The Impact of Private Industry on Public Health Care: How Managed Care is Reshaping Medicaid in Ohio

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OAHP Overview

Who We Are: The Ohio Association of Health Plans (OAHP) represents 16 member plans providing health insurance coverage to more than 9 million Ohioans. Ohio's health plans include carriers providing coverage in both the private and public markets.

Core Mission: To promote and advocate for quality health care and access to a variety of affordable health benefits for all Ohioans

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Current Membership:

- Aetna
- Anthem Blue Cross/Blue Shield
- AultCare
- Buckeye Health Plan
- CareSource
- Cigna Healthcare
- Gateway Healthcare
- Humana
- Medical Mutual of Ohio
- Meridian
- Molina Healthcare of Ohio
- Paramount Health Care
- SummaCare
- The Health Plan
- UnitedHealthcare Community Plan
- UnitedHealthcare of Ohio

Affiliate members: CVS Health; Delta Dental Plan of Ohio; Ohio State University Health Plan

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Overview

- History of Ohio's Managed Care Program
- Managed Care in Ohio Today
  - Cost-savings
  - Quality
  - Innovation
- Moving Forward

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Managed Care is Reshaping Ohio Medicaid

Managed care plans (MCPs) leverage best practices and innovations to help Ohio Medicaid improve care quality and reduce overall cost.

Managed care was first introduced into the Ohio Medicaid program in the late 1970s.

- ***Today, nearly 9 in 10 Medicaid beneficiaries are insured through managed care***

Today, MCPs provide Ohio's Medicaid program with the ability to modernize care delivery and improve health outcomes through care coordination, value-added services, and partnerships with providers and communities.

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History of Managed Care in Ohio

1978 - 1988 – Initial Voluntary Medicaid Managed Care Pilots

- 1978: Voluntary enrollment in Cuyahoga and Belmont counties.
- Mid-1980s: Voluntary enrollment in 28 counties.
- Appx. 85,000 Medicaid managed care beneficiaries

1989 - 1994 – Mandatory Medicaid Managed Care Begins

- 1989: 1115 waiver for mandatory enrollment in Montgomery County
- Voluntary enrollment in Butler, Green, Lorain, Marion, Stark, Summit, Trumbull, and Wood counties

1995 - 2001 – Ohio Care Waiver

- 1115 waiver to expand mandatory enrollment in 10 counties in the Akron, Cincinnati, Cleveland, Columbus, Dayton, and Toledo regions.
- Voluntary enrollment expanded to Mahoning and Miami counties
- Consolidation MCPs across Ohio
- Nearly 250,000 Medicaid managed care beneficiaries

History of Managed Care in Ohio

2001 - 2005 – Preferred Option

- 1915 (b) waiver allows for automatic managed care enrollment in Butler, Clark, Franklin, Hamilton, Lorain, and Montgomery counties
- Mandatory managed care in Cuyahoga, Lucas, Stark, and Summit Counties
- Voluntary managed care expanded to Clermont, Greene, Pickaway, Warren, and Wood counties
- More than 489,000 Medicaid managed care beneficiaries

2006 - 2012 – Statewide Mandatory Managed Care Expansion

- Legislature requires mandatory managed care for all of the CFC and part of the ABD programs.
- Pharmacy benefit carved into managed care
- 87 of 88 counties in mandatory managed care

2013 - present – Recent Developments

- More than 37,000 children with special health care needs transition to managed care
- 77 percent of ABD population in Medicaid managed care
- Budget requires children in foster care & adoption services to enroll in managed care
- 2016-17 budget calls for carve-in of behavioral health services by January 1, 2018

Managed Care in Ohio Today

Today, 86 percent of all Medicaid members – nearly 2.5 million Ohioans – receive care from one of five statewide MCPs.

Medicaid members enrolled in managed care include:

- Women, children, and families through the Covered Families and Children (CFC) program
- Aged, blind and disabled (ABD) individuals
- Childless adults between 19 and 64 years old with income less than 138 percent of the federal poverty level ("Expansion Population")
- Persons eligible for both Medicare and Medicaid who live in one of the seven multi-county MyCare Ohio demonstration regions
- Individuals enrolled in the Bureau for Children with Medical Handicaps (BCMH)
- Children in custody or receiving adoption assistance
- Breast and cervical cancer program enrollees
- Some individuals served by one of four Developmental Disability (DD) waivers

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Managed Care in Ohio Today

Ohio's current Medicaid managed care program went 'live' on July 1, 2013.

buckeye health plan

CareSource

MOLINA HEALTHCARE

PARAMOUNT ADVANTAGE
Affiliate of ProMedica

UnitedHealthcare COMMUNITY & STATE

aetna

***Aetna is a sixth plan serving the dual beneficiary population (MyCare Ohio)**

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Cost Savings: Strategies

Managed Care Plans rely on evidence-based practices and market innovations to improve Ohio's health care delivery system.

- **This leads to greater efficiency and improved health outcomes.**

The Department of Medicaid incentivizes the Medicaid managed care plans to lower health care costs through strategies that promote preventive care services and care coordination for members with complex conditions. The department also holds MCPs accountable for improving population health outcomes and enhancing provider network management.

- **All of this is needed to foster a sustainable Medicaid program for the future.**

These strategies assist plans and the State of Ohio to achieve programmatic savings by

- **promoting the efficient use of the health care system;**
- **eliminating wasteful spending by placing an emphasis on preventative care, care coordination to manage chronic conditions, the detection and treatment of serious illnesses early;**
- **and partnering with providers to improve quality outcomes.**

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Cost Savings: From Potential To Actual

Released in February, *The Impact of Private Industry on Public Health Care* report illustrates the cost savings that managed care has brought to Ohio Medicaid in recent years.

The Wakely Consulting Group conducted an evaluation of Ohio's Medicaid's programmatic savings 2013 – 2015. The report compares MCP capitation rates to the estimated costs that would have been incurred had those same members been covered by the traditional fee-for-service program during that time.

Wakely estimated that the capitation rates paid to the MCPs were 8.9 percent ($2.5B) to 11.3 percent ($3.2B) lower in the period from CY 2013 through CY 2015 than the estimated costs had ODM served those same members in the FFS program.

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Cost Savings: Managed Care to Fee-For-Service (FFS)

Estimated Savings Relative to Fee for Service *Based on Assumed Trend Differential (CY 2013 – 2015)*	
Estimated FFS Costs	$27,741,384,000
Calculated MCO Revenue (1)	$25,282,492,000
Total Dollars Saved	$2,458,892,000
Total Percentage Saved	8.9%
Based on 0.5% Annual Trend Differential (CY 2013 – 2015)	
Theoretical FFS Costs	$28,491,486,000
Calculated MCO Revenue (1)	$25,282,492,000
Total Dollars Saved	$3,208,994,000
Total Percentage Saved	11.3%

(1) Excludes Health Insuring Corporation Tax and Sales & Use Tax

Source: Ohio Medicaid Managed Care Savings Analysis – January 2013 through December 2015
http://oahp.org/wp-content/uploads/2017/02/Wakely_OH-Medicaid-2013-15-Managed-Care-Savings-Analysis_20170120.pdf

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Cost Savings: Medicaid Pharmacy Benefit

In 2011, Ohio Medicaid to a "carve-in" model of pharmacy management, meaning that prescription drugs would be included in the managed care capitation payments.

By federal fiscal year 2015, more than 86 percent of all Ohio Medicaid prescriptions were paid through managed care plans.

Under its pharmacy carve-in model, Ohio Medicaid requires that MCPs use a largely uniform Medicaid preferred drug list (PDL), so that at least 90 percent of the drugs match those that are found on the fee-for-service PDL

- **MCPs maintain the ability to include different drugs for up to 10 percent of their PDL.**

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Cost Savings: Medicaid Pharmacy Benefit

Medicaid Prescription Drug Net Costs and Usage – FFY2015

With the carve-in of the pharmacy benefit, Ohio has achieved low net costs per prescription, with the FFY 2015 average of $36.80 – which is 9.1 percent below the nationwide average of $40.50.

Among all states, Ohio had the 16th lowest net Medicaid costs per prescription during FFY 2015. During FFY 2015 there were six remaining pharmacy carve-out states – Indiana, Iowa, Missouri, Nebraska, Tennessee and Wisconsin. Ohio's Medicaid costs per prescription were 13.3 percent below the collective average of these carve-out states.

State of State Group	Prescription	Post-Rebate Medicaid Expenditures	Post-Rebate Cost Per Script
Ohio	39,023,162	1,435,927,158	$36.80
USA Total	661,915,649	28,805,862,192	$40.50
2015 Carve-Out State (IN, IO, MI, NE, TN, WI)	60,045,125	2,549,035,190	$42.45

Source: Menges Group tabulations using CMS State Drug Utilization data and drug rebate information from the CMS 64 reports. Note that the above table excludes from all jurisdictions three recently introduced high-cost drugs used to treat Hepatitis C – Harvoni, Sovaldi and Viekira Pak. This adjustment controls for variations in use of these drugs across states, which can otherwise distort the cost per prescription comparisons.
https://www.themengesgroup.com/Comparison-of-Medicaid-Pharmacy-Costs-and-Usage-in-Carve-In-Versus-Carve-Out-States.html#.WIZl0fkrLIU

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Driving Quality: Metrics & Pay for Performance

Unlike the old fee-for-service system, Medicaid managed care plans are held accountable to ensure that members receive quality care.

Ohio Medicaid's contract with the plans incorporates a series of quality metrics that measure the plans' success in improving care quality and health outcomes, as well as reducing costs.

ODM has established a pay for performance (P4P) system that incentivizes managed care plans for meeting minimum performance standards across a number of quality metrics.

- **To receive the full P4P bonus, a plan must be at or above the 75th percentile for P4P metrics.**
- **MCPs may also be sanctioned for failing to meet the minimum standards for non-P4P clinical metrics.**

***Since 2013, MCPs have been awarded more than $74 million in P4P incentive payments*.**

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Driving Quality: Care Coordination

Care coordination is key to managing the health and cost of patients with complex or chronic conditions. Individuals with such conditions often have trouble navigating the health care delivery system and coordinating their various healthcare needs.

Appropriate care coordination results in a better quality of life for the individual, fewer unmet needs, lower avoidable health care utilization (such as emergency department visits and inpatient admissions) and improved satisfaction with the experience of health care for the member and their support system.

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Driving Quality: Care Coordination

In order to provide beneficiaries with these benefits, managed care plans utilize care coordinators who work directly with individuals to assess their health care needs.

Care coordinators are accountable for the following responsibilities:

- ***Assessing and identifying a member's needs and addressing barriers to care***
- ***Developing an individualized care plan with the member and their support system***
- ***Educating the member and their support system on resources available***
- ***Facilitating communications among multi-disciplinary providers on the care team***
- ***Ensuring access to care***
- ***Monitoring the member for changes that impact the individualized care plan***

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Driving Quality: Providers and National Standards

Managed care helps to advance provider quality of care.

Plans conduct regular assessments, audits and performance-based review with their provider networks to ensure compliance with contractual obligations. Additionally, plans maintain strategies to monitor and report data concerning utilization, cost, and quality.

These efforts have proven effective as Ohio's Medicaid plans 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.

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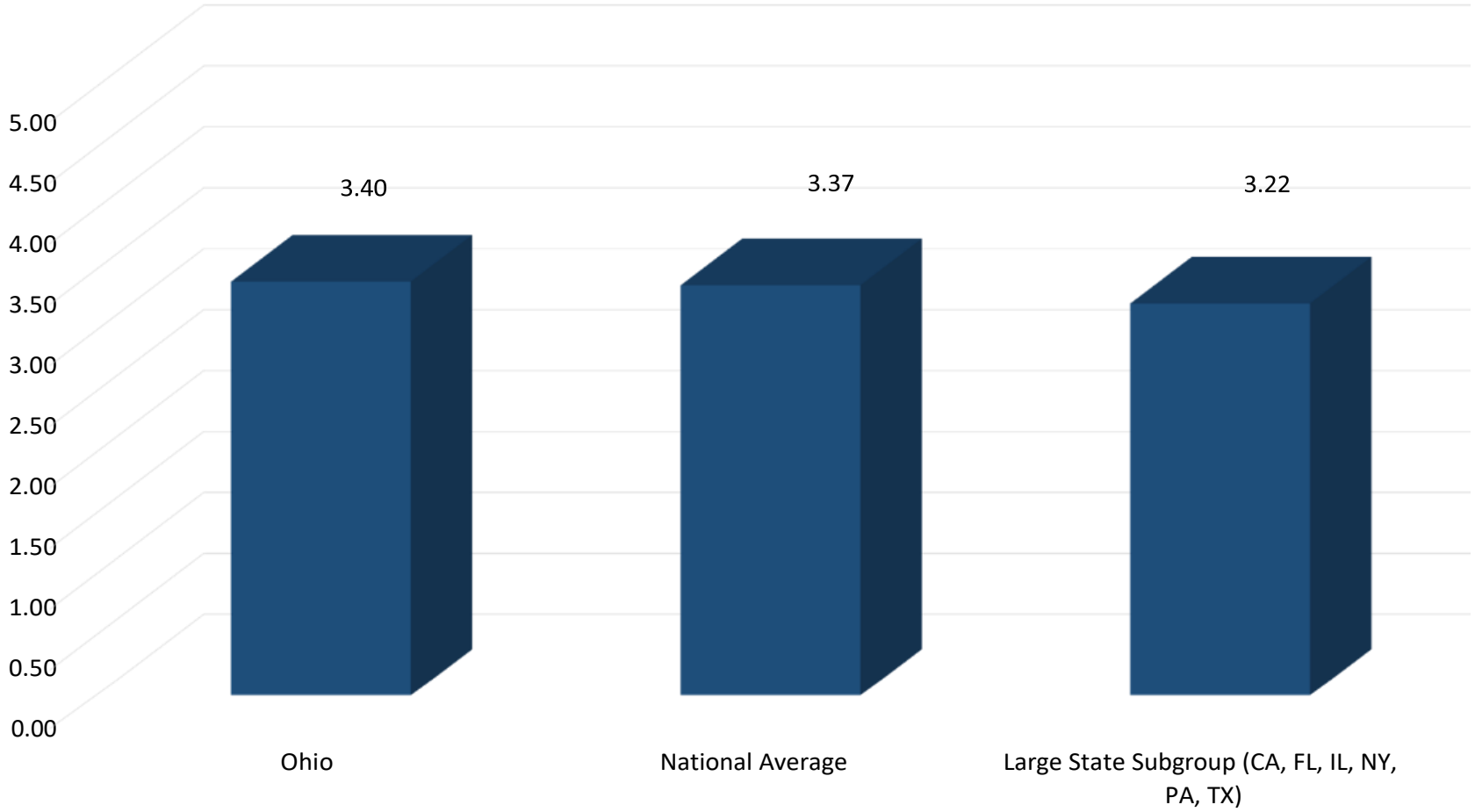
Driving Quality: Performance on Quality Measures

Ohio Scores Ahead of National and Large State Average on NCQA Measures (2016-17)



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Leveraging Innovation

Managed care plans assist Ohio in implementing transformative programs that meet state policy goals and member health care needs.

Plans have partnered with the State and providers to tackle population health issues, as well as efforts to shift from paying for volume to value. Examples of this include Comprehensive Primary Care (CPC) and Episode-based payments.

Ohio's health plans continue to develop and implement programs and payment modalities with the following coals in mind:

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

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Leveraging Innovation: Value-based Purchasing

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 metrics may vary amongst plans, most MCPs apply similar metrics related to primary and preventive care and often utilize national quality standards.

By 2020, all Medicaid managed care plans must link 50 percent of provider payment to value.

- ***The Impact of Private Industry on Public Health Care*** **report found that each Medicaid MCP has already linked at least 20 percent of payment to value, and that all are on track to hit the 50 percent target by 2020.**

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Managed Care: Moving Ohio Forward

Ongoing innovation is critical to providing the best services to Medicaid members while at the same time being responsible partners to the Ohio Medicaid program.

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.

Further service integration within managed care will reduce Ohio Medicaid costs and increase quality.

- **Integration of long-term services and supports into managed care;**
- **Integration of behavioral health services (set to be integrated 1/1/18).**

Ohio should continue to pursue opportunities to reduce administrative complexity wherever possible, advancing current initiatives to update and standardize coding practices and continue to build strong reliable partnerships with MCPs.

- **Provider greater PDL latitude**

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Questions? Comments?

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