Using Managed Care to Improve Health Outcomes and Manage Costs

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Managed Care in Ohio

- Managed care is mandatorily used to provide services to:
  - All Modified Adjusted Gross Income (MAGI) eligibility groups
  - Aged, Blind, and Disabled (ABD) not enrolled in 1915(c) waivers or living in institutions
  - Dual eligibles in Ohio’s duals demonstration program

- Excluded from mandatory enrollment is:
  - ABD enrolled in 1915(c) waivers or living in institutions
  - Foster Care
  - Adoption
  - Medicare Buy-in
Managed Care in Ohio (continued)

• There are 3 managed care regions in Ohio
• However, all plans are in each region which include:
  » CareSource
  » United
  » Buckeye (Centene)
  » Paramount
  » Molina
• They cover over 2.4 million lives as of August 2015

Managed Care in Ohio (continued)

• Duals Demonstration in Ohio is called MyCare Ohio
• There are 7 demonstration regions with 5 total plans:
  » Cleveland – CareSource, Buckeye, United
  » Columbus – Aetna and Molina
  » Cincinnati – Aetna and Molina
  » Dayton – Buckeye and Molina
  » Akron – CareSource and United
  » Toledo – Aetna and Buckeye
  » Youngstown – CareSource and United
• They cover over 93,000 million lives as of August 2015
Average Monthly Medicaid Enrollment: SFY 08 – SFY 15

Managed Care Oversight

• In 2011, close to 75% of the Medicaid enrollment was in managed care, but:
  » The Bureau of Managed Care only consisted of 10 people
  » The bureau was located under the Director of Policy
  » The bureau was not linked to the Office of Operations
  » There was a “wall” created between managed care and fee-for-service
Rebuilding Management Structure

• Started a cultural change in the department
  » Pulled the Office of Medicaid out of the Ohio Department of Job and Family Services (ODJFS) and created the Ohio Department of Medicaid (ODM)

• Changed the reporting structure
  » Bureau of Managed care was moved from Office of Policy to the Office of Operations
  » Consolidated managed care “IT” functions under the Bureau
  » Made some key personnel changes

Learning from Others

• Engaged with other states to learn and share
  » Went to Tennessee
  » South Carolina came to Ohio
  » Calls with:
    - Kentucky
    - West Virginia
    - Arizona
    - North Carolina
    - Florida
    - Virginia
Organizational Change

- Had to move from the old mentality I do/work on FFS or managed care
- Moved to a matrixed management approach
- Everyone works on Medicaid policy and implementation
  » That includes both FFS and managed care
- Still a “small” managed care bureau

Contracting Philosophy

- Allow the market to come up with solutions
- Do not mandate everything
- Allow for completion
- Plans need to be able to differentiate themselves otherwise they are just an Administrative Services Organization (ASO)
Actuarial Decisions

• ODM worked with its actuary to determine
  » Number of regions
  » Number of plans
  » Capitation rates set by region

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

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 percent of beneficiaries in high risk care management on a monthly basis.

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

Per Month Between 2012-2014

Illustrates the percent 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

• 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

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**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: Statewide Medicaid

<table>
<thead>
<tr>
<th>Trend/Measure (Performance Rate)</th>
<th>Performance Levels</th>
<th>Bonus/Measure</th>
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<tbody>
<tr>
<td>Follow-up after MH Inpatient (51.8%)</td>
<td>NCQA 90th Percentile</td>
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<td>Timeliness of Prenatal Care (86.0%)</td>
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<td>Control High Blood Pressure (48.4%)</td>
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<td>Appr. Use of Asthma Meds (83.1%)</td>
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<td>Diabetes: LDL Screening (70.3%)</td>
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<td>Appropriate Treatment for Upper Respiratory Infections (81.9%)</td>
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In Total, 5 MCPs were awarded $15 million (21%) of $70 million possible
Questions