The Impact of Private Industry on Public Health Care

Private Industry Innovations

Under a traditional fee-for-service (FFS) system, Ohio faces barriers to driving change and innovation. Managed Care Plans (MCPs) assist Ohio in implementing transformative programs that meet state policy goals and member health care needs alike. MCPs have partnered with the State and providers to tackle population health issues, as well as efforts to shift from paying for volume to value.

Constant innovation is critical to providing Medicaid members with quality services while at the same time being responsible partners to the State. Ohio's health plans continue to develop and implement programs and payment modalities with the goal of:

- Enhancing care
- Increasing access and accountability
- Improving health outcomes
- Paying for quality.

Future legislation must avoid policy changes that may further limit the MCP's ability to be creative in the areas of payment reform and health care delivery improvements.

MCP Progress Report

MCP	Progress toward Value-Based Purchasing Goals
Buckeye Health Plan	38 percent of primary care network physicians' total reimbursement is value-based
CareSource	26 percent of total payments are value-based and 50 percent of membership attributed to a value-based arrangement
Molina Healthcare	24 percent of aggregate net payments tied to value-based reimbursement with 19.6 percent in full-risk arrangements
Paramount Advantage	30 – 40 percent of its non-pharmacy medical expense tied to a value-based incentive arrangement
UnitedHealthcare Community Plan of Ohio	20 percent of payments (less pharmacy) in upside/downside risk contracts and 40 percent of medical spend in non-risk value-based contracts

Percentages as reported by MCPs at November 17, 2016 Joint Medicaid Oversight Committee hearing

Value-Based Payments

Well structured, value-based agreements increase access to care, raise health awareness, promote early detection, improve outcomes and reduce cost. Through these initiatives, providers are eligible to receive additional payments when they achieve a quality goal as outlined in their contract. While provider agreements vary by MCP and provider, most MCPs apply similar metrics related to primary and preventive care and often utilize national quality standards.

MCPs also have a variety of targeted value-based purchasing agreements, some with large health care organizations and specialty providers aimed at increasing quality and reducing cost in a specific geography. Additionally, MCPs have developed shared savings arrangements with providers that target specific outcomes.

MCPs are required to have at least 50 percent of provider contracts value-based by 2020. To date, all MCPs can link—at a minimum—20 percent of payments to value-based arrangements and are on target to meeting the 2020 requirement.

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Managed Care Supports State Initiatives

MCPs have partnered with the State to implement two multi-payer initiatives—patient-centered medical homes (PCMH) and episodes of care.

- The Comprehensive Primary Care (CPC) program is Ohio's patient-centered medical home program, which uses a team-based care delivery model, led by a primary care practice, that manages the needs of the patient. MCPs work with CPC practices to ensure members are receiving the care and support they need to achieve improved health outcomes.

  Participating providers may be eligible for two payments in addition to existing payment arrangements with the Medicaid MCPs. These include:
  - A per-member-per-month payment, to support activities required by the CPC program; and
  - A shared savings payment, to reward practices for achieving total cost of care savings.

- Episode of care payments establish an expected cost for a medical event and provide shared savings when the cost and quality of the episode is better than predicted. A demonstration period is followed by a performance period. The episodes selected are clinical conditions with an established body of evidence-based knowledge where the treatment is predictable and uniform. Using episode bundling of costs, the MCP pays providers for effectively and efficiently treating acute episodes.

  Ohio uses a retrospective bundling model wherein patients seek care, and providers deliver care much as they have always done. MCPs identify the principal accountable provider (PAP) for an episode and evaluate all costs associated with that episode of care and quality indicators. Depending on performance and the type of contract between the MCP and the provider, one of the following results occur, as seen below.

Cost of Episode Compared to Baseline	Type of Contract	Impact On Provider
Costs higher than average baseline	Risk Sharing	Provider pays MCP a share of cost of care
Costs higher than average baseline	Shared Savings	No impact on provider
Costs the same (within a range)	Shared Savings or Shared Risk	No impact on provider
Costs lower than average baseline	Shared Savings or Shared Risk	Providers receive incentive payment to share in savings

Innovation Showcase: Improving Relationships between Members and Providers

Members can pick any PCP within their MCP's network. If a member does not select a PCP, one is assigned using an algorithm approved by ODM. Further, members are permitted to seek care from any in-network PCP, even when not "assigned." Since members often do not inform an MCP when they seek care from a PCP other than their assigned one, MCPs have begun to use claims analysis to identify members who do this.

If a member has visited a PCP who is not assigned and has never visited the assigned PCP, the MCPs send members a letter informing them of reassignment to the PCP from whom they have sought care. In the event the member does not wish to be moved to the PCP selected, or wishes to be moved to another PCP, the member is instructed to contact Member Services. Since August 2016, MCPs have improved PCP assignments for 27,344 members.