Medicaid 101:
The Basics

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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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OAHP Overview

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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Today's Agenda:

- What is Medicaid?
- Fee-for-Service vs. Managed Care
- Who's Eligible?
- What's Covered?
- Payment
- Care Management
- Performance and Quality Measures

What is Medicaid?

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Overview

Medicaid is a jointly funded federal and state health insurance program that is administered by the individual state governments.

Created in 1965 with the addition of Title XIX to the Social Security Act

- Medicare was created simultaneously. Medicare is a strictly federal insurance program available to senior citizens and certain individuals living with disabilities.

State Medicaid programs must adhere to a broad set of federal guidelines under the oversight of the United State Department of Health and Human Services.

- However, states have the ability to establish their own levels of eligibility, consumer benefits, and payment rates – as long as they do so within federal parameters.

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Overview

State Medicaid programs are funded through a financing formula known as the **Federal Medicaid Assistant Percentage (FMAP)**.

- For Federal Fiscal Year 2018, Ohio's standard FMAP will be 62. 79%
- This means that's for every typical dollar spent on Ohio's Medicaid program, the federal government will reimburse the state nearly $0.63.

As of January 2018, nearly 3 million residents are insured through Ohio's Medicaid program.

- Nationwide, more than 74.4 million Americans are on Medicaid (includes CHIP)

Sources: The Ohio Department of Medicaid, January 2018 Caseload Report (www.Medicaid.ohio.gov)
Medicaid.gov, December 2017 Medicaid and CHIP Enrollment Data (www.Medicaid.gov)

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Fee-for-Service vs. Managed Care

Historically, **Fee-for-Service (FFS)** has been the common approach taken by state Medicaid programs.

- In a Fee-for-Service model, health care services are paid for as individual units of service; every type of service has a pre-defined rate.

- This is an a la carte approach that emphasizes quantity of care over quality.

Today, many states – including Ohio – are embracing a **Managed Care** model of health care delivery.

- Under such models, a state Medicaid program contracts with private managed care plans (MCPs) to provide health care coverage to beneficiaries. The state then pays an MCP a per member per month/capitation payment.

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Fee-for-Service vs. Managed Care

More than 85% of Ohio's Medicaid population is insured through six managed care plans.

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

Just 10 years ago, only 30% of Medicaid consumers were afforded the benefits of managed care.

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Medicaid Managed Care

Following a procurement process, Ohio moved to a new managed care model in July 2013.

The current program reduces fragmentation and ensures that all Medicaid managed care plans are available statewide.

Care quality and access standards are key components to Ohio's Medicaid managed care model.

Medicaid Managed Care

Eligible Populations

The majority of Ohio's Medicaid population is **required** to participate in managed care.

- Children and families
- Adult expansion (extension)
- Aged, Blind and Disabled (ABD) adults and children
- Children in custody or receiving adoption assistance
- Children receiving services through the Bureau for Children with Medical Handicaps (BCMH)
- Breast and Cervical Cancer Project enrollees
- Individuals on a Developmental Disabilities waiver *

*optional enrollment

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Medicaid Managed Care

Eligible Populations

However, some populations that are **excluded** from that ODM's managed care program:

- Individuals on home and community-based services waivers
  - *Members eligible through expansion are eligible to receive HCBS waiver services*
  - *MyCare Ohio demonstration beneficiaries are eligible to receive HCBS waiver services*
- Individuals who are institutionalized
- Individuals who are eligible for **both** Medicaid and Medicare
  - ***Except** beneficiaries living in MyCare Ohio demonstration counties*

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Medicaid Managed Care

Ohio Revised Code Chapter 5167 and Ohio Administrative Code Chapter 5061-26 contains laws and rules regulating Medicaid managed care plans.

Medicaid MCPs are also held to requirements contained in the Ohio Department of Medicaid's **Provider Agreement**. This ensures that Ohio continues to benefit from the partnership.

Requirements include:

- Quality measures and standards to evaluate plan performance in key program areas such as access, clinical quality and consumer satisfaction.
- MCPs must ensure adequate access is available to members for all required provider types.
- Plans must convene a Managed Care Plan Family Advisory Council at least quarterly in each region that the plan serves consisting of the MCP's current members.
- Sets requirements for MCPs to guard against fraud, waste, and abuse.

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Managed Care plans must cover **all services** that are included as under the state's FFS program.

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Lab and X-ray services
- Screening, diagnosis, and treatment services for children under 21 years (Healthchek/EPSDT)
- Immunizations
- Family planning services and supplies
- Home health and private duty nursing
- Podiatry
- Chiropractic Services
- Physical, occupational, development and speech therapy services
- Nurse midwife, certified family nurse practitioner, and certified practitioner services
- Prescription drugs
- Ambulance and ambulette services
- Dental services
- Durable medical equipment and medical supplies
- Vision care services
- Nursing facility services
- Hospice care
- Behavioral health services
- Respite services for eligible children receiving Supplemental Security Income (SSI)

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Medicaid Managed Care

Medicaid Managed Care plans may also provide **enhanced services** that are not available under the standard Fee-for-Service program.

Services may include:

- Additional Transportation Benefits
- Incentive Programs
- Self-Service Capabilities
- Disease Management and Health Education Programs
- Enhanced Dental and Vision Programs
- Extended Provider Office Hours

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Medicaid Managed Care

MyCare Ohio

In addition to the standard Medicaid Managed Care Program, Ohio launched the **MyCare Ohio** demonstration program in 2014.

- Time-limited program running through 2019.

MyCare Ohio provides coordinated benefits to individuals enrolled in both Medicaid and Medicare.

- Historically, there has been little to no coordination between state Medicaid programs and the federal Medicare program
- The dual-eligible population commonly has complex health care needs that require high-cost services.

The program is 'live' in seven geographical regions composed of 29 Ohio counties.

Ohio was among the first states to adopt a managed care approach to care for this population.

Medicaid Managed Care

Capitation Payments

Each Medicaid MCP receives a **monthly capitation payment** from the state. These payments are made in exchange for covering beneficiaries' health care needs.

All capitation rates are required to be actuarially sound, per federal regulations.

- Rates are updated annually and reviewed mid-year.
- ODM sets rates at the lowest quartile.

Under ODM's Managed Care Program, MCPs are at-risk for service costs exceeding the capitation payment.

- In turn, this incentivizes the plans to provide coordinated care to its members that result in positive health outcomes for individuals.

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Capitation Payments

Ohio is segmented into seven geographical rating regions for purposes of developing the capitation rates.

Regional differences and variances are taken into consideration during rate development, as are 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)
- Taxes

Medicaid Managed Care

Care Management

- All Medicaid managed care plans must implement a **care management** program through a model of care that broadly defines the way services will be delivered to meet population needs.

- A well-designed population health management program is driven by clinical, financial, and operational data from internal departments and larger delivery systems providing actionable data that can be used to improve quality of care, patient experience, health equity and cost of care.

- Such programs allow plans to better address the immediate needs of members and to partner with the providers to deliver valuable health care services to individuals.

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Key Care Management Requirements

- The MCP must develop a risk stratification level framework for the purpose of targeting interventions and allocating resources based on the member's needs.
- The MCPs must assess new members using a standardized health risk assessment within 90 days of enrollment for the purpose of risk stratification and to identify potential needs for care management.
- The MCP must ensure members are able to access care management services when needed.
- The MCP must develop and implement safeguards, systems, and processes that detect, prevent, and mitigate harm and/or risk factors that could impact an individual's health, welfare, and safety. When the MCP identifies or becomes aware of risk factors, it shall put in place services and supports to mitigate and address the identified issues as expeditiously as the situation warrants.

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Managed Care Plan Performance

Measuring Quality

The Ohio Department of Medicaid has established a series of **Quality Measures** and Standards to evaluate managed care plan performance in key program areas.

- Key Areas: Healthy Children, Women of Reproductive Age, Behavioral Health, Chronic Conditions, and Health Adults
- Total of 23 measures for SFY 2018

The quality measures align with specific priorities, goals, and focus areas of ODM's Quality Strategy.

All of the measures used in the performance evaluation are derived from national measurement sets (e.g., HEDIS, AHRQ) that are widely used for evaluating Medicaid and managed care programs.

ODM establishes minimum performance standards for each and MCPs may be sanctioned for not meeting those standards.

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Managed Care Plan Performance

Pay for Performance (P4P) – Ending in April 2018

ODM has historically operated **Pay for Performance (P4P)** incentive system to reward MCPs that achieve specific levels of performance in program priority areas.

For FY 2018 MCPs are eligible for P4P payments up to 1.25% of capitation revenues.

FY 2018 Performance Measures include:

- Timeliness of prenatal care
- Postpartum care
- Controlling high blood pressure for patients with hypertension
- 7-day follow-up after mental illness admission
- Adolescent well-care visits
- Comprehensive diabetes care (HbA1c Control)

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Quality Withhold Program – Beginning April 2018

The Kasich Administration established a **Quality Withhold Program** in HB 49 to replace the P4P program.

ODM will withhold 2% of the MCPs capitation and delivery payments beginning April 2018.

ODM will use Quality Indices to calculate the amount of the withhold payout. Quality Indices are comprised of multiple performance measures related to the index topic.

Quality Indices measure the effectiveness of the MCP's population health management strategy and quality improvement programs to impact population health outcomes.

Performance will be assessed on four equally weighted Quality Indices. The Quality Indices used in the Quality Withhold program for SFY 2019 (measurement year 2018) are:

- Chronic Condition: Cardiovascular Disease
- Chronic Condition: Diabetes
- Behavioral Health
- Healthy Children

Each index is composed of multiple quality measures which are assigned different weights.

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Managed Care Plan Performance

Quality Withhold Program – Index Scoring

Where applicable, ODM will apply Index Scoring in the evaluation of MCP performance in accordance with the methodology specified below. A separate Index Score will be calculated for each Index. Index Scores will be calculated using a two-step process: 1) Comprehensive Care Test; and 2) Point Value Assignment & Weighting.

Step 1: Comprehensive Care Test – If all measure results in an Index do not meet or exceed the minimum percentile benchmark the Index Score = 0.

- If all measure results meet or exceed the minimum percentile benchmark, proceed to Step 2 below to determine the Index Score.
- If one or more measure results in the Index are less than the minimum percentile benchmark: final Index Score = 0.

Step 2: Point Value Assignment & Weighting

- Point Value Assignment - If all Index measures pass the Comprehensive Care Test, assign a point value to each measure in the Index. Point values are based on a comparison of each measure's rate to a benchmark range
- Weighted Point Value - Multiply the Point Value for each measure in the Index by the measure Weight, as specified in Table 2.

Point Value x Weight = Weighted Point Value

- Index Score – The final Index Score equals the sum of the Weighted Point Values.

Sum of Weighted Point Values [for each measure] = Index Score

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Managed Care Plan Performance

Quality Withhold Program – Bonus Pool

If there are unreturned Quality Withhold Program dollars, ODM will create a Bonus Pool. Unclaimed Bonus Pool dollars will not carry over to the next year.

In order to qualify for a share of the bonus pool, MCPs must achieve the following:

1. An average Index Score of 75.0 points or greater across all indices included in the SFY 2019 Quality Withhold Program; and

2. At least 90.0% of CPC practices with MCP members attributed during the measurement year must remain in good standing on applicable quality and efficiency metrics. In order to remain in good standing, CPC practices must pass at least 50% of applicable quality metrics and at least 50% of applicable efficiency metrics. This determination will be made by ODM.

The Bonus Pool will be divided in proportion to each qualified MCP's net MMC premium and delivery payments made for the measurement year.

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Managed Care Plan Performance

ODM Managed Care Plans Report Card

In 2015, the Ohio Department of Medicaid established an annual **Managed Care Plans Report Card** to assist consumers in choosing a plan that best fits their needs.

- Another source of accountability and transparency.

The Report Card uses a 3-star rating system and utilizes data from a series of reporting sources.

Five reporting categories:

- Keeping Kids Healthy
- Doctors' Communication & Services
- Women's Health
- Getting Care
- Living with Illness

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Key Takeaways

- Ohio has become a leader in leveraging private industry to transform the state's Medicaid program.
- Managed care offers a 'hands-on' approach to Medicaid coverage.
- Accountability, quality and ongoing improvement are priorities for the State, the insurance industry, and consumer advocates alike.
- Constant innovation ensures that state Medicaid programs and our overall health care industry continue to evolve.

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Hot Topics

- Pharmacy issues
- MLTSS
- Behavioral Health update
- Other issues?

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Questions? Comments?

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Resources:

- ODM Provider Agreement
- ODM Managed Care Report Card
- OAHP Value of Private Industry Report
  - Additional Report Documents

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