The Impact of Private Industry on Public Health Care

Medicaid Managed Care Driving Quality Outcomes

Unlike traditional fee-for-service—which does not offer any accountability for quality outcomes—Medicaid managed care plans (MCPs) are held accountable to ensure their members receive quality care. MCPs are driving improvements in the lives and health of their members through care coordination and ongoing innovation.

Improved Health Outcomes Through Care Coordination

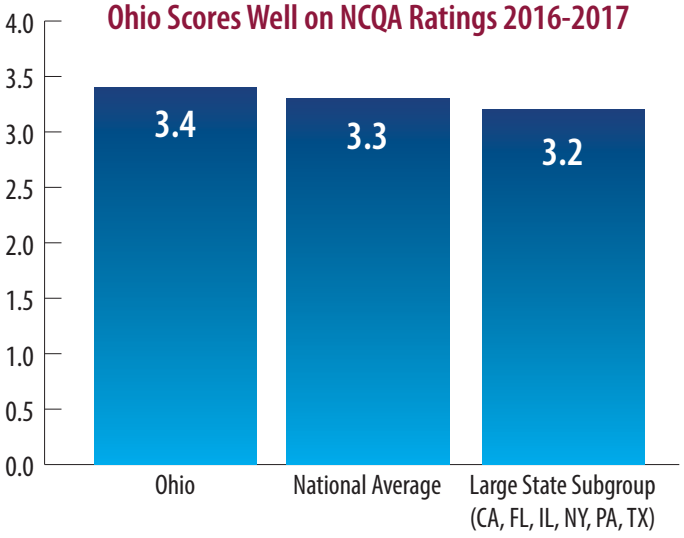
Care coordination is a core competency of MCPs and is key to managing the health and cost of caring for patients with complex chronic conditions. Care coordinators help members to develop and understand individualized care plans, access necessary services, and identify unmet needs (e.g., food and housing) in order to support and maintain positive health outcomes. Additionally, care coordinators connect members with appropriate supports to navigating the often overwhelming health care system. Through care coordination, MCPs are driving down costs by reducing service duplication and removing barriers to care that too often result in expensive and avoidable emergency room and inpatient visits.

The care management systems among MCPs must have 1 percent of membership in the intense risk level and 1 percent in the high-risk level. However, all members receive some level of care management that appropriately suits their health care needs.

Managed Care Quality Performance

The Ohio Department of Medicaid's (ODM) managed care contract incorporates a set of quality metrics that align with the ODM Quality Strategy. These metrics are used to measure the MCPs' success in improving members' health outcomes. As part of the Quality Strategy, ODM has established a pay for performance (P4P) system that awards the MCPs with bonuses for meeting minimum performance standards for a number of the quality metrics. To receive the full P4P bonus, the MCP must demonstrate they are at or above the 75th percentile for P4P metrics. MCPs may be sanctioned for failure to meet the minimum standards for non P4P clinical metrics. Since 2013, MCPs have been awarded more than $74 million in incentive payments.

Ohio's MCPs registered higher average quality scores than both the national and large state subgroup averages on National Committee for Quality Assurance (NCQA) metrics for 2016-2017. All of Ohio's Medicaid managed care plans are NCQA accredited, which is a rigorous and detailed process that many MCPs elsewhere are not required to meet.



230 East Town Street, Suite 200 | Columbus, Ohio 43215-3842 | 614-228-4662 | www.oahp.org

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Managed Care Promotes Provider Quality of Care

MCPs conduct regular assessments, audits and performance-based reviews with their networks of providers to ensure compliance with contractual obligations.

MCPs develop comprehensive strategies to track and report on the utilization, cost and quality of services. They use such data to evaluate the appropriateness, efficacy, and necessity of services to effectively manage the cost and quality of services delivered.

Medicaid Member Satisfaction

Member satisfaction is intimately related to engagement and thus quality in health care. When members are satisfied, they are more engaged and vice versa. Each year, the MCPs are required to conduct member satisfaction surveys. Based on the 2015 survey results, Ohio's MCPs have been rated as "good" to "excellent" compared to national Medicaid percentiles.

Areas of excellent performance included:

- How Well Doctors Communicate (both adult and general child populations)
- Rating of All Health Care (general child population)
- Getting Care Quickly (general child population)
- Customer Service (general child population)

For each of the areas, the program mean was at or above the 90th percentile compared to national Medicaid percentiles.

Addressing the Opiate Epidemic Coordinated Services Program Results

To help address the growing opiate epidemic across Ohio, MCPs and ODM collaborated to create the Coordinated Services Program (CSP). CSP allows MCPs to oversee member utilization and medication patterns that exceed medical necessity. Each MCP's CSP program must be approved by ODM and must meet minimum guidelines, such as identifying members every month who meet or exceed the standards from prescriptions for controlled substances during a 90-day period. This structure allows for common goals, but each MCP may develop innovations that are optimized for their members. Once members are identified and enrolled, they are subject to the restrictions of the CSP for 18 months and remain enrolled even if they change MCPs.

The state's External Quality Review Organization (HSAG) found that members who participated in the CSP generally experienced better outcomes. The study found that CSP participation led to:

- 27 percent fewer prescriptions for opioids and controlled substances
- A decrease in opioid consumption by 293 milligrams
- A 13 percent reduction in emergency department visits
- $172.79 reduction in average monthly member costs during the CSP enrollment period compared to the pre-CSP enrollment period