Perspectives on Medicaid

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Center for Medicaid Policy

Preparation for the Future of Healthcare, and Reflection from the Stakeholders
THE CHALLENGE: What is Medicaid?
If you’ve seen one Medicaid program, you’ve seen one Medicaid program
CONTEXT: How

The difference between Medicaid and Medicare

**Medicaid**
- Aid for some low-income and disabled Ohioans
- Eligibility based on income
- Children, parents, disabled and age 65+
- Primary, acute and long-term care
- State and federal funding
- Not funded by payroll deduction

Total annual Medicaid spending, SFY 2014
- $20.9 billion (across all Ohio agencies)
- $13.5 billion

64.5% federal

34.9% Ohio

$7.3 billion

Source: HPIO
CONTEXT: Where
Early and Periodic screening, diagnosis and treatment (EPSDT) for children

Inpatient hospital

Physician

Lab and X-ray

Outpatient, including services provided by hospitals, rural health clinics, and Federally Qualified Health Centers

Medical and surgical vision

Medical and surgical dental

Transportation of Medicaid services

Nurse midwife, certified family nurse and pediatric nurse practitioner

Home Health

Nursing facility

Medicare premium assistance
THE OPPORTUNITY:
## Innovation Framework

<table>
<thead>
<tr>
<th>Modernize Medicaid</th>
<th>Streamline Health and Human Services</th>
<th>Pay for Value</th>
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<tbody>
<tr>
<td><strong>Initiate in 2011</strong></td>
<td><strong>Initiate in 2012</strong></td>
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<tr>
<td>Advance the Governor Kasich’s Medicaid modernization and cost containment priorities</td>
<td>Share services to increase efficiency, right-size state and local service capacity, and streamline governance</td>
<td>Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement</td>
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- Extend Medicaid coverage to more low-income Ohioans
- Eliminate fraud and abuse
- Prioritize home and community services
- Reform nursing facility payment
- Enhance community DD services
- Integrate Medicare and Medicaid benefits
- Rebuild community behavioral health system capacity
- Create health homes for people with mental illness
- Restructure behavioral health system financing
- Improve Medicaid managed care plan performance

- Create the Office of Health Transformation (2011)
- Implement a new Medicaid claims payment system (2011)
- Create a unified Medicaid budget and accounting system (2013)
- Create a cabinet-level Medicaid Department (July 2013)
- Consolidate mental health and addiction services (July 2013)
- Simplify and replace Ohio’s 34-year-old eligibility system
- Coordinate programs for children
- Share services across local jurisdictions
- Recommend a permanent HHS governance structure

- Participate in Catalyst for Payment Reform
- Support regional payment reform initiatives
- Pay for value instead of volume (State Innovation Model Grant)
  - Provide access to medical homes for most Ohioans
  - Use episode-based payments for acute events
  - Coordinate health information infrastructure
  - Coordinate health sector workforce programs
  - Report and measure system performance
## CONTEXT

<table>
<thead>
<tr>
<th>FEE FOR SERVICE</th>
<th>MANAGED CARE</th>
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<tr>
<td>Rates developed by Agency</td>
<td>Rates developed by an actuary</td>
</tr>
<tr>
<td>Providers reimbursed based on fee schedule</td>
<td>Providers contract with a plan and providers reimbursed based on contract</td>
</tr>
<tr>
<td>Rates are not bound by “actuarial soundness”</td>
<td>Rates are bound by “actuarial soundness”</td>
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![Graph showing trends](image-url)
Ohio Managed Care Rating Regions

- Rate is set by a contracted actuary
- Constructed from a variety of sources
  - Base Data: Information submitted by managed care plans such as:
    - encounter data;
    - financial statements; and
    - reported National Association of Insurance Commissioners (NAIC)
  - financial statements
- Program Changes
- Trends
- Efficiency Adjustments
- Plan Administration and Care Coordination
Performance Measurement
Performance Incentive

Method: Higher Performance = Higher Pay
  • Evaluation Period: CY 2014
  • Measures: 6 measures aligned with Medicaid’s Quality Strategy (7 measures in 2016)
  • Data Source: MCP self-reported audited HEDIS

Amount: 1.25% of premium (1.5% in 2016)

Standards:
  • Based on HEDIS 2013 national Medicaid percentiles
  • Payout starts above 25th percentile
  • 1.25% awarded if at or above 75th percentile

New for 2015 – Quality Improvement
  • MCP required to implement one Quality Improvement Project (QIP) for each P4P measure that does not meet specified standards
Performance Incentive

Trend/Plan (Performance Rate)  

Performance Levels  

Payout

- MCP awarded $30.1 million (26%) of $116 million possible

NCQA 75th Percentile  
100%

- 87%

- 74%

- 61%

- 50%

- 39%

NCQA 50th Percentile  
28%

- 19%

- 11%

- 4%

- 0%

NCQA 25th Percentile

- Follow-up After Hospitalization for Mental Illness (49.5%)

- Timeliness of Prenatal Care (85.9%)

- Appropriate Treatment for Children with URI (85.3%)

- Appropriate Use of Asthma Medications (82.4%)

- Controlling High Blood Pressure (49.4%)

- HbA1c Control ≤ 8.0% (37.4%)
Beyond MCOs

Population-based
(PCMH, ACOs, capitation)

Episode-based

Fee-for-service
(including pay for performance)
## 5-Year Goal for Payment Innovation

**Goal**
80-90 percent of Ohio’s population in some value-based payment model (combination of episodes- and population-based payment) within five years

**State’s Role**
- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 3</th>
<th>Year 5</th>
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<tr>
<td>Patient-centered medical homes</td>
<td>Episode-based payments</td>
<td>Patient-centered medical homes</td>
</tr>
<tr>
<td><strong>In 2014 focus on Comprehensive Primary Care Initiative (CPCI)</strong></td>
<td><strong>State leads design of five episodes: asthma acute exacerbation, perinatal, COPD exacerbation, PCI, and joint replacement</strong></td>
<td><strong>Model rolled out to all major markets</strong></td>
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<tr>
<td><strong>Payers agree to participate in design for elements where standardization and/or alignment is critical</strong></td>
<td><strong>Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year</strong></td>
<td><strong>50% of patients are enrolled</strong></td>
</tr>
<tr>
<td><strong>Multi-payer group begins enrollment strategy for one additional market</strong></td>
<td></td>
<td><strong>20 episodes defined and launched across payers</strong></td>
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<table>
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<th>Year 5</th>
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<td><strong>Scale achieved state-wide</strong></td>
<td><strong>50+ episodes defined and launched across payers</strong></td>
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<td><strong>80% of patients are enrolled</strong></td>
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Episodes

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average episode cost per provider)

- **Ave. cost per episode $**
  - **Risk sharing**
    - Pay portion of excess costs
  - **No change in payment to providers**
  - **Gain sharing**
    - Eligible for incentive payment

Acceptable

Commendable

Gain sharing limit

Principal Accountable Provider
Example

Total Episodes: 328

Episodes Inclusion and Exclusion:
- 29% (95 Episodes) Inclusion
- 71% (233 Episodes) Exclusion

Risk Adjusted Average Cost per Episode:
- Acceptable ($5,100)
- Commendable ($2,400)
- Exceeding ($1,400)

Quality Metrics:
- HIV Screening: 99%
- GBS Screening: 87%
- Chlamydia Screening: 90%

Potential Gain/Risk Share:
If you had performed in the top quartile, your gain sharing would have been between $18,500 and $53,000.
The State Health Assessment & The State Health Improvement Plan

The purpose of the SHA is to:
- Inform identification of priorities in the state health improvement plan (SHIP)
- Provide a template for state agencies and local partners, with a uniform set of categories and metrics to use in related assessments

The SHA was conducted from March to July 2016 and the SHIP will be completed by the end of 2016.

The purpose of the SHIP is to:
- Provide state agency leaders, local health departments, hospitals and other state and local partners with a strategic menu of priorities, objectives and evidence-based strategies
- Signal opportunities for partnership with sectors beyond health
### Figure ES.1. Ohio’s rank on national scorecards

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<thead>
<tr>
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<th>Overall rank</th>
<th>Rank for health outcomes*</th>
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<tbody>
<tr>
<td>America’s Health Rankings, 2015 edition</td>
<td>39</td>
<td>41</td>
</tr>
<tr>
<td>Commonwealth State Scorecard, 2015 edition</td>
<td>33</td>
<td>41</td>
</tr>
<tr>
<td>Gallup-Healthways Wellbeing Index, 2014</td>
<td>47</td>
<td>45</td>
</tr>
<tr>
<td>HPIO 2014 Health Value Dashboard</td>
<td>47</td>
<td>40</td>
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- Ohio ranks in the top quartile of states**.
- Ohio ranks in the second quartile of states**.
- Ohio ranks in the third quartile of states**.
- Ohio ranks in the bottom quartile of states**.
The Social Determinants of Health

To address health inequalities, you must address social and economic inequities.

Social & Economic Factors
- Education
- Employment
- Income
- Family & Social Support
- Community Safety

Quality of care
Access to care
Physical environment
Healthy behaviors

Data from “County Health Rankings & Roadmaps,” University of Wisconsin Population Health Institute.
Thank You