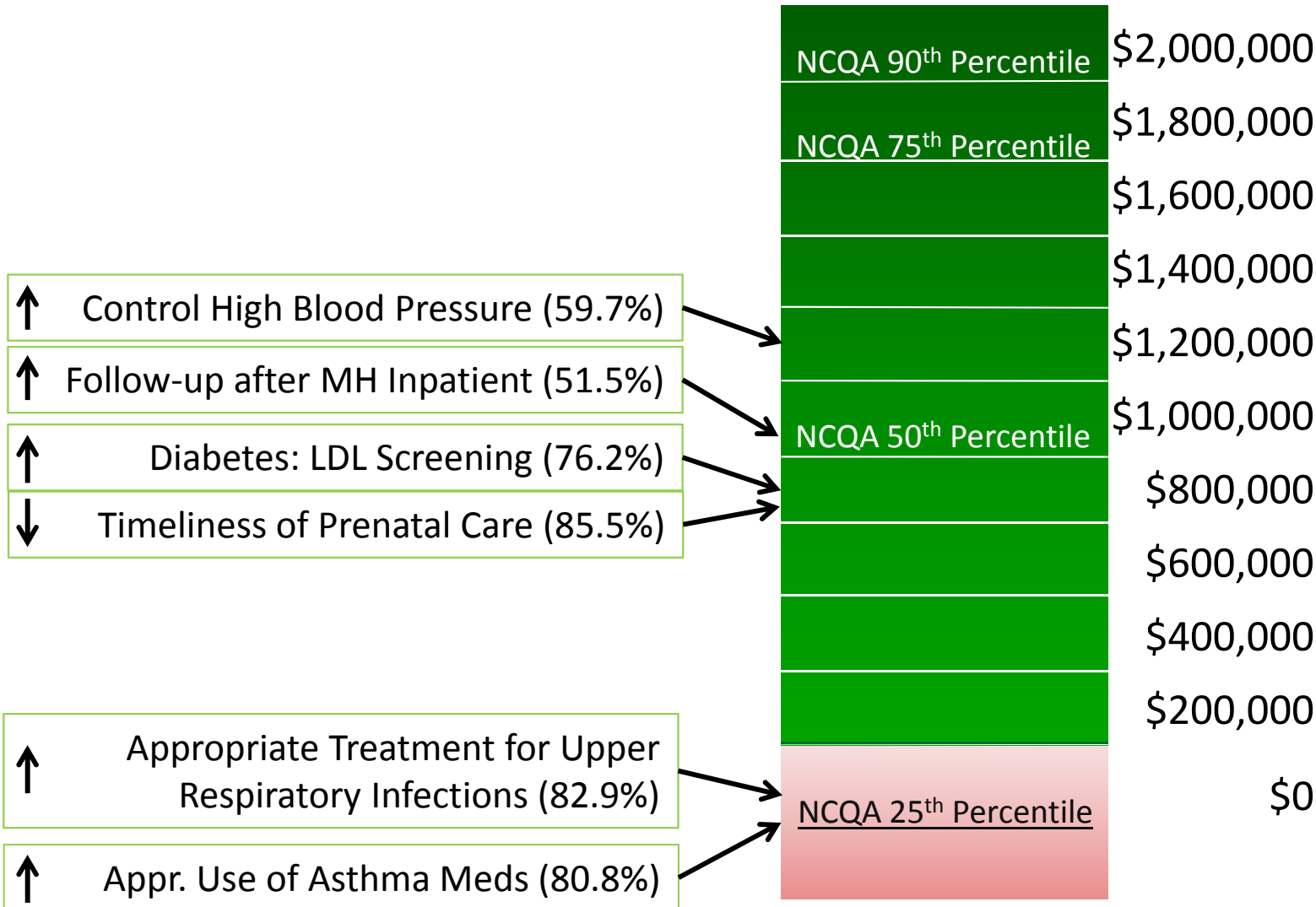


In Total,
CareSource
was awarded
\$7.4 million
(18%) of \$40
million possible



2014 P4P: Molina

<u>Trend/Measure (Performance Rate)</u>	<u>Performance Levels</u>	<u>Bonus/Measure</u>
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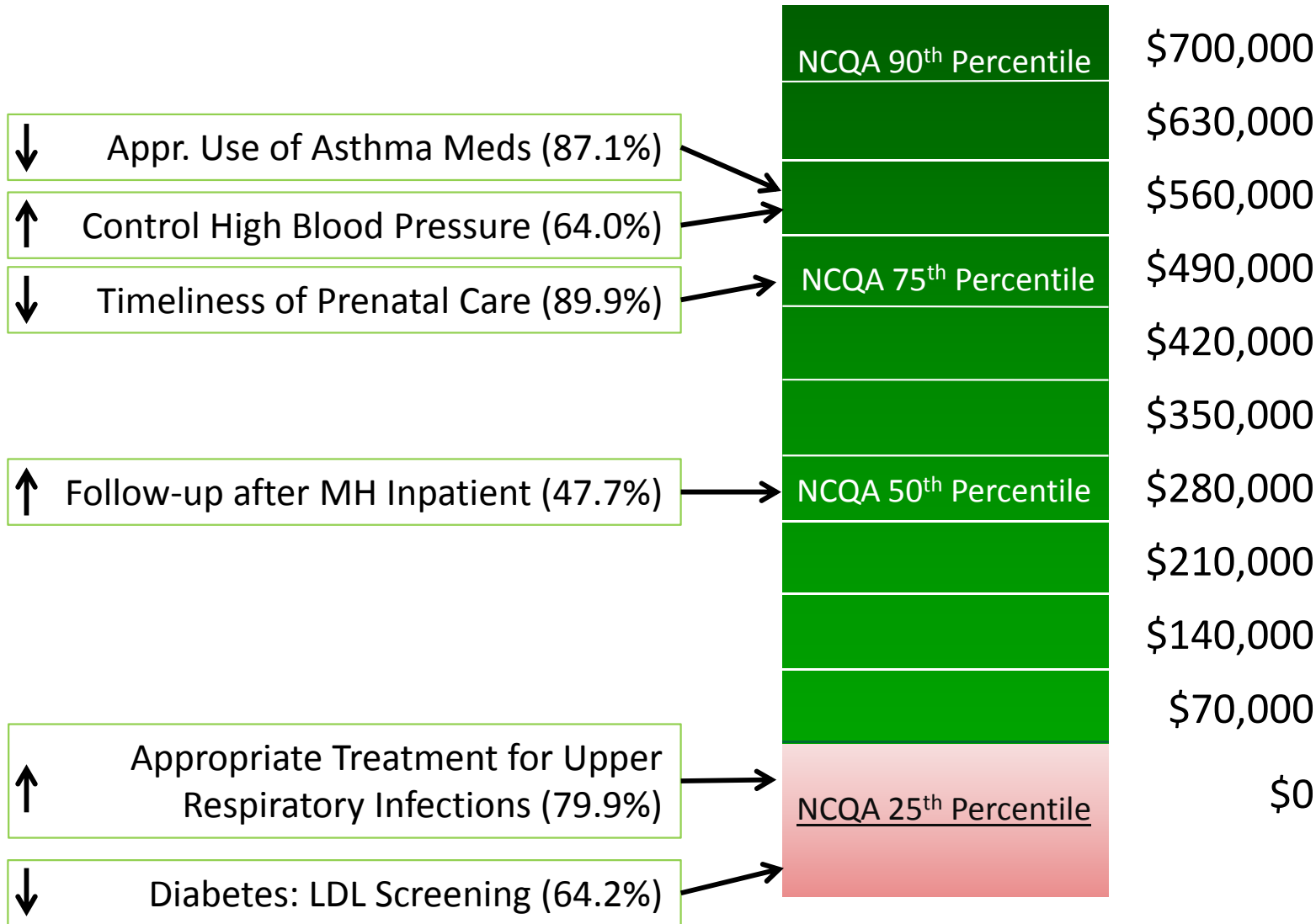


In Total, Molina was awarded \$4 million (32%) of \$12 million possible



2014 P4P: Paramount

<u>Trend/Measure (Performance Rate)</u>	<u>Performance Levels</u>	<u>Bonus/Measure</u>
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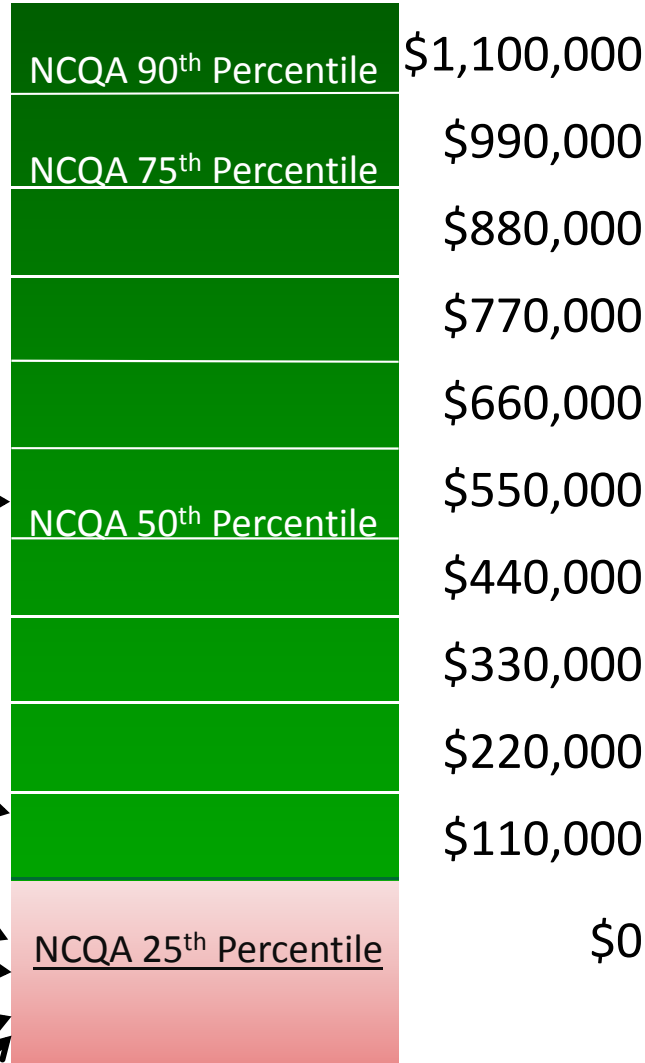


In Total,
Paramount was
awarded
\$1.8 million
(45%) of \$4
million possible



2014 P4P: United HealthCare

Trend/Measure (Performance Rate) Performance Levels Bonus/Measure



In Total,
Paramount was
awarded
\$.6 million
(10%) of \$6
million possible

↓ Timeliness of Prenatal Care (86.9%) →

↓ Follow-up after MH Inpatient (39.9%) →

↓ Control High Blood Pressure (46.7%) →

↑ Diabetes: LDL Screening (67.9%) →

↑ Appropriate Treatment for Upper Respiratory Infections (79.6%) →

↓ Apr. Use of Asthma Meds (79.6%) →



2014 P4P: Statewide Medicaid

<u>Trend/Measure (Performance Rate)</u>	<u>Performance Levels</u>	<u>Bonus/Measure</u>
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	NCQA 90 th Percentile	\$12,100,000
		\$11,000,000
	NCQA 75 th Percentile	\$9,900,000
↑ Follow-up after MH Inpatient (51.8%) →		\$8,800,000
↓ Timeliness of Prenatal Care (86.0%) →		\$7,700,000
↓ Control High Blood Pressure (48.4%) →	NCQA 50 th Percentile	\$6,600,000
↑ Appr. Use of Asthma Meds (83.1%) →		\$5,500,000
		\$4,400,000
		\$3,300,000
↓ Diabetes: LDL Screening (70.3%) →		\$2,200,000
↑ Appropriate Treatment for Upper Respiratory Infections (81.9%) →	NCQA 25 th Percentile	\$1,100,000
		\$0

In Total, 5 MCPs were awarded \$15 million (21%) of \$70million possible

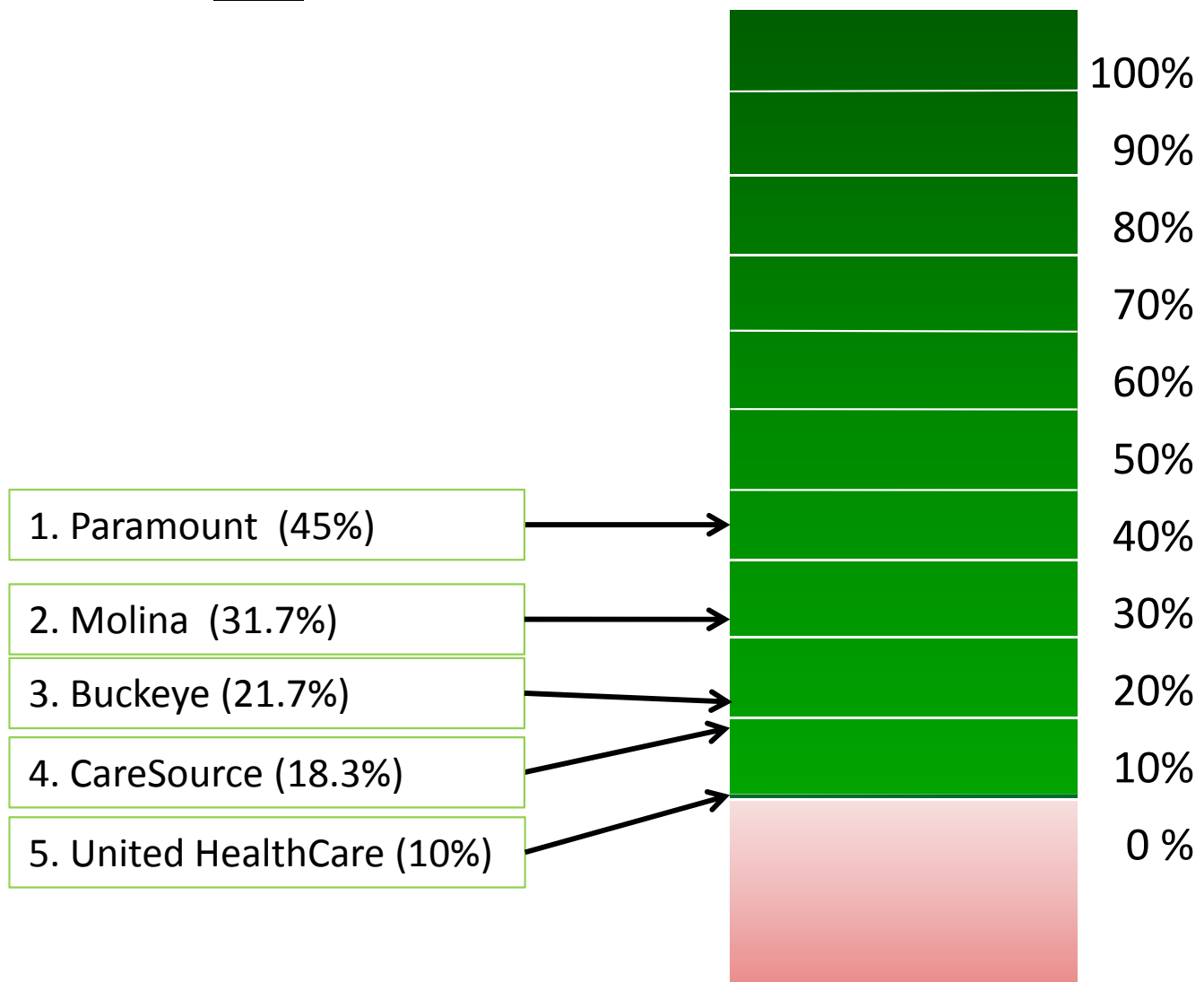


2014 P4P – Plan Ranking

Percent Awarded for All Measures

MCP

Performance Levels Bonus



MCPs awarded \$15 million (22%) of \$70 million possible



Pay-for-Performance In Review

- **How much money was awarded to MCPs through the P4P program in 2014?**
 - \$17 million (22%) of a possible \$70 million
- **How many years has this P4P program been in place?**
 - Since 1/1/2012; the second year's results are available for review; the third year's results won't be available until 10/1/2015
- **Is the incentive program working?**
 - It is too early to tell. We only have two years to evaluate and there were significant program changes in the second measurement year.



MCP Capitation Rate Methodology

Ohio Medicaid makes monthly capitation payments to its Medicaid managed care plans.

The managed care plans are then responsible for covering the cost of all services for beneficiaries.

Capitation rates are developed by the actuary from a variety of sources.



MCP Capitation Rate Methodology

Capitation Rates - Geographical Variances

MCP capitation rates take into consideration variances between the seven geographical rating regions. Regional differences are impacted by various informational sources, including:

Base data (i.e., utilization, unit costs, per member per month) separated by age and gender for each of the rating regions

Program changes (e.g., outpatient facility reimbursement updates)

Adjustments (e.g., Pricing Adjustments)

Sales and use taxes

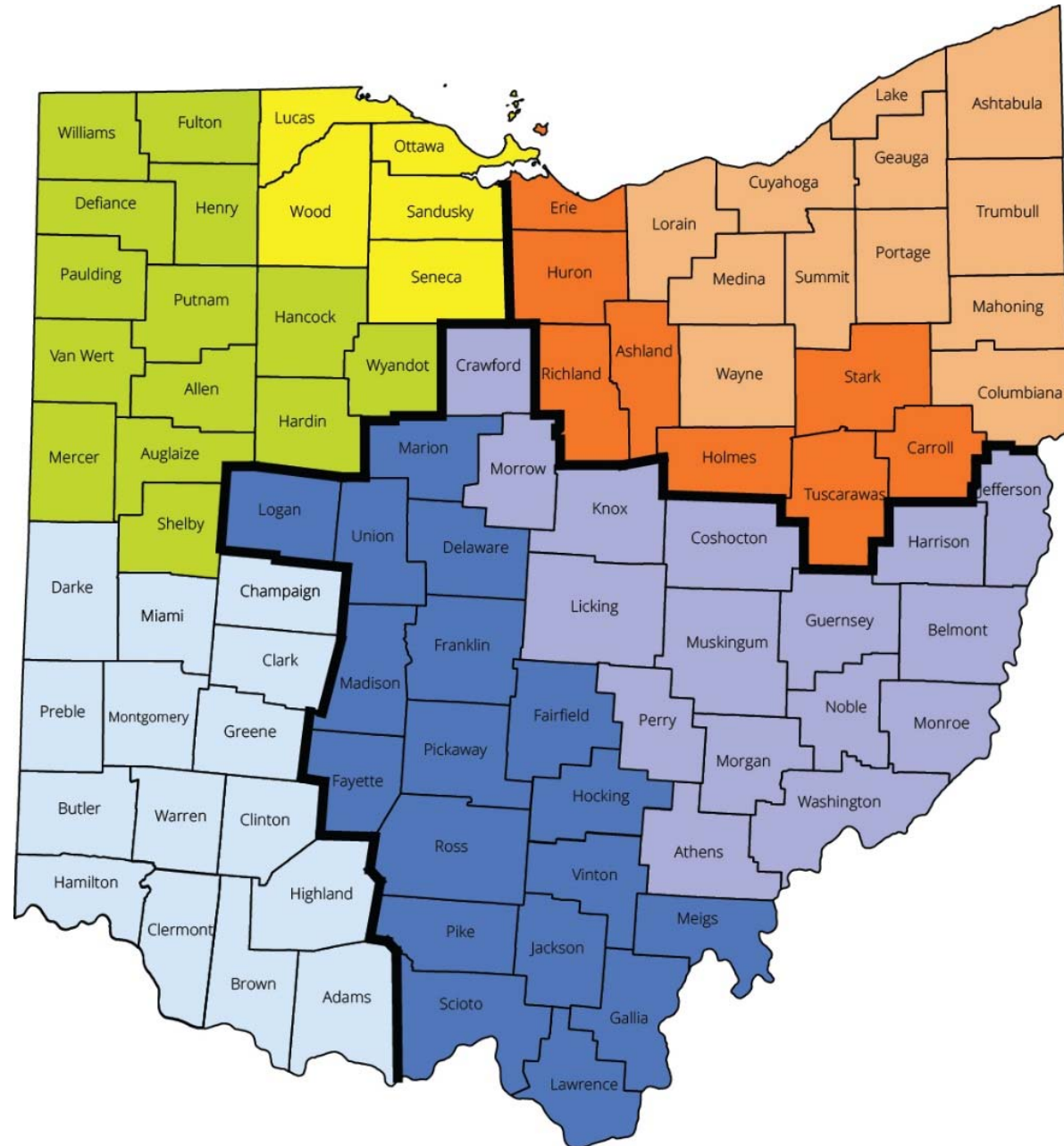


Ohio Managed Care Rating Regions

WEST	
A1 - North Central	
A2 - Northwest	
A3 - Southwest	

CENTRAL / SOUTHEAST	
B1 - South Central	
B2 - Southeast	

NORTHEAST	
C1 - Northeast	
C2 - Northeast Central	





EXAMPLE: MCP Regional Capitation Variances

CY 2015 Capitation Rate for the Healthy Families/Healthy Start

Rating Region	Proposed Capitation Rate	% of All Regions Capitation Rate
A1 - North Central	\$ 131.62	98%
A2 - Northwest	\$ 122.19	91%
A3 - Southwest	\$ 139.98	104%
B1 - South Central	\$ 140.03	104%
B2 - Southeast	\$ 142.84	107%
C1 - Northeast	\$ 126.11	94%
C2 - Northeast Central	\$ 128.92	96%
All Regions	\$ 134.06	100%



MCP Capitation Rate Methodology

Cost Drivers of Regional Variances – Examples of Differences

Inpatient Hospital PMPMs (Combined Utilization and Unit Cost) are higher on average in the A3 – Southwest rating region

Inpatient Hospital PMPMs (Combined Utilization and Unit Cost) are lower on average in the A2 – Northwest rating region

Emergency Room PMPMs (Combined Utilization and Unit Cost) are higher on average in the A1 – North Central rating region

Emergency Room PMPMs (Combined Utilization and Unit Cost) are lower on average in the C2 – Northeast Central rating region

Pharmacy PMPMs (Combined Utilization and Units Cost) are higher on average in the B2 - Southeast rating region



MCP Capitation Rate Methodology

Sources used to develop capitation rates:

Base Data: Information submitted by managed care plans such as encounter data; financial statements

Program Changes: Estimates developed from encounter data, estimates developed internally at ODM, and surveys reported by MCPs

Trends: Estimates from examining encounter data, plan financials, as well as external trend sources

Efficiency Adjustments: Encounter data from plans

Care Coordination: Plan submitted financial statements, external sources

Capitation rates are risk adjusted based on the enrolled acuity of each health plan.



MCP Capitation Rate Methodology

There are various 'cost drivers' that may impact the rate development process as well as per member per month (PMPM) costs:

Specialty Pharmacy including Hepatitis C (and other FDA Breakthrough Therapy Designation drugs)

Emergency Room (Utilization and Unit Cost)

Outpatient Hospital (Utilization and Unit Cost)

Inpatient Hospital (Unit Cost)



Questions