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

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Executive Summary

Managed care plans (MCPs) partner with the Ohio Department of Medicaid (ODM) to improve the health and lives of nearly 2.5 million Ohioans statewide.

MCPs are incentivized to control costs and improve quality through innovation driven by their expertise and resources.

MCPs are ODM’s primary catalysts in their efforts to modernize care delivery and improve health outcomes through care coordination, value-added services, and partnerships with providers and communities.

Managed care’s innovations and flexibility to control costs and improve quality are unmatched by the single-payer Medicaid fee for service (FFS) system.
Ohio Managed Medicaid Overview

Managed care is the largest payer of Medicaid services in Ohio. Managed care plans (MCPs) manage health care services for nearly 2.5 million Ohioans, representing 86 percent of Ohio Medicaid members, including women, children, and the aged, blind and disabled. Ohio implemented mandatory managed care in 1995 and has expanded the platform statewide to include most Medicaid populations.

Many states have implemented Medicaid managed care to contain costs and improve quality of care through best practices and unique innovations. MCPs implement effective utilization management practices to reduce duplicative and unnecessary expenditures. In contrast to managed care's focus on value, the core of fee for service (FFS) Medicaid is volume-based reimbursement, which essentially pays for each service provided in a one-size fits all program. The traditional Medicaid FFS system is unmanaged and results in increased expenditures with no accountability for outcomes.

In managed care, the state contracts with MCPs to provide services for a capitated per member per month (PMPM) rate. MCPs are placed at financial risk - they must provide the agreed-upon services within the established monthly capitation rate and are at-risk for costs that exceed the rate. MCPs bear responsibility for the health of their members and ensure medically necessary and appropriate services are provided in a timely fashion. Unlike traditional FFS, MCPs conduct outreach and actively monitor utilization data to identify members at increased risk of health-related complications to ensure early and active intervention. Cost reduction is incentivized and actively monitored through state oversight and can be measured to determine impacts and improvements to the system. One of the many benefits of managed care is their proven operating and data systems, evidence-based practices, established provider relationships, and comprehensive resources. Because multiple MCPs operate statewide, market competition drives improved outcomes and member experience.

The relationship between best practices, innovations, quality, and cost (shown in Figure 1) illustrates why states, including Ohio, continue to expand Medicaid managed care.

Figure 1. Managed Care Framework
Executive Summary

Selection of MCPs. Ohio selects MCPs on a competitive basis through a Request for Application (RFA). In July 2013, the Ohio Department of Medicaid (ODM) selected the following statewide MCPs:

- Buckeye Health Plan
- CareSource
- Molina Health Care
- Paramount Advantage
- UnitedHealthcare Community Plan of Ohio

Each MCP is required to establish and actively monitor comprehensive provider networks. If a member needs a service, MCPs are required to coordinate that care, including out-of-network care when necessary. In addition to all covered Medicaid benefits, each MCP offers a selection of value-added benefits to enhance the member’s experience. These value-added benefits are provided at no cost to the state and are an avenue by which plans compete. Value-added services vary among plans and include in part:

- Health and wellness programs
- Enhanced prenatal programs
- Enhanced dental and vision benefits
- Additional transportation options
- Job readiness and connections to mentoring

Unlike FFS, MCPs must meet state and nationally-defined quality metrics and provide expanded service offerings, such as person-centered care coordination aimed at improving members’ overall health and well-being.

Ohioans Benefit from Medicaid Managed Care

The proportion of Ohioans served by Medicaid managed care has increased even while overall Medicaid membership has grown. Enrollment growth is illustrated in Figure 2.

Figure 2. Growth in Medicaid Managed Care vs. FFS

Ohio Medicaid Increasingly Relies on Managed Care
Medicaid-Medicare Demonstration Program. In 2012, Ohio became the third state to receive CMS approval to use managed care to coordinate benefits for individuals covered by both Medicare and Medicaid, also known as “dual eligibles”. Serving over 97,500 Ohioans, the MyCare Ohio dual demonstration project has the second largest enrollment of the 11 dual demonstration projects in the country. Despite being voluntary, MyCare Ohio has achieved the highest member selection rate in the nation. Although the formal evaluation of the demonstration is not yet complete, MyCare Ohio has shown promise through its success in attracting participation and retention among voluntary participants. The following Medicaid MCPs serve MyCare Ohio members:

- Aetna Better Health of Ohio
- Buckeye Health Plan
- CareSource
- Molina Healthcare
- UnitedHealthcare Community Plan of Ohio

Additional High-Cost, High-Need Populations. Ohio has transitioned complex populations into Medicaid managed care. Beginning in 2013, 34,000 aged, blind and disabled (ABD) persons transitioned into managed care as well as more than 37,000 Children with Special Health Care Needs (CSHCN). Ohio moved more of its ABD population into managed care in SFY 2014, with 171,279 ABD members representing 77 percent of the total ABD population eligible to enroll.

Other populations will move into Medicaid managed care in 2017, including:

- Individuals enrolled in the Bureau for Children with Medical Handicaps (BCMH)
- Children in custody
- Children receiving adoption assistance
- Breast and cervical cancer program recipients
- Individuals enrolled in one of four Developmental Disability (DD) waivers can voluntarily enroll in Medicaid managed care

Cost Savings in Medicaid Managed Care

By improving the delivery of health care through evidence-based practices, MCPs help control Medicaid costs. MCPs are incentivized to lower health care costs through innovative strategies that promote preventive care services, provide care coordination for members with complex conditions, promote population health improvement initiatives, and improve provider network management.

OAHP retained the Wakely Consulting Group, Inc. to provide actuarial analysis of the cost of providing Ohio Medicaid services in a traditional FFS model versus MCPs. The analysis found that MCPs operate efficiently and produce significant savings for Ohio in a traditional FFS versus managed care platform. The study compared MCP capitation rates to estimated costs for those same members if they had been covered by traditional FFS Medicaid. It is estimated that capitation rates paid to MCPs were 9 to 11 percent lower in calendar year 2013 through 2015 than the cost of serving Ohioans through traditional FFS - an estimated $2.5 to $3.2 billion dollars in savings.

Carving pharmacy benefits into managed care has significantly lowered costs. An analysis of the pharmacy benefit performed by The Menges Group shows that Ohio had the nation’s 16th lowest cost per prescription during 2015 which were 9.1 percent and $3.70 per prescription below the national average. Ohio’s costs were 13.3 percent and $5.66 per prescription below the carve-out states’ collective performance with an annual net cost savings of $123 million relative to the average cost per prescription across the remaining carve-out states.
Further information on Medicaid managed care’s impact on cost can be found in Chapter 2 – *Impact of Medicaid Managed Care on Cost.*

**Medicaid Managed Care Quality Performance**

MCPs are ODM’s key partners to achieve its Quality Strategy goals and deliver enhanced quality relative to FFS. MCPs leverage their expertise in care coordination, planned care transitions, value-added services, programs to address social determinants of health, and community partnerships to drive quality improvements. Managed care’s focus on quality also translates to providers through best practices such as continuous monitoring and support to transition to patient-centered medical homes. Thus, managed care aligns the incentives to focus on quality at all levels.

Ohio’s contracts with MCPs incorporate quality metrics that measure how well financial incentives drive quality and reduce costs. As part of the Quality Strategy, Pay for Performance (P4P) incentives are given to MCPs who demonstrate high levels and continuous improvement in quality metrics. A sample of MCP performance on these metrics is found in Chapter 3.

Ohio MCPs score higher than both the national and large state subgroup averages on National Committee for Quality Assurance (NCQA) metrics for 2016-2017. All five of Ohio’s statewide Medicaid MCPs are NCQA accredited, which is a rigorous and detailed process that many MCPs elsewhere are not required to meet.

**Managed Care Drives Innovation**

The managed care system incorporates best practices that are common to MCPs but not for FFS. With deep experience in both Ohio and other states, MCPs are uniquely positioned to partner with ODM to develop and implement innovations that meet the policy goals of the state and the health needs of their members. A few of the innovations discussed in Chapter 4 include:

- Pay-for-value strategies such as the Comprehensive Primary Care (CPC) program and Episodes of Care
- Promoting maternal health to address infant mortality
- Implementing safeguards in prescribing practices to address the opioid crisis
- Helping inmates manage their health before their release from prison to prevent recidivism

MCPs are the central implementers of these innovations which would not be possible within an uncoordinated FFS system. Each plan performs their own innovations unique to their members’ needs, which are highlighted throughout the report (see innovation showcases).

**The Future of Medicaid Managed Care**

As Ohio moves towards meeting its strategic goals for improving quality and value in the Medicaid program, MCPs remain committed to developing, testing and implementing programs that meet such goals to improve the health and lives of Ohioans. In addition to the new populations that will enroll in managed care in 2017, MCPs will implement new requirements and services aimed at improving care coordination, population health management and value-based purchasing. In 2018, MCPs will assume responsibility for covering community behavioral health services in order to integrate physical and behavioral health to provide more holistic care that recognizes the need to treat the whole person. Providing all services to all populations within the managed care platform will further leverage the benefits of managed care (e.g., expanding the MyCare Ohio dual eligible demonstration statewide). Chapter 5 - *Moving Forward* provides further discussion of such opportunities.
The Ohio Medicaid program provides healthcare coverage for low-income adults, children, parents, pregnant women, individuals with disabilities, elderly, and other adult populations.

In Ohio, 86 percent of all Medicaid enrollees – nearly 2.5 million Ohioans – are covered by one of five statewide Medicaid managed care plans (MCPs).

Managed care has been part of the Medicaid program since the late 1970s. Since then, the state has expanded its geography, covered populations and services. In 2014, the MyCare Ohio program was established as the managed care program for the Medicare/Medicaid “dual eligible” population.

Medicaid managed care is a key strategy to improve healthcare quality and achieve better health outcomes for Ohioans.
Medicaid is a joint federal and state program that provides health care and long term services and supports (LTSS) for over 72 million people in the United States including pregnant women, children, low-income adults, and individuals with disabilities regardless of age. Nearly 3 million Ohioans receive coverage for medical care and long-term services and supports (LTSS) through Medicaid.

In Ohio, 86 percent of all Medicaid members – nearly 2.5 million Ohioans – receive care from one of five statewide Medicaid managed care plans (MCPs). The shift from Medicaid fee for service (FFS) to managed care has been a key strategy in strengthening Ohio Medicaid by containing costs, improving quality and driving innovation.

**FFS Medicaid vs. Medicaid Managed Care**

Under traditional FFS Medicaid, the state directly contracts with providers and pays them a set fee for each service provided (such as an office visit, test, or procedure). Providers are therefore paid based on the volume of services rather than the value of those services, and there is no formal structure for utilization review or care coordination. A FFS system operates similarly to a single payer model — a one-size-fits-all approach with little room to accommodate the unique needs of people or the communities in which they live. Under FFS, there is limited accountability or quality measurement.

Access to care is an ongoing issue in FFS. There is no assignment of a primary care physician, and while members are given a Medicaid card, they must search for their own providers who will see them. Without a regular doctor or primary care physician (PCP), they often go to the emergency department for care. In contrast, MCPs are required to maintain an adequate network of specialists and assign members to a PCP.

In Medicaid managed care, Ohio pays Medicaid MCPs a fixed monthly capitation rate to cover certain services to members and to be responsible for the health of their members. The MCPs are financially at-risk to provide all health care services included in their contract with the Ohio Department of Medicaid (ODM). The MCP is also responsible for active member engagement and monitoring to ensure its members’ health care needs are being met, providers are available, and care is being effectively managed to improve outcomes. Medicaid managed care benefits required in the MCP contracts include:

- Inpatient hospital services
- Outpatient hospital services, including those provided by rural health clinics and federally qualified health centers
- Physician services
- Laboratory and x-ray services
- Healthchek or EPSDT services (screening, diagnosis, and treatment services for children under age 21)
- Immunizations
- Family planning services and supplies
- Home health and private duty nursing services
- Podiatry
- Chiropractic services
- Physical, occupational, developmental, and speech therapy services
- Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services
- Prescription drugs
- Ambulance and ambulette services
- Dental services
- Durable medical equipment and medical supplies
- Vision care services, including eyeglasses
- Nursing facility services (limited to short-term rehabilitative stays for certain population groups)
- Hospice care
- Behavioral health services, excluding OMHAS-certified community behavioral health centers
- Respite services for eligible children receiving Supplemental Security Income (SSI)
In addition, each MCP offers value-added benefits to enhance their members’ experience, health and well-being. Examples of value-added benefits include:

- Care management to help members coordinate care and ensure they receive the care they need
- Access to a toll-free 24/7 nurse hotline for medical advice
- Access to a toll-free member services hotline
- Secure member portal
- Grievance resolution system
- Preventive care reminders
- Health education materials and activities, including disease management
- Community resources guide
- Extended office hours (varies among MCPs)
- Wellness and disease management incentive programs (varies among MCPs)
- Enhanced dental and vision benefits
- Additional transportation benefits
- Smoking cessation programs
- Online health tools
- Home healthcare for specific conditions
- Prenatal and pregnancy rewards program
- Mobile healthcare app

The Innovation Showcase below describes how one MCP’s additional benefit resulted in improved quality and reduced costs.

**Innovation Showcase: Paying for Value to Improve Medication Adherence**

Only about one-half of Americans take their medications as prescribed. This contributes to the overall burden and toll of chronic disease and a vast portion of unnecessary health care costs.

While community pharmacists have the patient expertise and access to improve medication adherence, FFS values filling prescriptions rather than patient interventions. In July 2012, one of Ohio’s MCPs began offering a medication therapy management (MTM) benefit to its members. MTM relies on a network approach, hands-on training, and professional autonomy.

In the first 18 months, 1,800 pharmacists delivered more than 100,000 MTM services to its members. Over 2000 consultations helped avert serious events such as emergency department visits, hospitalizations, and life-threatening complications.

In the first year, the program demonstrated a $1.35 return on investment (ROI) in drug cost savings for every dollar invested. Total savings, including avoided hospitalizations, emergency department visits, and other unnecessary health care consumption, yielded an ROI of $4.40 for each invested dollar.

**The Transition from Medicaid FFS to Managed Care**

In an effort to improve quality and access while stabilizing costs, Ohio Medicaid first used managed care in 1978 as a pilot program in two places in order to experiment with different forms of managed care. The Cuyahoga County pilot utilized HealthAmerica, a large network health maintenance organization (HMO), while the Belmont County pilot leveraged a rural health clinic, the Medicaid Foundation of Bellaire, established by the United Mineworkers for union members in Eastern Ohio. The success of these initiatives led to an expansion of voluntary Medicaid managed care through the 1980s. In voluntary enrollment, eligible members can choose between an MCP or FFS. In 1989, Ohio developed a Medicaid 1115 waiver (a demonstration program approved by the federal government that gives states the flexibility to do innovative projects) that utilized mandatory Medicaid managed care in Montgomery County, while continuing to expand voluntary Medicaid managed care in other counties.
During the early 1990s, managed care penetration in Ohio’s private healthcare sector was not very high, which made the transition to Medicaid managed care difficult. As the market matured, the state expanded voluntary managed care in metropolitan areas with some managed care infrastructure. Figure 1.1 illustrates the dramatic growth in Medicaid managed care penetration over the past several decades.

**Ohio Care Waiver (1995 – 2001)**

In 1995, the state developed a mandatory managed care pilot in Hamilton County through an 1115 Medicaid waiver called “Ohio Care”. Under the waiver, the state proposed to use anticipated savings from Medicaid managed care to cover more pregnant women and children under Medicaid. It quickly expanded mandatory enrollment in five additional counties the next year, followed by three more counties in 1998.

The areas of the state using mandatory enrollment corresponded to the six geographic regions that the state had designated for perinatal care regionalization (Akron, Cincinnati, Cleveland, Columbus, Dayton, and Toledo), so women residing in these areas had access to high intensity pediatric and obstetric care.

However, the large number of MCPs that entered the market resulted in low enrollment for many of them. To limit the number of MCPs and support the remaining MCPs, in 1998, the state established a requirement that each participating MCP retain at least 10 percent of all Medicaid members in the county in order to remain in the market. This requirement led to consolidation among MCPs in the state.

**Figure 1.1 Growth in Medicaid Managed Care vs. FFS¹**

![Ohio Medicaid Increasingly Relies on Managed Care](image)

**“Preferred Option” (2001 – 2006)**

In 2001, Ohio transitioned to a 1915(b) waiver to implement the Medicaid managed care “Preferred Option.” The Preferred Option automatically enrolled eligible Medicaid members if they did not actively select Medicaid FFS, moving along the continuum of voluntary to mandatory Medicaid managed care. At the same time, voluntary managed care continued to expand.
Statewide Delivery Model (2006 – 2012)

Facing unsustainable growth in spending and programmatic challenges, the Ohio Commission to Reform Medicaid recommended transforming the program to focus on improving quality and outcomes while controlling Medicaid’s main cost drivers. Ohio’s managed care waiver program reported high consumer satisfaction and clinical performance. In addition to adding value for members, managed care also saved the state $68 million state FY2004 and 2005. Under House Bill 66, the Ohio General Assembly mandated statewide Medicaid managed care for the majority of Medicaid members, including the majority of the Covered Families and Children (CFC) population and some of the Aged, Blind and Disabled (ABD) population.

In July 2011, the Ohio General Assembly passed House Bill 153 authorizing the Ohio Department of Job and Family Services (ODJFS) to include additional groups in Medicaid managed care. In October 2011, the pharmacy benefit was carved into managed care. In 2012, ODJFS issued a competitive request for applications (RFA) to provide services to Ohio’s Medicaid members.

Recent Developments (2013 – present)

In 2013, more than 37,000 Children with Special Health Care Needs (CSHCN) transitioned to Medicaid managed care. These children have complex, long-term medical conditions, however, in FFS, they lack the appropriate care coordination and access to care to manage their health issues.

The Ohio General Assembly further expanded Medicaid managed care through the state budget process. The 2016-2017 biennial budget required children in foster care and children being adopted to enroll in managed care. It also repealed the prohibition on including alcohol, drug addiction, and mental health services in Medicaid managed care, carving in all behavioral health services no later than January 1, 2018. The Joint Medicaid Oversight Committee (JMOC) is required to monitor the actions of ODM on a quarterly basis. The review includes the proposed timeline, issues related to access, provider network adequacy and payment levels. JMOC will also provide ongoing monitoring of the restructuring of behavioral health.

Figure 1.2 provides an overview of the major phases and milestones as Medicaid managed care expanded throughout Ohio.
Figure 1.2 History of Ohio Medicaid Managed Care

1978 – 1988

**Initial Voluntary Medicaid Managed Care Pilots**
- 1978: Voluntary enrollment in Cuyahoga and Belmont counties
- Mid-1980s: Voluntary enrollment in 28 counties
- ~85,000 Medicaid managed care enrollees

1989 – 1994

**Mandatory Medicaid Managed Care Begins**
- 1989: 1115 waiver for mandatory enrollment in Montgomery County
- Voluntary enrollment in Butler, Greene, Lorain, Marion, Stark, Summit, Trumbull, Wood counties

1995 – 2001

**Ohio Care Waiver**
- 1115 waiver to expand mandatory enrollment in 10 counties in Akron, Cincinnati, Cleveland, Columbus, Dayton and Toledo regions
- Voluntary enrollment expands to Mahoning, Miami counties
- Consolidation of MCPs in state
- Nearly 250,000 Medicaid managed care enrollees

2001 – 2005

**Preferred Option**
- 1915(b) waiver to automatically enroll in managed care unless member actively selects FFS in Butler, Clark, Franklin, Hamilton, Lorain and Montgomery counties
- Mandatory managed care in Cuyahoga, Lucas, Stark, Summit counties
- Voluntary managed care expanded to Clermont, Greene, Pickaway, Warren, Wood counties
- More than 489,000 Medicaid managed care enrollees

2006 – 2012

**Statewide Mandatory Medicaid Expansion**
- General Assembly requires mandatory Medicaid managed care for almost all CFC program and portion of ABD population
- Pharmacy benefit carved into managed care
- 87 of 88 counties in mandatory Medicaid managed care

2013 – present

**Recent Developments**
- More than 37,000 children with special needs transition to Medicaid managed care
- 77% of ABD individuals enrolled in Medicaid managed care
- State budget requires children in foster care and adoption services to enroll in Medicaid managed care
- 2016-2017 budget repeals prohibition on including alcohol, drug addiction and mental health services in Medicaid managed care, carving in behavioral health services no later than January 1, 2018
Medicaid Managed Care Today

Today, nearly 2.5 million Ohioans are covered by one of five statewide Medicaid MCPs or one of the five regional MyCare Ohio plans.

**Statewide Medicaid MCPs**
- Buckeye Health Plan
- CareSource
- Molina Health Care
- Paramount Advantage
- UnitedHealthcare Community Plan of Ohio

**Regional MyCare Ohio MCPs**
- Aetna Better Health of Ohio
- Buckeye Health Plan
- CareSource
- Molina Health Care
- UnitedHealthcare Community Plan of Ohio

Since 2008, Ohio Medicaid has added new categories of eligibility as well as expanded managed care to new populations. Figure 1.3 illustrates enrollment trends from state fiscal years (SFY) 2008 to 2017. Ohio Medicaid experienced tremendous growth, including:

- The CFC population grew from 1.1 million in SFY 2008 to 1.6 million in SFY 2017.
- The ABD population has steadily grown to over 170,000 members.
- The Adult Extension Population has grown to over 700,000 Ohioans.
- The MyCare Ohio dual demonstration project doubled in size since 2014 with slightly over 97,500 Ohioans.

The growth in the Adult Extension population and MyCare Ohio is discussed in further detail below.

**Figure 1.3 Medicaid Managed Care Enrollment, SFY2008-2016**

[Graph showing Medicaid Managed Care Growth by Population]
Adult Extension Population

On January 1, 2014, Ohio extended Medicaid coverage through managed care to childless adults (19 and 64 years of age) with incomes less than 138 percent FPL who are not otherwise eligible for Medicaid. These are often referred to as the “Adult Extension Population”. Since its inception in 2014, the Adult Extension Population has grown to over 700,000 enrollees.

MyCare Ohio

MyCare Ohio is a joint federal and Ohio initiative to integrate funding and services for persons eligible for both Medicaid and Medicare or “dual eligible” individuals. Medicare and Medicaid are administered as two different programs, and the current bifurcated health care system for the dual eligible population has hampered efforts to provide integrated services. Fragmentation between Medicare and Medicaid causes difficulties in monitoring quality of care and duplication of expenses. Without such a demonstration project, the health care and long term services and supports (LTSS) needs of this group would go uncoordinated, resulting in suboptimal care and wasteful spending. The dual eligible population drives a disproportionate share of Medicaid spending. At the time of MyCare Ohio’s conceptualization, dual eligible individuals comprised only 14 percent of Medicaid enrollment, but drove an estimated 34 percent of Medicaid spending.3

MyCare Ohio is designed to streamline both the cost and experience of care by placing both Medicaid and Medicare services under a single MCP. Ohio is not the first state to implement a dual demonstration project, but it is the first to obtain approval from CMS to extend its demonstration beyond the initial three-year project. Approved for an additional two-year extension by CMS, MyCare Ohio will continue until December 2019. MyCare Ohio is the second largest project of its size in the country with 97,500 members.

Figure 1.4 shows the counties in each of the seven MyCare Ohio demonstration regions.

Figure 1.4 MyCare Ohio Demonstration Regions

Member Spotlight: Mildred, a MyCare Ohio Member

Mildred’s primary medical problem is severe COPD, and she requires oxygen 24 hours a day, 7 days a week. She had multiple hospitalizations due to frequent upper respiratory infections and lived in a challenging home for a 95 year old woman. Mildred’s MCP Care Manager referred her for HCBS waiver services and set up a service plan to provide home assistance and emergency support. The Care Manager also recommended home modifications such as a chair lift to help with steep steps. These services met Mildred’s needs in her home. As a result, she feels much better and exerts far less effort in getting around her home. Due to her care coordination and service plan, Mildred has experienced fewer hospitalizations.
New Groups Transitioning into Managed Care

With a track record of improving care and quality in Medicaid services while promoting budget stability, Ohio plans to transition the following groups into managed care:

**Figure 1.5 Groups Transitioning into Medicaid Managed Care**

<table>
<thead>
<tr>
<th>Transition Group</th>
<th>Planned Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Extension members in need of Home &amp; Community Based Services Waiver</td>
<td>August 2016</td>
</tr>
<tr>
<td>Individuals enrolled in the Bureau of Children with Medical Handicaps (BCMH) program</td>
<td>January 2017</td>
</tr>
<tr>
<td>Children in Custody and Children Receiving Adoption Assistance</td>
<td>January 2017</td>
</tr>
<tr>
<td>Breast &amp; Cervical Cancer Project Recipients</td>
<td>January 2017</td>
</tr>
<tr>
<td>Recipients enrolled on a DD waiver</td>
<td>Voluntary January 2017</td>
</tr>
</tbody>
</table>

**Excluded Populations**

By 2017, only a limited number of populations will be excluded from managed care. These include:

- Individuals who are not part of the Adult Extension Population who live in an institutional setting, such as a nursing facility
- Individuals eligible for both Medicaid and Medicare (except for MyCare Ohio)
- Home and community based long term care services are provided on a FFS basis

**Integrating Services in Managed Care – Behavioral Health Redesign**

Ohio recognizes that individuals with behavioral health conditions have special health care needs. Therefore, several initiatives are underway to improve the health care system and health care outcomes for members with behavioral health conditions. These innovations include providing expanded services for members with high intensity conditions such as serious and persistent mental illness (SPMI) and other complex behavioral conditions as well as implementing mechanisms to better coordinate physical and behavioral healthcare for members with co-morbid conditions. As Ohio moves toward including behavioral health in managed care in 2018, MCPs will be positioned to further integrate and coordinate the services of these individuals.

Care coordination will have meaningful impact for individuals with compromised ability to understand and navigate a fragmented health care delivery system by providing guidance and support with such navigation and tools and education to help individuals begin to engage and manage their own health. Ideally this results in greater adherence to the person-centered plan of care, which improves outcomes as well as utilization costs.
Summary

Medicaid managed care has grown from small pilot programs in the late 1970s into a statewide program serving 86 percent of all Medicaid members or nearly 2.5 million Ohioans. Unlike traditional FFS, which reimburses providers on a set fee schedule based on the volume of services provided, managed care plans are financially at-risk and receive a fixed monthly capitation rate to cover certain services for members. MCPs are not only responsible for the care delivered to its members—they also share in the responsibility of their health and well-being. The financial incentives in managed care serve to reduce ineffective and harmful treatments that often go unchecked in a FFS system. Much like private insurance, members are afforded a choice of managed care plans when enrolling in a Medicaid managed care model. In managed care, members receive care coordination, disease management, and valued-added benefits that serve to improve quality, enhance access, and increase the financial stability of Medicaid. Members can determine which plan offers the best provider network and value-added services to best meet their health needs. Care coordination is provided to members with greater health care needs and serves to help members better navigate the health care system and coordinate care with the member’s respective health care team.

MCPs have proven operating systems, established provider relationships and comprehensive resources at their disposal, as well as local and national presence and industry experience that is leveraged in the delivery of health care services to Ohio’s Medicaid enrollees. Ohio’s managed care program continues to drive innovation, serving more populations and providing additional services while allowing members to have active choice, be personally responsible and engaged in their health care choices. Finally, unlike a single payer FFS system, there are multiple MCPs that operate throughout the state of Ohio, incentivizing market competition to improve outcomes, member experience, and cost. MCPs are actively monitored through state oversight and their performance are measured to determine impacts and improvements to the system.
MCPs achieve programmatic savings by promoting efficient use of the health care system and eliminating wasteful or inefficient spending by placing an emphasis on preventive care, managing chronic patients, and detecting and treating serious illnesses early.

It is estimated that capitation rates paid to MCPs were 9 to 11 percent lower in calendar year 2013 through 2015 than the cost of serving Ohioans through traditional FFS – an estimated $2.5 to $3.2 billion dollars in savings.

MCPs effectively manage Ohio’s prescription drug benefit, resulting in Medicaid pharmacy cost savings for the state. Ohio’s prescription costs were 9.1 percent and $3.70 per prescription below the national average. Ohio had the nation’s 16th lowest costs per prescription during 2015.
As states face the reality of Medicaid being a significant budget item, many have shifted from Medicaid fee for service (FFS) to managed care to rein in costs and delivery better quality services. As of 2014, 80 percent of Medicaid members nationally are enrolled in managed care. In Ohio, 86 percent of Medicaid members are enrolled in a MCP. Because managed care provides a monthly capitation rate in which the MCPs assume risk, it provides predictability to the state budget.

Recognizing the importance of Medicaid to the Ohio budget, particularly in light of the Affordable Care Act (ACA), in late 2013 the 130th Ohio General Assembly’s Senate Bill 206 created the Joint Medicaid Oversight Committee (JMOC) consisting of five State Senators and five State Representatives. JMOC’s primary function is to provide continuous oversight of all facets of the state’s Medicaid program. It oversees Medicaid compliance with legislative intent, evaluates legislation for long-term impact on Medicaid, and assists in limiting the rate of spending growth, while improving quality of care and health outcomes for Medicaid members.

Under Ohio Revised Code (ORC) Section 5162.70, the Medicaid Director must limit growth in the Medicaid program for the upcoming biennium across all Medicaid members on a monthly per capita basis (commonly referred to as per member per month or PMPM) to the lower of the JMOC rate or the three-year average Consumer Price Index (CPI) for medical services. PMPM spending must be limited to 2.9 percent increase in FY 2016 and 3.3 percent in FY 2017.

Since Medicaid is an entitlement program (i.e. everyone who meets the eligibility criteria must be offered coverage), Ohio has little ability to control costs through managing growth in Medicaid membership. Thus, to control costs, Ohio must focus on managing the per-member spending and improving value for its expenditures.

Ohio Medicaid Managed Care Savings Analysis—January 2013 through December 2015

OAHP retained the actuarial services of the Wakely Consulting Group, Inc. to assess the cost of providing Ohio Medicaid services in a traditional FFS model versus MCPs. The report found that MCPs operate efficiently and produce significant savings when compared to FFS. The analysis compared MCP capitation rates to estimated costs for those same members if they had been covered by traditional FFS Medicaid. It is estimated that capitation rates paid to MCPs were 9 to 11 percent lower in calendar year 2013 through 2015 than the cost of serving Ohioans through traditional FFS, resulting in an estimated $2.5 to $3.2 billion dollars in savings.

The Wakely report is included below.
Wakely Consulting Group, Inc. (Wakely) has been retained by the Ohio Association of Health Plans (OAHP) to assist in an evaluation of the programmatic savings that the Managed Care Plans (MCPs) achieved for the State of Ohio’s Managed Medicaid program under oversight by the Ohio Department of Medicaid (ODM) during the Calendar Years (CY) 2013 through 2015. The original January 2013 capitation rates were adjusted in July 2013. The CY 2014 and CY 2015 rates were not adjusted during the course of their respective years. We have accounted for the July 2013 rating changes in our estimates for the CY 2013 period. This report includes a comparison of capitation rates for members enrolled with participating MCPs to estimated costs if those same members were enrolled in the State of Ohio’s Fee for Service (FFS) program.

Wakely relied on data provided by each of the MCPs as well as capitation rates and rating documentation from ODM in performing this analysis. We relied on the accuracy of this documentation and the assumptions imbedded in the rate development. If those assumptions differ from actual experience, then our estimates will be affected. Actual results will likely vary from our estimates. This report was prepared to assist OAHP in estimating savings achieved by MCPs participating in the Ohio Managed Medicaid program during Calendar Years 2013 through 2015, and satisfies Actuarial Standard of Practice 41 reporting requirements. Other uses may be inappropriate.

We understand this report may be shared with outside parties. When it is shared, it should be shared in its entirety. This document and the supporting exhibits/files constitute the entirety of the report and supersede any previous communications on the project. Wakely does not intend to create a reliance by outside parties receiving this report. Outside parties receiving this report should retain their own qualified experts in interpreting the results. It is the responsibility of the organizations receiving this report to review the assumptions carefully and notify Wakely of any potential concerns.

Executive Summary

This report compares MCP capitation rates to estimated costs for those same members if they had been covered by traditional FFS Medicaid. MCPs achieve programmatic savings by promoting efficient use of the health care system and eliminating wasteful or inefficient spending by placing an emphasis on preventative care, managing chronic patients, and detecting and treating serious illnesses early.

In states where recent FFS data is used to set managed care rates, the comparison of estimated FFS costs to MCP capitation rates is relatively straightforward. When plan encounter data is the primary data source, it is more difficult to develop comparable FFS cost estimates. While this exercise necessarily incorporates review of older FFS experience, it uses all of the available information and, in our opinion, is reasonable and actuarially sound. The estimates in this report include all MCP dollars associated with the Medicaid program, except those associated with the MyCare dual-eligible demonstration program, inclusive of both state and federal funding components.

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

The low end of the estimated range assumes that the trend assumptions used by the state’s actuaries in the capitation rate development are representative of FFS trends, and the high end assumes that annual FFS trends would have been 0.5% higher than the state actuaries’ trend assumptions.

The following figure shows additional detail regarding the range above:
Figure 2.1: Estimated Savings Relative to Fee for Service

<table>
<thead>
<tr>
<th>Based on no assumed trend differential</th>
<th>CY 2013 – CY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated FFS Costs</td>
<td>$27,741,384,000</td>
</tr>
<tr>
<td>Calculated MCO Revenue [1]</td>
<td>$25,282,492,000</td>
</tr>
<tr>
<td>Total Dollars Saved</td>
<td>$2,458,892,000</td>
</tr>
<tr>
<td>Total Percentage Saved</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Based on 0.5% annual trend differential</th>
<th>CY 2013 – CY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical FFS Costs</td>
<td>$28,491,486,000</td>
</tr>
<tr>
<td>Calculated MCO Revenue [1]</td>
<td>$25,282,492,000</td>
</tr>
<tr>
<td>Total Dollars Saved</td>
<td>$3,208,994,000</td>
</tr>
<tr>
<td>Total Percentage Saved</td>
<td>11.3%</td>
</tr>
</tbody>
</table>

[1] Excludes Health Insuring Corporation (HIC) tax and Sales and Use tax.

Definitions and Programmatic History

The following definitions and information may be helpful in understanding the various assumptions and methodology used in our analysis:

Capitation Rates – Capitation rates are the monthly payments made to each MCP for Medicaid enrollees. They are published by the state’s actuary and vary by rate cell and geographic region. We have not risk adjusted plan-level capitation rates, as the composite risk level across all plans is 1.0.

Fee for Service Administrative Costs – We have assumed that ODM administrative costs to operate the FFS program are 2 percent higher than ODM administrative costs to operate the managed care program. This assumption is consistent with assumptions used in other states. Therefore, our savings estimates are approximately 2 percent higher than they would be otherwise in recognition of decreased state administrative costs for the managed care program.

Managed care has a long history in Ohio’s Medicaid program. A review of the rate setting methodology from historical rating periods was necessary as the actuarial assumptions used to set those rates include the managed care savings necessary for MCPs to achieve targeted financial performance. To develop comparable FFS cost estimates for CY 2013 through 2015, we used rate setting information underlying the CY 2008 through CY 2010 and CY 2012 through CY 2015. From CY 2006 through CY 2008 the state of Ohio transitioned the majority of the Covered Families and Children (CFC) and Aged, Blind and Disabled (ABD) 21+ populations into the Medicaid managed care program. As a result, the CY 2008 through CY 2010 rate developments for these populations relied on a blend of FFS, Encounter, and Cost Report base data. The following figures illustrate the transition from FFS base data to encounter and cost report base data that occurred from CY 2008 through CY 2010 for each population.
The pharmacy benefit was carved-out of the Medicaid managed care program for CY 2010 and thus was not included in the rate development for that period. Pharmacy was again included as a managed care benefit for the CY 2012 and CY 2013 rating periods. The prospective development of pharmacy costs for CY 2012 and CY 2013 were based on one month of managed care data (January 2010) and eleven months of FFS data (February through December 2010). During that time, non-pharmacy rates were developed using a blend of managed care Encounter and Cost Report data. Pharmacy and non-pharmacy components of the CY 2014 and CY 2015 CFC and ABD 21+ capitation rates were based exclusively on managed care data from CY 2012 and CY 2013, respectively.

Beginning July 2013 Ohio expanded the managed Medicaid program to include the ABD <21 population. A blend of CY 2009 and CY 2010 FFS base data was used to set the July 2013 rates for this population. CY 2012 FFS base data was used to develop ABD <21 capitation rates for CY 2014 and CY 2015.

Effective January 2014 Ohio again expanded its managed Medicaid program to cover the ACA Extension population. Since no historical experience previously existed for this population, both the CY 2014 and CY 2015 rates were developed based on a blend of ABD adult and CFC adult managed care experience.

**Methodology, Assumptions, and Results**

Wakely estimated savings produced by the MCPs by comparing capitation payments from ODM for the managed Medicaid populations to estimated costs for those same populations if they had been enrolled in the FFS program. In developing these estimates, we performed the following steps:
In estimating the savings for the CY 2013 through CY 2015 rating periods for the ABD 21+ and CFC populations we initially assumed that the 2008, 2009, 2010, 2012 and 2013 base period encounter and cost report data used to develop those rates already reflected estimated MCP historical FFS to managed care cost differentials. This is based on aggregate MCP financial results for 2008 through 2010, 2012, and 2013 that generally conformed to the state actuaries’ assumptions regarding expected loss ratios. CY 2008 was not directly used in developing the CY 2013 through CY 2015 capitation rates. However, it was used to develop the CY 2010 rates and therefore had an indirect impact on CY 2013 through CY 2015 savings. The figure below summarizes the observed and estimated loss ratios for each of these base period years:
Figure 2.5: Comparison of Observed and Estimated Loss Ratios (2008 – 2010, 2012, and 2013)

<table>
<thead>
<tr>
<th>Rating Period</th>
<th>Expected Loss Ratio</th>
<th>Observed Loss Ratio</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2008</td>
<td>90.2%</td>
<td>95.9%</td>
<td>6.3%</td>
</tr>
<tr>
<td>CY 2009</td>
<td>90.3%</td>
<td>95.4%</td>
<td>5.6%</td>
</tr>
<tr>
<td>CY 2010</td>
<td>88.8%</td>
<td>85.3%</td>
<td>-4.0%</td>
</tr>
<tr>
<td>CY 2012</td>
<td>89.5%</td>
<td>87.5%</td>
<td>-2.2%</td>
</tr>
<tr>
<td>CY 2013</td>
<td>89.3%</td>
<td>87.1%</td>
<td>-2.5%</td>
</tr>
</tbody>
</table>

We were not able to obtain rating documentation for CY 2007 and instead assumed the FFS to managed care cost differential for this period was similar to our estimate for CY 2008. Since pharmacy was carved out for CY 2010, we made adjustments to the CY 2008 through CY 2010 MCP financials to estimate the non-pharmacy loss ratios for comparison to the expected non-pharmacy loss ratios implied by the rate setting documents.

As illustrated in Figure 2.5, the observed non-pharmacy loss ratios for CY 2008 and CY 2009 were higher than the state actuaries’ expected loss ratio. This deviation resulted in lower estimated managed care cost savings than were implied by the rate setting documents. The observed non-pharmacy loss ratio for CY 2010 and the observed total loss ratios (pharmacy and non-pharmacy combined) for CY 2012 and CY 2013 were lower than the state actuaries’ expected loss ratios. This deviation resulted in higher estimated managed care cost savings than were implied by the combination of the rate setting methodology and the historical FFS to managed care cost differentials that were carried forward from the prior base periods. Favorable MCP loss ratio deviation does not necessarily indicate a higher level of MCP profits. Such results may have been driven by more intensive medical management and efficiencies and associated additional administrative costs not reflected in the favorable loss ratio.

Beginning with CY 2014, the Extension population was included in the managed Medicaid program. The CY 2014 and CY 2015 Extension rates were based on a blend of ABD adult and CFC adult managed care experience. The employed rating methodology results in the same expected net managed care savings percentage as was achieved by the other populations (ABD <21, ABD 21+ and CFC). This estimated savings percentage was reduced by explicit adjustments made by the state actuaries’ during rate development. These adjustments were made to account for the Extension population being new to the managed care environment.

Figure 2.6 summarizes the results of our savings analysis by year and Figure 2.7 illustrates the various components that result in our final savings estimates.
Figure 2.6: Estimated Savings Relative to Fee for Service

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated FFS Costs</td>
<td>$6,807,035,000</td>
<td>$9,325,294,000</td>
<td>$11,609,055,000</td>
<td>$27,741,384,000</td>
</tr>
<tr>
<td>Calculated MCO Revenue [1]</td>
<td>$6,442,694,000</td>
<td>$8,473,027,000</td>
<td>$10,366,771,000</td>
<td>$25,282,492,000</td>
</tr>
<tr>
<td>Total Dollars Saved</td>
<td>$364,341,000</td>
<td>$852,267,000</td>
<td>$1,242,284,000</td>
<td>$2,458,892,000</td>
</tr>
<tr>
<td>Total Percentage Saved</td>
<td>5.4%</td>
<td>9.1%</td>
<td>10.7%</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Based on 0.5% annual trend differential</th>
<th>CY 2013</th>
<th>CY 2014</th>
<th>CY 2015</th>
<th>CY 2013 - CY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical FFS Costs</td>
<td>$6,986,636,000</td>
<td>$9,575,544,000</td>
<td>$11,929,306,000</td>
<td>$28,491,486,000</td>
</tr>
<tr>
<td>Calculated MCO Revenue [1]</td>
<td>$6,442,694,000</td>
<td>$8,473,027,000</td>
<td>$10,366,771,000</td>
<td>$25,282,492,000</td>
</tr>
<tr>
<td>Total Dollars Saved</td>
<td>$543,942,000</td>
<td>$1,102,517,000</td>
<td>$1,562,535,000</td>
<td>$3,208,994,000</td>
</tr>
<tr>
<td>Total Percentage Saved</td>
<td>7.8%</td>
<td>11.5%</td>
<td>13.1%</td>
<td>11.3%</td>
</tr>
</tbody>
</table>

Figure 2.7: Summary of Estimated Savings by Component

<table>
<thead>
<tr>
<th></th>
<th>CY 2013</th>
<th>CY 2014</th>
<th>CY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Cost Savings versus FFS Implied in Base Period Rate Development</td>
<td>-7.8%</td>
<td>-10.9%</td>
<td>-13.2%</td>
</tr>
<tr>
<td>Base Period MCP Financial Savings (MLR)</td>
<td>-2.1%</td>
<td>-2.0%</td>
<td>-2.4%</td>
</tr>
<tr>
<td>State Administrative Savings</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Prospective Additional Managed Care Savings</td>
<td>-4.5%</td>
<td>-4.1%</td>
<td>-2.3%</td>
</tr>
<tr>
<td>MCO Administrative Allowance</td>
<td>10.1%</td>
<td>8.9%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Total Estimated Savings (no trend differential)</td>
<td>-5.4%</td>
<td>-9.1%</td>
<td>-10.7%</td>
</tr>
<tr>
<td>Impact of Annual 0.5% Trend Differential</td>
<td>-2.6%</td>
<td>-2.6%</td>
<td>-2.7%</td>
</tr>
<tr>
<td>Total Estimated Savings (0.5% annual trend differential)</td>
<td>-7.8%</td>
<td>-11.5%</td>
<td>-13.1%</td>
</tr>
</tbody>
</table>
National Report on Pharmacy Costs in Medicaid Managed Care

Ohio’s Medicaid prescriptions are largely paid for by the state’s Medicaid managed care plans (MCPs). Over 86 percent of all Ohio Medicaid prescriptions were MCP-paid during FFY2015. In 2011, the Ohio Medicaid program switched from a “carve-out” model where prescriptions benefits were excluded from managed care, to a “carve-in” model, in which prescription drugs are included in the Medicaid MCP capitation payments. Within the carve-in model, the Ohio Department of Medicaid (ODM) requires that MCPs use a largely uniform Medicaid preferred drug list (PDL), such that at least 90 percent of the drugs match those on Ohio’s Medicaid FFS PDL, with the MCPs having latitude to include different drugs on their PDL for up to 10 percent of the drugs.


This study examined 35 states and the District of Columbia that used the MCP model in their Medicaid program and either included (carved-in) or excluded (carved-out) pharmacy benefits from coverage. The data used for this report included, at the National Drug Code level, all Medicaid pharmacy costs in each state (with each state’s MCP-paid and FFS-paid drugs discernible from one another), as well as all rebates the states and MCPs received for Medicaid prescriptions. Using this data, each state’s net (post-rebate) costs per prescription were quantified and compared with one another.

Key findings of the report were compelling and are summarized below:

- Across 28 states using the carve-in model, the net cost per prescription was 14.6 percent lower than the average net cost per prescription in states not carving in pharmacy during FFY2014.

- Prior to factoring rebates, MCP costs per prescription were 30 percent below FFS, driven by a 4.8 percentage point difference in generic usage. MCPs also had lower costs per brand, and lower costs per generic, than occurred in the FFS setting. While the FFS setting yielded higher rebates per prescription than MCP-paid prescriptions – and the FFS setting also has the advantage of not being subject to the Affordable Care Act (ACA) Insurer Fee – these dynamics did not come close to offsetting the “front-end” 30 percent savings the MCPs achieved through their pharmacy benefits management efforts.

- Thirteen states carved-out pharmacy in 2011, six of which switched to a carve-in approach by FFY2014. These dynamics permitted a comparison of cost-per-prescription trends among the two groups of states. The seven remaining carve-out states as of FFY2014 had a 20 percent increase in net costs per prescription from FFY2011-FFY2014. Conversely, the six states that switched to a carve-in model (one of which was Ohio) collectively experienced just a 1 percent increase in net costs per prescription during this same timeframe.

- In addition to yielding large monetary savings relative to a carve-out, the carve-in model supports the whole-person, integrated care and coverage model that states are striving to obtain in partnership with their Medicaid MCP contractors. Conversely, the carve-out model separates and isolates the pharmacy benefit – a sub-optimal programmatic approach given how central prescription drugs are to effective treatment and to care coordination.

Ohio-Specific Overall Cost and Usage Analyses

The remainder of this chapter focuses on Ohio and primarily draws upon FFY2015 data, which is the most recent nationwide Medicaid data currently available for all states. Figure 2.8 compares FFY2015 net costs per prescription in Ohio relative to the nation, to the collection of five states neighboring Ohio, and to the collection of five states still using a pharmacy carve-out model during FFY2015. These figures include all Medicaid-paid prescriptions, with the exception of three costly Hepatitis C medications (Harvoni, Sovaldi, and Viekira Pak). State policies have ranged widely regarding usage of these medications, and these policies can affect a state’s overall Medicaid cost per prescription by more than $2.00. Removing these drugs allows for a better comparison of prescription drug benefits management across states.
Ohio has achieved fairly low net costs per prescription, with the FFY2015 average of $36.80 being 9.1 percent below the nationwide average of $40.50. At Ohio’s Medicaid prescription volume of 39 million during FFY2015, its Medicaid pharmacy costs were $144.4 million lower than the expenditures that would have occurred at the national average net cost per prescription. Among all states, Ohio had the 16th lowest net Medicaid costs per prescription during FFY2015.

**Figure 2.8: Medicaid Prescription Drug Net Costs and Usage, FFY2015**

<table>
<thead>
<tr>
<th>State or State Group</th>
<th>Prescriptions</th>
<th>Post-Rebate Medicaid Expenditures</th>
<th>Post-Rebate Cost Per Script</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio</td>
<td>39,023,162</td>
<td>1,435,927,158</td>
<td>$36.80</td>
</tr>
<tr>
<td>USA Total</td>
<td>661,915,649</td>
<td>28,805,863,192</td>
<td>$40.50</td>
</tr>
<tr>
<td>Neighboring States (IN, KY, MI, PA, WV)</td>
<td>99,773,613</td>
<td>3,526,036,050</td>
<td>$35.34</td>
</tr>
<tr>
<td>2015 Carve-Out States (IN, IO, MI, NE, WI, WV)</td>
<td>60,045,125</td>
<td>2,549,035,190</td>
<td>$42.45</td>
</tr>
</tbody>
</table>

Ohio as % of USA

Ohio as % of Neighboring States

Ohio as % of Carve-Out States

Source: Menges Group tabulations using CMS State Drug Utilization data and drug rebate information from the CMS 64 reports. Note that the above figure 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.

Ohio’s Medicaid costs per prescription (4.1%) were slightly above the average across its neighboring states during FFY2015. Three of these five states – Kentucky, Michigan and West Virginia – were among the nation’s lowest-cost states. These findings suggest that while Ohio has had good success to date, there is still room for Ohio to achieve lower Medicaid pharmacy costs.

There were six remaining pharmacy carve-out states during FFY2015 – 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. This finding is consistent with the AHIP study conducted using FFY2014 data, regarding the relative merits of a pharmacy carve-in versus carve-out policy.

Generic dispensing rates for each state Medicaid program were also tabulated. In Ohio during FFY2015, 81.5 percent of prescriptions were generics. This is just below the nationwide figure of 81.6 percent, below the collective figure across Ohio’s neighboring states (83.0%), and above the average across the remaining carve-out states (79.6%). Ohio had the 22nd highest generic dispensing rate among state Medicaid programs during FFY2015, a statistic that while not subpar, it does suggest room for further cost savings (consistent with the overall costs per prescription analyses described earlier). Each percentage point increase in the generic dispensing rate translates to approximately a 2.5 percent reduction in overall net prescription drug expenditures. Ohio’s net (post-rebate) cost per prescription in FFY2015 were nearly eight times higher for brand drugs than for generics.

**Tabulations Within Selected Therapeutic Classes**

We tabulated Ohio MCP usage trends in two therapeutic classes where there is mounting evidence that reductions in overall prescribing and usage may be warranted. One class assessed is opioid prescriptions, where a national epidemic of abuse, addiction, and overuse clearly exists. The Centers for Disease Control (CDC) recently published that “No evidence shows a long-term benefit of opioids in pain and function versus no opioids for chronic pain with outcomes examined at least 1 year later (with most placebo-controlled randomized trials ≤6 weeks in duration). Extensive evidence shows the possible harms of opioids (including opioid use disorder, overdose, and motor vehicle injury). Extensive evidence suggests some benefits of nonpharmacologic and nonopioid pharmacologic treatments compared with long-term opioid
therapy, with less harm.”

The second class assessed is atypical antipsychotic medications, where compelling evidence is accumulating that many individuals are being over-medicated. Study researcher G. Cale Alexander, MD, an assistant professor in the department of medicine at the University of Chicago Hospitals iterated that “Atypical agents were once thought to be safer and possibly more effective”; however, “what we’ve learned over time is that they are not safer, and in the settings where there’s the best scientific evidence, they are no more effective.”

While usage of opioid prescription and atypical antipsychotic medications can be extremely valuable clinically for a given member/patient, the excess prescribing and use that has occurred in these therapeutic classes does suggest that an optimal care coordination program would experience reductions in usage of these drugs during the past few years. In tabulating Ohio’s prescription drug usage in these therapeutic categories, however, it is important to take into consideration Ohio’s evolving Medicaid MCP enrollment dynamics. As shown in Figure 2.9, the past few years have been a period of tremendous growth in Ohio’s Medicaid MCP enrollment, with average enrollment increasing by 588,169 between 2013-2015. The vast majority of this growth, roughly 500,000 persons, occurred in the Medicaid adult extension population. This population is overwhelmingly comprised of adults (the majority of whom are male). Therefore, substantial increases in raw usage of prescription drugs will occur in Ohio as the covered population grows, particularly in therapeutic classes (such as opioids) where usage is largely driven by adult males.

**Figure 2.9 Medicaid MCP Enrollment in Ohio (Averages During Each Year by Major Eligibility Category)**

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Aged, Blind, and Disabled (ABD)</th>
<th>Covered Families and Children (CFC)</th>
<th>Extension Group</th>
<th>MyCare (Dual Eligibles Demonstration)</th>
<th>Total</th>
<th>Total Excluding MyCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY2013</td>
<td>173,156</td>
<td>1,528,978</td>
<td>-</td>
<td>-</td>
<td>1,702,134</td>
<td>1,702,134</td>
</tr>
<tr>
<td>CY2014</td>
<td>172,478</td>
<td>1,616,237</td>
<td>208,646</td>
<td>47,048</td>
<td>2,044,409</td>
<td>2,290,303</td>
</tr>
<tr>
<td>CY2015</td>
<td>151,772</td>
<td>1,637,904</td>
<td>500,627</td>
<td>92,143</td>
<td>2,382,446</td>
<td>2,290,303</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>-0.4%</td>
<td>-12.0%</td>
</tr>
<tr>
<td>5.7%</td>
<td>1.3%</td>
</tr>
<tr>
<td>139.9%</td>
<td>95.8%</td>
</tr>
<tr>
<td>20.1%</td>
<td>16.5%</td>
</tr>
<tr>
<td>17.3%</td>
<td>14.7%</td>
</tr>
</tbody>
</table>

Source: Tabulations using Ohio’s Medicaid Managed Health Care Enrollment Reports [http://www.medicaid.ohio.gov/RESOURCES/ReportsandResearch/MedicaidManagedCarePlanEnrollmentReports.aspx](http://www.medicaid.ohio.gov/RESOURCES/ReportsandResearch/MedicaidManagedCarePlanEnrollmentReports.aspx)

The tabulations in Figure 2.10 show that the MCPs’ collective volume of opioid prescriptions dropped substantially up to (and even past) the point where the Medicaid extension enrollment began enrolling. MCP-paid opioid volume decreased by 29 percent from the first calendar quarter of 2013 to the third calendar quarter of 2014.
Figure 2.10 Progression of Opioid Usage

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Prescriptions Paid by Ohio MCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2013</td>
<td>563,051</td>
</tr>
<tr>
<td>Q2 2013</td>
<td>490,015</td>
</tr>
<tr>
<td>Q3 2013</td>
<td>446,494</td>
</tr>
<tr>
<td>Q4 2013</td>
<td>431,509</td>
</tr>
<tr>
<td>Q1 2014</td>
<td>413,836</td>
</tr>
<tr>
<td>Q2 2014</td>
<td>400,673</td>
</tr>
<tr>
<td>Q3 2014</td>
<td>400,896</td>
</tr>
<tr>
<td>Q4 2014</td>
<td>585,654</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>572,467</td>
</tr>
<tr>
<td>Q2 2015</td>
<td>641,292</td>
</tr>
<tr>
<td>Q3 2015</td>
<td>598,255</td>
</tr>
<tr>
<td>Annual Totals</td>
<td></td>
</tr>
<tr>
<td>CY2013</td>
<td>1,931,069</td>
</tr>
<tr>
<td>CY2014</td>
<td>1,801,059</td>
</tr>
<tr>
<td>CY2015*</td>
<td>2,416,019</td>
</tr>
<tr>
<td>% Change</td>
<td></td>
</tr>
<tr>
<td>2013-2014</td>
<td>-7%</td>
</tr>
<tr>
<td>2014-2015</td>
<td>34%</td>
</tr>
<tr>
<td>Scripts Per Medicaid Eligible (excluding MyCare)</td>
<td></td>
</tr>
<tr>
<td>CY2013</td>
<td>1.13</td>
</tr>
<tr>
<td>CY2014</td>
<td>.90</td>
</tr>
<tr>
<td>CY2015*</td>
<td>1.05</td>
</tr>
</tbody>
</table>

* 2015 calendar year total extends average usage of the first three quarters to the fourth quarter.

Similarly, the tabulations in Figure 2.11 show that the MCPs’ collective volume of atypical antipsychotics volume decreased by 26 percent from the first calendar quarter of 2013 to the third calendar quarter of 2014.

All these tabulations indicate that Ohio’s MCPs have been successful in lowering the usage of medications that are prone to abuse, over-use, and/or are not representing optimal treatment.
**Figure 2.11 Progression of Atypical Antipsychotic Usage**

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Prescriptions Paid by Ohio MCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2013</td>
<td>161,963</td>
</tr>
<tr>
<td>Q2 2013</td>
<td>136,478</td>
</tr>
<tr>
<td>Q3 2013</td>
<td>131,881</td>
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<tr>
<td>Q4 2013</td>
<td>131,881</td>
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<tr>
<td>Q1 2014</td>
<td>122,136</td>
</tr>
<tr>
<td>Q2 2014</td>
<td>120,405</td>
</tr>
<tr>
<td>Q3 2014</td>
<td>116,756</td>
</tr>
<tr>
<td>Q4 2014</td>
<td>178,337</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>180,738</td>
</tr>
<tr>
<td>Q2 2015</td>
<td>196,291</td>
</tr>
<tr>
<td>Q3 2015</td>
<td>190,256</td>
</tr>
</tbody>
</table>

**Annual Totals**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CY2013</td>
<td>565,587</td>
</tr>
<tr>
<td>CY2014</td>
<td>537,634</td>
</tr>
<tr>
<td>CY2015*</td>
<td>756,380</td>
</tr>
</tbody>
</table>

**% Change**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-2014</td>
<td>-5%</td>
</tr>
<tr>
<td>2014-2015</td>
<td>41%</td>
</tr>
</tbody>
</table>

**Scripts Per Medicaid Eligible (excluding MyCare)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CY2013</td>
<td>0.33</td>
</tr>
<tr>
<td>CY2014</td>
<td>0.27</td>
</tr>
<tr>
<td>CY2015*</td>
<td>0.33</td>
</tr>
</tbody>
</table>

* 2015 calendar year total extends average usage of the first three quarters to the fourth quarter.
Summary

An evaluation of managed care performed by Wakely Consulting Group, Inc., found that Ohio’s MCPs operate efficiently and produce significant savings for the state when compared to FFS. It is estimated that capitation rates paid to MCPs were 9 to 11 percent lower than the cost of serving Ohioans through traditional FFS, resulting in an estimated $2.5 to $3.2 billion dollars in savings.

Additionally, all of the Medicaid pharmacy costs and usage analyses conducted – whether Ohio-specific, nationwide, or regional – suggest that the Medicaid MCPs effectively manage Ohio’s prescription drug benefit for the members they serve. Ohio’s recent experience is favorable relative to the performance of the carve-out setting. Ohio had the nation’s 16th lowest costs per prescription during 2015, and Ohio’s costs were 9.1 percent and $3.70 per prescription below the national average. Ohio’s costs were 13.3 percent and $5.66 per prescription below the carve-out states’ collective performance. This $3.66 cost per prescription differential represents an annual net cost savings of $123 million relative to the average cost per prescription across the remaining carve-out states.

Notwithstanding these favorable findings, opportunities exist for further Medicaid savings to occur. Ohio’s pharmacy costs are several percentage points above those of many other states where MCPs pay for the vast majority of the prescriptions, including large neighboring states such as Kentucky and Michigan.

MCPs must cover all of the drugs that FFS covers. Where MCPs may have variation is in the prior authorization/ utilization management. However, the combined list of drugs requiring prior authorization for each MCP must result in a combined percentage agreement that is no less than 70 percent. Given that Ohio substantially regulates PDL content, it appears likely that the health plans can achieve a more favorable drug mix (and thus further lower pharmacy costs) if the plans are afforded greater PDL latitude by the State’s policymakers. If given the latitude to manage the mix of drugs in accordance with their own algorithms (and considering that nearly 90 percent of Ohio’s Medicaid prescriptions are now paid by MCPs), Ohio is positioned to become one of the nation’s highest-performing states with regard to cost-effective management of the Medicaid prescription drug benefit.
Chapter 3
Medicaid Managed Care’s Impact on Quality

Managed care plans (MCPs) are the Ohio Department of Medicaid’s (ODM) primary partners for achieving its Quality Strategy.

Payment is increasingly being tied to performance and quality outcomes to improve the service delivery system for members.

MCPs also drive quality through their alternative payment arrangements with providers that reward quality improvement.

MCP performance on key measures are analyzed each year and the bar is raised each subsequent year.
Nationwide, the shift towards managed care has been driven by the need for better outcomes and accountability in the Medicaid program. In collaboration with Medicaid agencies and health care providers, MCPs are driving quality initiatives to provide better care for their members. States and the federal government have established quality standards and enabled MCPs to implement innovative strategies and work with providers to support efforts that improve the quality and delivery of care to members.

In Ohio, ODM’s partnership with MCPs is critical to achieving its mission to improve the health of Ohioans through transformative and coordinated health care. The Ohio Medicaid Quality Strategy, shown in Figure 3.1, is grounded on three primary pillars: delivering better care, contributing to healthy people and healthy communities, and practicing best evidence medicine across the care continuum.

**Figure 3.1 Ohio Medicaid Quality Strategy**

As can be seen in Figure 3.1, there are many moving pieces in the Ohio Medicaid Quality Strategy. To achieve the Quality Strategy’s goals, MCPs must be empowered to develop and administer various strategies to drive quality with both individual members and providers. The following benefits offered by MCPs underscore how they are uniquely positioned to innovate in response to changing environments since they have the flexibility to use Medicaid dollars differently than is allowed under traditional Medicaid.

**Care Coordination**

Care coordination is a core competency of MCPs and is key to managing the health and cost of patients with complex or chronic conditions. Persons with such conditions often have trouble navigating the health care system and coordinating all their various healthcare needs. MCPs utilize care coordinators to serve these members and are accountable for the following responsibilities:

- Assessing a member’s needs and identifying any unmet needs and 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
Appropriate care coordination results in better quality of life for the member, 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. Care coordinators also guide members and their families to community resources and consumer groups that can facilitate access to other services that can improve their health. MCPs often develop partnerships with these resources to better serve their members.

MCPs use care coordinators to help members develop and understand their individualized care plan, access necessary services as well as identify unmet needs and additional supports to maintain health (e.g., food and housing). Care coordination lowers costs by reducing service duplication and removing barriers to care that result in expensive and avoidable emergency room and inpatient visits.

Care coordination is particularly important and effective for members with chronic conditions. A small number of Medicaid members drive a disproportionate amount of spending - the top 5 percent of the health care utilizers account for over 50 percent of the health care costs. Moreover, the dual eligible population accounts for 46 percent of Medicaid LTSS spending and 16 percent of behavioral health service spending despite accounting for an estimated 7 percent of total Medicaid membership.

**Planned Care Transitions to Prevent Adverse Outcomes**

MCPs must effectively and comprehensively manage transitions of care between settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or other adverse outcomes. Each MCP has a process to identify members who require assistance transitioning between settings. They further evaluate the risk of readmission in order to determine the intensity of follow-up required post-discharge. The MCPs further facilitate communications with providers and actively participate in discharge planning activities to ensure that timely follow-up and post-discharge services are provided. In contrast, FFS does not provide these services.

**Innovation Showcase: Journey to Safe, Effective Transitions of Care**

As part of a system-wide working group, one of Ohio’s MCPs helped create a Care Management Collaborative (CMC), a strategic, system-wide intervention to prevent service fragmentation as its members move from one care setting to another. The CMC stratifies the plan’s members according to risk into one of five levels, and a partnership is developed with the member across all episodes of care to ensure safe transitions of care. Level one members, who have the highest stratification risk, work directly with a transitional care navigator in the inpatient setting and face-to-face with an ambulatory care navigator in the office setting.

In the first year of the program, the MCP realized significant reductions in acute care utilization metrics, including:

- Emergency room visits decreased by 37 percent
- Hospital admissions reduced by 56 percent
- Medical costs decreased $710 per member per month

Through its collaboration in different care settings and holistic health approach, this plan’s innovation reduced costs while improving its members’ quality of life.
Continuity of Care for Persons Entering Managed Care

As FFS members enroll in managed care, MCPs are required to utilize information and data provided by ODM and/or collected from MCP assessments (or new member outreach) to identify existing health care needs to help create a new member profile prior to enrollment. MCPs are further required to aid the member’s transition by allowing them to continue receiving certain services from network and out-of-network providers. These requirements for continuity of care ensure high quality care and prevent members from experiencing breaks in service coverage or in their treatment plan.

Extra Services – “Value-Added Services”

Each MCP offers a selection of value-added services that are not paid for by the Medicaid program. These services can enhance members’ health, promoting not just quality of life but also lowering costs. Providing transportation to and from doctor appointments or extra dental benefits for adults are examples of popular value-added services.

A list of some of the value-added services provided by MCPs is provided in Chapter 1.

Innovation Showcase: Promoting Continuity of Care by Using Community Resources to Locate Members

One of the MCPs had 3,000 members that could not be assessed because their enrollment records either lacked contact information, or they were listed as homeless. The MCP dedicated a team of individuals known as Member Locators to review claims, hospital records, fire and police records, and additional contact information. Member Locators were deployed in the community to pursue these members, and when they could not locate an individual, a member of the MCP’s Community Connector team went into the community to visit the address on record to find and connect members with their Care Manager.

In the first six months the program, 40 percent of the MCP’s members were found and connected with care.

Innovation Showcase: Addressing Social Determinants of Health

One of Ohio’s MCPs sought to make a sustained impact in their members’ lives by effectively addressing the obstacles that impede progress in their journey toward self-sufficiency, improved health, and well-being. Barriers that its members faced include transportation, childcare, education, training, job placement, ongoing mentoring, and health care. The MCP added Life Services as an enhanced benefit to provide a holistic approach that assists its members to overcome these barriers and address key social determinants.

Life Services includes a pilot program that seeks to connect voluntary members who are interested in employment and education opportunities. This signature program is designed to help members achieve self-sufficiency by removing nonclinical barriers to stable employment while providing area employers with a pipeline of job-ready talent.

There were 759 program volunteers, and 387 individuals worked with coaches to stabilize their lives, find employment and access education. Nearly 120 people were employed, and many others continued to work with case management to address their ongoing needs.

Addressing Social Determinants of Health

Social determinants of health are economic, environmental and social factors that impact the overall health and well-being of an individual. Social determinants are pervasive barriers in health care, including issues of poverty, unemployment, lack of or inadequate housing, lack of access to healthy food, and low literacy levels. These social determinants particularly impact the health of Medicaid members. These factors affect life expectancy and increase the prevalence of chronic conditions. As a result, focusing on social determinants of health is a key part of the Ohio Medicaid Quality Strategy.

In Ohio, some of the work by MCPs to address social determinants include:

- Working with Ohio Mental Health and Addiction Services on addressing the opioid epidemic
- Developing programs to address childhood obesity
- Implementing population health evidence-based practices including smoking cessation, preventive screenings, and management of chronic conditions
- Providing cultural competency training for providers

The Innovation Showcase below illustrates how one MCP uses a population health team to support providers to increase quality and improve health outcomes of its members.
Innovation Showcase: Supporting Providers via Value-Based Purchasing, Continuous Monitoring and Technology

MCPs bring expertise and experience to select practices engaged in value-based arrangements and population health initiatives. For one MCP, its Population Health Team provides the following practice support:

- Serve as the dedicated relationship manager and single point of contact for the MCP
- Provide education, training, and support adoption of a technology platform for data analysis, workflow analysis and enhancements. Providers can use this technology to assess member information in a meaningful way to easily identify specific, at-risk members and opportunities for care improvement
- Provide regular data and metric reviews (daily/weekly as indicated by practice size) of performance trends on total cost of care, utilization trends and quality outcomes
- Review and identify high-risk members needing care and services
- Support regular care rounds especially for complex members around key clinical events such as a hospital discharge
- Coordinate with the health plan’s care management and quality teams to ensure resources are well coordinated
- Support the member and their circle of support to attend all appointments
- Support the providers’ practice transformation in alignment with their workflows, processes and goals
- Align and drive additional resource alignment and care coordination opportunities such as care coordination with a hospital system or behavioral health provider

By assigning population health specialists to providers, this MCP fosters collaborative relationships that drive innovation and ultimately better health outcomes for its members.

MCPs Promote Provider Quality of Care

With their ability to align incentives, MCPs are key drivers of quality throughout the healthcare system. As ODM sets quality standards for MCPs, the MCPs innovate to design strategies that pay providers based on value rather than volume. Some strategies that MCPs use to drive quality with providers are detailed below.

Provider Engagement: MCPs facilitate committees that allow for physician participation and guidance. These committees review quality initiatives, credentialing standards and pharmaceutical formulary changes to ensure accountability of the MCP to the practicing network of providers. These committees also promote a rich experience for the providers to guide and assess the impact of various practices and initiatives. Engaging providers enhances common understanding, which further drives quality.

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

MCPs use continuous monitoring of both network adequacy of providers and quality metrics as a key strategy to drive quality care. ODM outlines network adequacy requirements within the provider

Innovation Showcase: Paying Providers for Quality Care

For one MCP, their rate of 80 percent for Appropriate Treatment for Children with Upper Respiratory Infection (URI) was below the 25th percentile nationally according to NCQA’s Quality Compass®. This translated to over 1,000 children who were prescribed an unnecessary antibiotic in 2013. The implementation of provider and parent education tactics alone, over the prior few years, did not have enough impact.

To address this issues in 2015, this MCP notified providers that all claims with a URI diagnosis would be pended for payment review. Those without an antibiotic prescribed would be released for payment, while those with an antibiotic filled would require record review to establish a valid reason for the drug. If no indication for the antibiotic was found in the record, the provider’s claim would be denied.

Two years after implementation of this innovation, the MCP has improved the quality of care for nearly 700 children.
agreement. MCPs must provide or arrange for the delivery of all medically necessary, Medicaid-covered health services, as well as ensure compliance with federally defined provider access standards as required by 42 CFR 438.206.

In addition to provider monitoring performed by MCPs, ODM contracts with Automated Health Systems (AHS) to produce the Managed Care Provider Network (MCPN) file that health plans submit on a continual basis. The MCPN is used by ODM to determine compliance with network adequacy requirements for preventive, primary and specialty services. Members also use it to determine whether providers are in network.

ODM contracts with Health Services Advisory Group, Inc. (HSAG) as its External Quality Review Organization (EQRO) to perform a variety of monitoring and assessment activities to ensure high quality of services for Ohio Medicaid members, including:

- Review of call center metrics (Each MCP provides an ask-a-nurse advice line and customer service call center)
- Oversight for consumer complaints and grievances
- Evaluation of MCP performance on access, quality, and patient satisfaction

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

**Patient-Centered Medical Homes (PCMH):** MCPs promote the development of medical homes that foster a strong relationship between a PCP and a patient, which is a critical component of a PCMH. PCMHs are more likely to yield a whole-person plan of care that provides comprehensive, high-quality health care services.

In collaboration with the Ohio Department of Health (ODH), MCPs support the development of medical homes by managing the provider network that serves Medicaid members and working with the state to facilitate and support the statewide expansion of PCMHs. As Ohio providers play a larger role in managing population health, medical homes will be encouraged to expand their use of team-based medicine and offer care coordination services to improve health outcomes of their assigned patient populations.

**ODM Pays MCPs for Performance**

Payment for value is integral to the design and implementation of Ohio Medicaid’s Quality Strategy. The contracts between ODM and MCPs include pay for performance (P4P) bonuses. To receive 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.

Offering financial incentives to MCPs drives accountability and higher quality care. The State of Ohio sets quality standards to ensure MCPs meet the intent of the program. Further, ODM publishes a publicly accessible report card that allows members to compare MCP performance on key quality and satisfaction metrics. These results can then influence the success of a MCP in attracting membership, which is another financial incentive.

The P4P measure set includes national performance measures from the National Committee for Quality Assurance (NCQA) and Healthcare Effectiveness Data and Information Set (HEDIS) measurement set, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures and the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set). In addition, two non-HEDIS, Children’s Health Insurance Program Reauthorization Act (CHIPRA) measures are calculated. Each MCP is required to self-report annually on the measures and then participate in a NCQA compliance audit to validate reported metrics.

MCPs are put at risk for 1.25 percent of total premium dollars. In 2016, the program had seven-selected HEDIS measures, where the MCPs could earn the 1.25 percent of premium as a bonus if they achieve specified levels of quality on all of the measures. Previously in 2015, the program used six HEDIS measures where the plans could earn 1 percent of the
premium. The higher the scores, based on the NCQA percentile ranking, the greater the quality bonus received. Since 2013, MCPs have been awarded more than $74 million in incentive payments.

**MCP Performance on Quality Measures**

Ohio MCPs demonstrate high quality on a national scale. The NCQA recently published state average quality scores for the 2016-2017 year\(^1\). In this report, Ohio had higher average quality scores than both the national average and the large state subgroup average as shown in the chart below.

**Figure 3.2 NCQA Ratings 2016-2017**

It is important to note that achieving “average” results within the field of Medicaid MCPs that have achieved NCQA certification denotes high performance in quality measurement and achievement. All five of Ohio’s statewide Medicaid MCPs are NCQA accredited, which represents a rigorous and detailed process. Many states do not require NCQA certification because it is difficult for some MCPs to achieve.

**HEDIS Quality Measures for Specific Populations**

ODM’s Medicaid Quality Strategy focuses on specific populations that disproportionately drive health care costs. ODM evaluates MCPs on a set of measures specific to these populations in order to foster an environment of accountability in which MCPs can deliver evidence-based prevention and treatment practices. HEDIS is a national set of quality performance measures used to evaluate health plans’ performance. The HEDIS measures that ODM selected for SFY 2016 are grouped by the following populations in accordance with its Quality Strategy: Healthy Children, Healthy Adults, Women of Reproductive Age, Behavioral Health, and Chronic Conditions.

Ohio MCPs perform well in comparison to national Medicaid benchmarks. Figure 3.3 provides examples of measures where Ohio MCP performance statewide is higher than the national NCQA 50th percentile.
As discussed earlier, performance relative to the minimum performance standards determines financial incentives or disincentives for MCPs. More specific data is provided below.

**Women of Reproductive Age**

*The Frequency of Ongoing Prenatal Care* measures the proportion of deliveries that received the expected percentage of prenatal visits. For SFY2016, the statewide average rate for all MCPs was 69.1 percent, exceeding ODM’s minimum performance standard of 43.7 percent.

**Figure 3.4 Frequency of Ongoing Prenatal Care, CY2013-2015**

As discussed earlier, performance relative to the minimum performance standards determines financial incentives or disincentives for MCPs. More specific data is provided below.

**Women of Reproductive Age**

*The Frequency of Ongoing Prenatal Care* measures the proportion of deliveries that received the expected percentage of prenatal visits. For SFY2016, the statewide average rate for all MCPs was 69.1 percent, exceeding ODM’s minimum performance standard of 43.7 percent.

**Figure 3.4 Frequency of Ongoing Prenatal Care, CY2013-2015**
Postpartum Care evaluates how care is provided to mothers. One aspect of Postpartum Care measures the percentage of deliveries for which a postpartum visit was provided on or between 21 and 56 days after delivery. For SFY2016, the statewide average rate for Postpartum Care was 62.8 percent, ranking between the national HEDIS 2015 50th and 75th percentiles. Once again, the average statewide rate exceeded the minimum performance standard for the SFY2016 measurement period.

Figure 3.5 Postpartum Care, CY2013-2015

Healthy Children

Visit to a Primary Care Practitioner. Preventive screenings for children, such as visits to primary care practitioners, are critical to ensuring that they reach their full health potential. HEDIS measures the percentage of children who have visited a primary care practitioner during the year, stratified into age categories. The statewide average rates for each age group SFY2016 are as follows in Figure 3.6.

Figure 3.6 MCP Statewide Average Rate of Children and Adolescent Access to PCP, SFY2016
Appropriate Treatment for Children with Upper Respiratory Infection. This indicator measures the percentage of children (ages 3 months to 18 years) who were given a diagnosis of an upper respiratory infection and were not dispensed an antibiotic prescription. For SFY 2016, the average statewide rate was 90 percent. All MCPs had at least 88 percent of eligible children receiving appropriate treatment for their URI, which exceeded the minimum performance standard of 81.6 percent for SFY2016.

Figure 3.7 Appropriate Treatment for Children with Upper Respiratory Infection, CY2013-2015

Behavioral Health

Follow-up after Hospitalization for Mental Illness. This measure evaluates the percentage of members who have a follow-up visit within seven days after a discharge from a hospitalization for a mental illness. The average statewide rate for seven-day follow-up after a mental illness discharge for SFY2016 was 50.8 percent. This exceeded the minimum performance standard of 31.7 percent. Over the past several years, MCPs have remained consistent with their performance for follow-up to hospitalizations.

Figure 3.9 Follow-up after Mental Health Hospitalization, CY2013-2015
Chronic Conditions

Ohio’s Medicaid Quality Strategy identifies individuals with the following chronic conditions as a key focus area: asthma, diabetes, and hypertension.

*Comprehensive Diabetes Care* measures the quality of care provided to members with diabetes, and one sub-measure is Eye Exam (Retinal). For SFY2016, the statewide average rate for Eye Exam performance was 56 percent, exceeding the minimum performance standard of 46.3 percent.

*Medication Management for People with Asthma.* This measure looks at the percentage of members with persistent asthma who were dispensed appropriate medication and remained on the medication during the period of treatment. MCPs are required to report the percentage of members who remained on the medication for at least 75 percent of the treatment period. For SFY2016, the statewide average rate for medication compliance was at 38.2 percent. This result ranks the MCPs above the national HEDIS 75th percentile, in which all MCPs had at least 30 percent of compliance with medication for at least 75 percent of the treatment period.

**Potentially Preventable Readmissions (PPR)**

PPR is an important quality measure of the effectiveness in managing the health of the Medicaid population and the safety of care. Preventing readmissions of any kind is critical for managing cost and quality, but certain readmission types are deemed clinically preventable and serve as an indicator of potential quality concerns. Readmission that occurs within 30 days of the index admission may be an indicator of a quality failure in the initial admission or in the management of the patient post-discharge.

Every six months, the State of Ohio publishes a report card with PPR rates for MCPs and hospitals. For SFY 2015, MCPs held the actual to expected PPR rate even, meaning that MCPs delivered the expected PPR rate.

**Member Satisfaction**

Member satisfaction is intimately related to engagement and thus quality in healthcare. When members are satisfied, they are more engaged. Each year, the MCPs are required to conduct member satisfaction surveys using the CAHPS® tool. Based on the CAHPS® survey results in 2015, Ohio’s MCPs have been rated as good to excellent performance 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 these areas, the program average was at or above the 90th percentile compared to national Medicaid percentiles.

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**Innovation Showcase: Team-Based Care to Decrease PPR**

One MCP identified that heart failure represented half of their PPRs. Further, only one-fifth of their members with heart failure were being treated with Guideline-Directed Medical Therapies (GDMT). In January 2016, the MCP implemented the Best Beats program, which takes lessons learned from academic institutions and weaves them into their existing expertise of care management and disease management. MCP Care Managers, community health workers, pharmacy team, and behavioral health staff work with members and their providers with the goal of successful GDMT for all members with congestive heart failure. This innovation leads to improved quality of life, fewer admissions/readmissions, and reduced emergency visits— all resulting in lower costs.
Summary

MCPs serve as ODM’s primary partner to improve quality for its members and to achieve Ohio Medicaid’s Quality Strategy. Aligning with the Quality Strategy, MCPs focus on designing and implementing strategies that underscore performance and value. “Pay for value” allows MCPs to implement evidence-based practices that link payment with quality improvement. The HEDIS measures that ODM selected for SFY 2016 focus on high-impact populations such as children, pregnant women, individuals with behavioral health conditions, and persons with chronic conditions. Evaluated by Ohio Medicaid, MCPs must meet performance standards to receive incentive payments, fostering an environment of accountability and higher quality care for their members.

Quality outcomes are monitored and tracked using nationally recognized standards. All five of Ohio’s statewide Medicaid MCPs are NCQA accredited and have higher average quality scores than both the national average and large state subgroup average. MCPs perform well in comparison to national Medicaid benchmarks and have continuously exceeded the state’s minimum performance standards, demonstrating their commitment to improve quality and achieve the goals of Ohio Medicaid’s Quality Strategy.
Medicaid managed care plans (MCPs) have the flexibility, expertise, resources, and incentives to drive innovation in Ohio.

MCPs help align providers to improve performance by implementing innovations that further the goals of the Ohio Department of Medicaid (ODM).

MCPs collaborate in statewide innovation programs that address:

- Value-based purchasing
- Specific populations including pregnant women, infants, and released inmates
- Population health crises such as opioid abuse
Managed care plans (MCPs) leverage private industry expertise and resources to foster critical innovations that achieve better care, better health, and lowered costs for Ohio. Unlike a one-size fits all fee for service (FFS) system based on volume, MCPs have an incentive to innovate since they assume financial risk and have greater accountability for the health of their members. Moreover, managed care allows Ohio MCPs to spend Medicaid dollars in a way not allowed in FFS. MCPs can essentially provide alternative services and supports that encourage individuals to become more involved in their health care. Persons who are involved in decisions about their health care are more likely to change behaviors and do more to improve their well-being.

In Ohio, MCPs align their innovations with both the Governor’s Office of Health Transformation and the Ohio Medicaid Quality Strategy (discussed in more depth in Chapter 3). Focusing on the three main themes of the Quality Strategy, MCPs propel innovation by:

- Addressing populations with complex health needs
- Implementing value-based strategies
- Using a population health-based approach to improve health and health equity

Member Spotlight: Managed Care Helps Sherry Return Home

Sherry (age 61), is on a ventilator. For several years, she lived in a skilled nursing facility (SNF). Sherry needed to move to another facility when her SNF stopped providing ventilator care. However, the only SNF available was two hours away. Sherry decided to try living at home on the ventilator with assistance from her husband and home health care.

Sherry's MCP Care Manager held an interdisciplinary care team meeting with Sherry, her husband, the home health agency and a skilled nurse to discuss her options. At the meeting, Sherry voiced her concerns about her husband's ability to properly manage her vent care. The team increased her nursing hours and provided additional vent and tracheotomy care training for her husband. Her husband now feels much more secure with his ability to care for Sherry with support of the in-home nurses. Sherry has been home since February 2016 with no emergency department visits or hospitalizations.

Integration of Behavioral and Physical Health Care

Individuals with severe and persistent mental illness (SPMI) often have co-occurring chronic medical conditions, complex health needs, and a high incidence of substance use disorder. The separation of behavioral and physical health services often leads to uncoordinated medical care and prevents holistic member care.

In January 2018, Ohio will “carve-in” behavioral health and substance abuse services in managed care contracts. Previously, Ohio implemented a Health Homes initiative to integrate behavioral and physical health services. However, it was not successful in engaging high risk members and therefore was cancelled in favor of including behavioral health care in managed care. The integration of behavioral health into managed care provides a significant cost-savings opportunity through better care coordination as MCPs are positioned to holistically manage the health of their members.
Innovation Showcase: Ensuring Members Receive Follow-up Counseling and Appropriate Care after a Behavioral Health Inpatient Stay

One MCP’s Behavioral Health Discharge Planning Program assists patients with behavioral health follow-up care. The MCP found that only 14 percent of its members received a follow-up visit within 7 days of discharge, and only 25 percent received a follow-up visit within 30 days. The MCP began contacting behavioral health facilities directly to ensure that follow-up care was coordinated for its members. Discharge instructions and follow-up were communicated directly to the MCP. The MCP care coordinator then reached out to members to confirm that the follow-up visit had occurred and the 30-day follow-up appointment was scheduled. The results showed a dramatic improvement in follow-up:

- 7-day follow-up visits increased by 52.8 percent
- 30 day follow-ups increased by 46.7 percent

Value-Based Purchasing Agreements with Providers

Ohio statute and MCP contracts with ODM require that MCPs implement value-based purchasing agreements with providers. By 2020, at least 50 percent of MCP provider contracts must be value-based, and MCPs are well on their way to achieving this goal (see Figure 5.1 in Chapter 5 – Moving Forward). Currently, more than 25 percent of MCP’s provider agreements are value-based.

When well structured, value-based agreements increase access to care, raise health awareness, promote early detection and reduce costs. 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 saving arrangements with providers that target specific outcomes. For example, some MCPs share in the savings attributed to the reduction in emergency department visits.

Value-Based Initiatives in Partnership with MCPs and Ohio

The Governor’s Office of Health Transformation, in collaboration with the MCPs, continues to pursue payment models that aim to achieve better care and lower costs. Utilizing federal funding from State Innovation Model (SIM) grants, the state has partnered with MCPs to implement two multi-payer initiatives – patient centered medical homes (PCMH) and episodes of care.

Comprehensive Primary Care Program

The Comprehensive Primary Care Program (CPC) is Ohio’s patient-centered medical home program, which uses a team-based care delivery model led by a primary care practice who manages the needs of the patient. The CPC financially
rewards primary care practices that keep individuals healthy and contains or reduces the total cost of care. Members, providers and MCPs all work together to ensure the success of this model.

Under the CPC program, primary care practices that submit an application and agree to the program requirements will be eligible to receive additional payments for providing a medical home for their Medicaid patients. Practices must agree to provide the following activity requirements:

- Same-day appointments
- 24/7 access to care
- Risk stratification
- Population management
- Team-based care management
- Follow-up after hospital discharge
- Tracking of follow-up tests and specialist referrals
- Patient experience

The MCPs have worked closely with ODM to prepare practices for the CPC program. MCPs will be responsible for managing and administering the program, including the following activities:

- Program administration
  - Attributing MCP members to primary care practices according to state guidelines
  - Serve as single point of contact for practices to navigate MCP processes
  - Integrate results of CPC practice quality metrics to Quality Improvement program
  - Hold practices accountable for activity attestations
- Reimbursement – Provide the PMPM and shared savings payment for meeting quality and financial scores and continue refining the incentive model to encourage innovation.
- Benefit design – Ensure physicians and patients are aware of CPC benefits including patient incentives and invest or promote community-based prevention programs where relevant.
- Network and patient access – Develop a network of culturally-versed, high quality providers and recognize high-performing CPC practices with a preferential network position.
- Care management resources and activities – Provide support for ongoing communication and action to support the care plan.
- Facilitating data sharing – Includes utilization and family/social factors, quality and cost opportunities and performance in a timely and usable manner.

The CPC program is scheduled to launch with an early entry cohort in January 2017 and then open to any primary care practice that meets program requirements in January 2018.

Episodes of Care

The second provider initiative implemented through MCPs is episode of care payments. 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 delivering providers for effectively and efficiently treating acute episodes.

Ohio uses a retrospective bundling model where patients seek care, and providers deliver care much as they have always done. After the fact, 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, seen in Figure 4.1:
Figure 4.1 Episodes of Care

<table>
<thead>
<tr>
<th>Cost of Episode Compared to Baseline</th>
<th>Type of Contract</th>
<th>Impact On Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs higher than average baseline</td>
<td>Risk Sharing</td>
<td>Provider pays MCP a share of cost of care</td>
</tr>
<tr>
<td>Costs higher than average baseline</td>
<td>Shared Savings</td>
<td>No impact on Provider</td>
</tr>
<tr>
<td>Costs the same (within a range)</td>
<td>Shared Savings or Shared Risk</td>
<td>No impact on Provider</td>
</tr>
<tr>
<td>Costs Lower than average baseline</td>
<td>Shared Savings or Shared Risk</td>
<td>Providers receive incentive payment to share in savings</td>
</tr>
</tbody>
</table>

Participating providers are supplied with reports that allow them to continuously evaluate and improve their own performance. ODM estimates that with 50 acute condition types, approximately 70 percent of acute health care costs can be supported by episode-based payments in the future.

The demonstration period for Wave 1 episodes was January 1, 2016 - December 31, 2016. Episodes for both Wave 1 and Wave 2 are as follows:

Wave 1
- Perinatal
- Asthma exacerbation
- Chronic obstructive pulmonary disease exacerbation
- Total joint replacement
- Acute percutaneous coronary intervention
- Non-acute percutaneous coronary intervention

Wave 2
- Upper respiratory infection
- Urinary tract infection
- Appendectomy
- Cholecystectomy
- Colonoscopy
- GI hemorrhage
- Upper GI endoscopy
- Coronary intervention

Strengthening Member and Primary Care Provider’s Relationships

Increasingly, providers are paying closer attention to the assignment of members on their panels. They work closely with the MCP to understand what members are assigned and make efforts to reach out to those who have never been into the clinic to establish a primary care relationship. Directly resulting from the incentive contracts created by MCPs, providers must reevaluate their

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 with an algorithm approved by ODM. Further, members are permitted to seek care from any in-network PCP, even when they are not “assigned”. Since members often do not inform a MCP when they seek care from a PCP other than their assigned provider, MCPs have begun to identify members who do so via claims analysis.

If a member has never visited their assigned PCP but visits a different provider, MCPs send a letter informing the member 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 they wish to be moved to another PCP, the member is instructed to contact Member Services.
business model, which previously focused more on patients who walked through their practice doors. Additionally, MCPs are improving member outreach in order to ensure that their members are seeing established care providers.

**Population Health Innovations**

Healthy behaviors improve lives and reduce health care costs. Ohio identified the following areas for population health improvement that leverage established MCP and provider partnerships:

- Opioid crisis
- Inmates released from prison
- Improving maternal health to reduce infant mortality
- Reducing tobacco use
- Population health planning

Given the impact on Ohio's population health, many of these innovations are statewide collaborations in which all MCPs participate. The scale of these collaborations would not have been possible in a FFS system where providers have little incentive to collaborate without significant state involvement and coordination.

**Addressing the Opioid Crisis in Ohio: The Coordinated Services Program**

Opioid abuse is a major public health issue facing the State of Ohio. Ohio has seen a 366 percent increase in drug overdose deaths involving prescription drugs from 2000 to 2012. In 2015, 3,050 Ohio residents died from an unintentional drug overdose; a large majority of those deaths were attributed to opioids.

To battle this growing epidemic across the state, ODM launched the Ohio Coordinated Services Program (CSP), a patient review and restriction initiative. ODM requires each MCP to develop and implement the CSP to oversee member utilization and medication patterns that exceed medical necessity (by frequency or amount). ODM approves each MCP's CSP which 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 can 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.

MCPs collaborated with ODM to implement several strategies as part of the CSP to prevent over-prescribing and over-utilization of certain drugs:

- Designate a single pharmacy and/or prescriber for a member requiring the use of controlled substances.
- Identify members, pharmacies, prescribers that may be over-utilizing or over-prescribing medications through monthly medical and pharmacy claims. Data that shows potential fraud or abuse is sent to the Special Investigations Unit for review and follow-up.
- Implement restriction policies on prescribers and individuals.
- Implement programs that override prior authorization requirements for prescribing providers of medications, such as Suboxone. These programs create guidelines for providers and establish provider performance criteria to ensure certain drugs are administered and used properly.

The state's EQRO (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

Figure 4.2 summarizes CSP’s impact on key measures.

**Figure 4.2 Summary Results of CSP Impact during CSP Enrollment Months**

<table>
<thead>
<tr>
<th>CSP Improved Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome</strong></td>
</tr>
<tr>
<td><strong>Utilization</strong></td>
</tr>
<tr>
<td>Inpatient Utilization</td>
</tr>
<tr>
<td>Emergency Department (ED) Utilization</td>
</tr>
<tr>
<td>Number of Prescriptions for Controlled Substances</td>
</tr>
<tr>
<td>Number of Prescriptions for Opioids</td>
</tr>
<tr>
<td>Opioid Utilization (Morphine Equivalency Dosage [MED])</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td>Total Cost</td>
</tr>
<tr>
<td>Inpatient Cost</td>
</tr>
<tr>
<td>Medical Cost</td>
</tr>
<tr>
<td>Outpatient Cost</td>
</tr>
<tr>
<td>ED Cost</td>
</tr>
<tr>
<td>Pharmacy Cost</td>
</tr>
<tr>
<td>Dental Cost</td>
</tr>
</tbody>
</table>
Pre-release Program for Inmates

MCPs are key to improving quality and outcomes for people transitioning from prison to the community. These individuals often have physical and behavioral health conditions that may perpetuate recidivism such as chronic disease, mental illness and substance abuse. Ohio’s MCPs have partnered with the Ohio Department of Rehabilitation and Correction and ODM to enroll inmates who meet certain criteria into Medicaid (which was expanded to include pregnant women or women who gave birth while incarcerated). The Pre-Release Program coordinates their care upon release with the goal of supporting successful reintegration back into the community, maintaining continuity of services to reduce medical costs, reducing non-urgent emergency department utilization, decreasing recidivism, addressing social service needs and mental health conditions, and providing access to needed medications. Figure 4.3 provides an overview of the Pre-release Program.

To date, more than 8,000 individuals have benefited from the Ohio Medicaid Pre-Release Enrollment Program, which has helped them transition from prison to the community by providing access to the services they need to stay healthy and support recovery. The work delivered by MCPs for this unique population is critical to the success of reintegrating these individuals into the community.

Member Spotlight: Lee

Lee is a 46 year-old male diagnosed with hypertension, Hepatitis C, anxiety and bipolar disorder. The Medicaid Pre-Release Program enrolled Lee prior to his release from prison. Lee participated in a teleconference meeting with his assigned MCP Care Manager who explained the transition program and the MCP’s healthcare benefits and reviewed his draft transition plan. Upon initial contact after release, Lee reported that he is working at his son’s roofing company and is working towards having his own place. He attended a scheduled PCP appointment to fill his necessary medications and scheduled a visit with a social worker. Lee has a very positive attitude and is thankful for the Medicaid Pre-release program. Lee continues to maintain employment and contact with his MCP Care Manager.

Figure 4.3 Overview of Pre-release Program

Enrollment
- Eligible inmates identified 90 to 120 days before release
- Inmate agrees to participate and apply for Medicaid

Care Planning
- Develop transition plan
- Review the transition plan in a video conference with an MCP care manager
- Schedule post-release appointments and coordinate care for identified needs

Release
- Ability to access needed health care services
- 30-day supply of medicine for those with mental health conditions
- 14-day supply of medicine for others

Care Management
- Care manager outreach within 5 days
- Integrated physical and behavioral health care
- Connect to needed social services

Improving Maternal Care and Reducing Infant Mortality

Infant mortality is defined as a child’s death within the first year of life. In Ohio, infant mortality accounts for 63 percent of all childhood deaths. In 2013, Ohio’s infant mortality rate was 7.72 infant deaths per 1,000 live births for Medicaid paid births compared to the 5.29 for non-Medicaid paid births. The infant mortality rate among African Americans was 15.45, more than twice the rate of 6.39 found in the Caucasian population.

Medicaid plays a significant role in the health care of pregnant women and children in Ohio. In 2013 and 2014, Medicaid paid for approximately 52 percent of births in Ohio, similar to national trends. As most pregnant women enroll in
managed care, MCPs are uniquely positioned to drive quality improvements. ODM has recognized the importance of managed care innovation to improve birth outcomes, reduce infant mortality and optimize health outcomes for women and their infants. Innovations in this area include both statewide collaborations and local MCP-led innovations.

**Member Spotlight: Audrey**

Audrey started using drugs at age 14. Years later, addicted and pregnant, Audrey wanted to change her life, but lacked the knowledge or resources to do so. Audrey’s parents helped her enroll in an MCP where she was offered the Addiction in Pregnancy program. This program introduced Audrey to a Care Manager who helped her connect with a Medical Home and participate in a 12 Step Recovery program. The MCP helped Audrey coordinate obstetrics, primary care and behavioral health. Audrey credits the MCP with providing the information and the resources to live independently in her first apartment and build her life with her healthy son.

ODM developed the *Enhanced Maternal Care Services* requirements effective June 1, 2016. MCPs are required to develop an enhanced maternal care services standard. ODM and MCPs partner to innovatively use data, including:

- Sharing monthly vital statistics data to aid MCPs in the timely identification of and intervention with high risk women in need of enhanced maternal care
- Geographic targeting of birth outcome improvement efforts to the areas with the highest infant mortality rates
- Integrating eligibility and MCP specific information into mobile messaging applications to improve patient engagement and connectivity to Care Management

Further information relative to Enhanced Maternal Care Services is provided in Chapter 5 – *Moving Forward*.

**Community Initiatives to Improve Maternal and Infant Care**

ODM and MCPs have also partnered to pursue a community-tailored, population-based approach to engage communities and address the health needs of pregnant women and their families. Initiatives led by MCPs to reduce infant mortality include providing care management to all pregnant women in high risk neighborhoods and working with leaders in the community to engage women in their health care. MCPs also work with community health workers (CHWs) who live in high risk neighborhoods and understand their health needs. With the ability to build stronger levels of trust and remove barriers to care, CHWs help encourage women and connect them with appropriate care.

In the FY2016-2017 budget, MCPs received an estimated $27 million to fund projects in nine communities with the highest infant mortality rates in the state. Together with ODM and local community leaders, the MCPs launched community-tailored initiatives to improve quality of care and care management for women and their babies. Figure 4.4 highlights the community projects undertaken in each county.
## Figure 4.4 County Initiatives to Improve Care for Pregnant Women and Infants

<table>
<thead>
<tr>
<th>County</th>
<th>Awarded</th>
<th>Initiatives</th>
</tr>
</thead>
</table>
| Butler County       | ~$2.5 million | - Development of new Centering Pregnancy practices to provide services for African American women.  
- Training for community health workers to reach out to high-risk pregnant women.  
- Transportation for highest-risk, low-income participants based on screening performed by community health workers and service coordinators.  
- Celebrate Fatherhood Initiative: Parenting, fatherhood classes and support system provided.  
- Health education provided by faith-based organizations. |
| Cuyahoga County     | ~$3 million  | - Resources including staff (coordinators and midwives) and medical equipment for Centering Pregnancy programs at Federally Qualified Health Centers to expand number of total participants to 375 women.  
- Capacity of home visiting programs to support approximately 800 pregnant women.  
- The Cuyahoga Fatherhood Initiative: Expand Bootcamp for Dads program to serve 600 fathers in the community. |
| Franklin County     | ~$2.3 million | - HandsOn Central Ohio: Hiring a resource specialist to provide resource support for community health workers.  
- StepOne: Care coordination services to link women to prenatal care after initial health screenings, also provide support for scheduling appointments transportation coordination, appointment reminders, and follow-ups.  
- Moms2B: Community health education on prenatal care and first-year-of-life in different neighborhoods.  
- Centering Pregnancy programs: Serve women in high-risk neighborhoods to provide assessments, education, and support.  
- Maternal and Infant Recovery Clinic: Provide additional prenatal support and programs for pregnant women with addictions. |
| Hamilton County     | ~$2.8 million | - Centralize intake for families and support the United Way 211 line, advertising, marketing, and navigators.  
- Hiring of 18 community health worker and 6 home visitors to reach pregnant women.  
- Health Care Access Now: Serve as the community hub for referral distribution of clients from the centralized intake.  
- Assistance in obtaining continuing education credits for community health workers and home visitors.  
- Center for Closing the Health Gap: Recruit and train 14 community wellness coaches to help communities build a culture of health and collaborations to deliver education and interventions on infant mortality. |
| Lucas County        | ~$3.2 million | - Care coordination agency training for 12 full-time community health workers.  
- Training for community health clinics, emergency departments, pediatric practices, and schools to implement assessments and referrals. Also hire a coordinator to assign referrals to appropriate community health workers or resources.  
- Hiring of a project coordinator to perform outreach and community awareness.  
- Hiring 2 mental health counselors. |
| Mahoning County     | ~$2.4 million | - Hiring of 2 community health workers.  
- Training centering facilitators and establishing Centering Pregnancy Programs at 2 new sites.  
- Adding 2 care coordination agencies and 4 community health workers.  
- Transportation services for pregnant and parenting women. |
| Montgomery County   | ~$1.7 million | - Increasing home visits for pregnant women.  
- Enhancing services provided by programs to include no-cost child care and transportation during appointments.  
- Five Rivers Health Center Healthy Start Program: Extend to all patients and focus on highest risk communities.  
- Screening, Brief Interventions, and Referral to Treatment (SBIRT) trainings provided at no charge for health care providers, community health workers, home visiting nurses, social workers, and others who work with pregnant women in these communities.  
- Expand Nurturing Parent Program to high-risk communities.  
- Referring prenatal patients to housing counselors based on housing need assessments by physician offices and social service agencies.  
- Fatherhood program initiative to provide education to fathers to-be in the communities.  
- Support groups for both pregnant women and their significant others.  
- Ministry leadership training to identify women at-risk and promote programs and services for mental health and overall well-being. |
| Stark County        | ~$3 million  | - Perform intake, assessment, and care for pregnant women in high-risk communities through a partnership with HUB and care coordinating agencies.  
- Recruit 9 community health workers to support at-risk pregnant women for a healthy pregnancy and child.  
- Provide on-site child care at Centering Pregnancy programs (both currently established and newly created).  
- Employ a full-time fatherhood coordinator to work with expecting and young fathers and provide resources on parenting/family strategies and responsibilities.  
- Assist faith-based organizations, grassroots agencies and community groups to create awareness of infant mortality and assist residents find resources.  
- Expand or implement new home visiting programs focusing on at-risk pregnant women. |
Ohio MCPs have designed and implemented strategies that connect women with the necessary services, including patient-centered medical homes and community resources and lead outreach that systematically addresses modifiable risk factors that drive measurable improvements in birth outcomes over the next two years. In addition, MCPs actively participate directly in existing organized infant mortality/preterm birth prevention efforts, such as ODM-endorsed Improvement Projects (e.g., Progesterone and Post-Partum Care) and community-based efforts (e.g., Ohio Equity Institute communities, Cradle Cincinnati, CelebrateOne). Preterm birth prevention strategies include eliminating payment for any planned delivery prior to the 39 gestational weeks unless medically necessary, and providing 17P (progesterone) injections to women who have prior preterm births.

MCPs assist members in arranging for timely receipt of evidence-based services, removing barriers to care (e.g., transportation, addressing social/safety aspects to care), establishing communication pathways across systems, and sharing data with/between providers.

Figure 4.5 provides a sample of MCP programs and results related to pregnant women and infants.
Figure 4.5 MCP Programs and Results Related to Pregnant Woman and Infants

**UnitedHealthcare Incentivizes Pregnant Members**
- UnitedHealthcare members can earn up to 8 great rewards with the Baby Blocks program. Baby Blocks rewards women for visiting their doctor or reporting information online about their pregnancy and their baby’s first 15 months of life. When they join Baby Blocks, members receive rewards such as a gift card or a diaper bag. If the member stays with the program after the baby is born, they can earn more Baby Blocks rewards. Baby Blocks focuses on improving maternity health, controlling costs, and ensuring babies are given the best possible start in life.

**Buckeye’s Addiction in Pregnancy Program Offers Intensive Case Management**
- Buckeye identifies and engages pregnant women struggling with addiction and offers intensive care management to help moms deliver and then raise healthy babies. Members with a current or previous history of substance abuse are invited to join the program. The program helps eliminate fragmentation in the care delivery system, establishes rapport and builds trust to engage the member in treatment, and provides support to maintain adherence with treatment. In two years, the Addiction in Pregnancy Program reduced the average length of stay in special care and intensive care nurseries from 13 days to 7.5 for babies suffering from neonatal abstinence syndrome. Buckeye member Audrey benefitted from the program. Her story can be found in a Member Spotlight in Chapter 4.

**CareSource’s Free Mobile Phone Application Engages Pregnant Women**
- Care4Moms gives expectant mothers a place to learn about their pregnancy, select an OB-GYN, connect to the 24-hour nurse advice line and participate in fun features and tools. After members answer a few easy questions, the Care4Moms app turns into an individualized tool that helps guide them to a healthy pregnancy. Our fun features allow members to track the development of their baby by learning about specific pregnancy milestones, learn about factors that would potentially increase their risk of a pregnancy complication, learn about different pregnancy topics like pre-term birth, breastfeeding, nutrition, and complete weekly items to help with planning to bring their baby home.

**Paramount’s Infant Mortality Steering Committee**
- Paramount’s collaboration with ProMedica is a community collaborative designed to identify and implement strategies to keep more babies alive through their first year of life. Through the collaboration, a system for referrals of pregnant women was implemented, followed by a lifestyle assessment and care coordination for high risk moms. The Pregnancy Lifestyle Assessment tool was created to support providers to enable high-risk, low income patients access to appropriate resources and includes evidenced-based questions related to preterm birth risk, food insecurity, depression, drugs, alcohol, smoking and other risks that contribute to infant mortality. In the Toledo metro area, Paramount’s Infant Mortality Steering Committee resulted in a 57 percent decrease in preterm births and a 73 percent decrease in low-birth-weight babies, with expectations that these leading indicators will result in reduced infant mortality.

**Molina’s Partnership with ODM Helps Prevent Preterm Births**
- ODM rolled out the Progesterone Performance Improvement Project (PIP) in late 2014 with the initial focus on timely initiation of Progesterone to prevent preterm birth. Through multiple strategies, Molina’s pregnant members gained an average of 4.5 weeks of pregnancy compared to the member’s most recent preterm delivery. Molina’s efforts yielded an average projected savings per member of about $74,397 from avoiding NICU admission costs.
Reducing Tobacco Use

Ohio’s adult tobacco use rate is 23.4 percent, higher than the national average of 18.1 percent. MCPs have taken to task to educate members on the harmful impact of smoking and supporting their efforts to quit or reduce their tobacco use.

Because smoking during pregnancy contributes to low-birth weight babies and preterm births, Ohio funded two standardized tobacco cessation tool kits, one for quitting and one for staying tobacco free. The MCPs work with providers, and health centers promote these tools to pregnant women. Each MCP has a healthy pregnancy program that provides care management, education and resources to support the achievement of a healthy, full-term infant at delivery.

MCPs also support the goal of reducing tobacco use through disease management programs and by holding physicians accountable for providing smoking cessation recommendations (i.e. quality metrics).

Population Health Planning

Improvements to population health planning include the creation of community partnerships to effectively meet public health needs. Community partnerships provide valuable resources to help improve chronic conditions and other health issues that impact specific populations and as result can help foster stronger relationships between MCPs and their members. MCPs also partner with primary care providers to provide resources in the community.

Innovation Showcase: Food for Thought and Sesame Street Get Moving

MCPs work with community partners to build healthier communities, such as a partnership with Sesame Workshop to develop Food for Thought, a bilingual (English and Spanish) initiative that helps families make food choices that are affordable, nutritional and set the foundation for lifelong healthy habits. One MCP combined the program with Sesame Street Get Moving, which gives users with easy-to-do activities that get young children moving, both at home or outside. Both programs offer tips and strategies that are easy to implement.

The MCP’s Food for Thought educational sessions have been held at community and faith-based events, and more recently the plan partnered with the Ohio State Extension Services, the Ohio Child Care Resource and Referral Agency, and Children’s Hunger Alliance to distribute over 5,000 Food for Thought and Sesame Street Get Moving Kits. The plan distributed nearly 3,000 Food for Thought and Get Moving Kits to nearly 800 family-based child care providers in the Children’s Hunger Alliance statewide network.

Summary

We often hear that the Medicaid program is broken and needs fixing. However, over the last few years we have seen better outcomes and value in Ohio Medicaid managed care’s delivery of services. Under a single payer system like traditional FFS Medicaid, the state faced barriers in driving change and innovation. The first major barrier was that the FFS system itself encourages inefficient service delivery by paying for every test and procedure. The second barrier was the inability of FFS to use Medicaid dollars in a person-centered manner. In a managed care platform, Medicaid dollars can be used to pay for services not considered as a Medicaid benefit to positively impact the health of members and lower costs for the program, such as paying for transportation to medical appointments, therapy dog visits for persons with mental health or physical disabilities, or buying an air conditioner for an asthmatic to prevent harm. This flexibility promotes more effective and efficient personalized health care and leads to less dependency on more expensive and disruptive medical interventions.

As noted in this chapter, the Ohio MCPs in partnership with ODM have launched a number of innovations to address particular population health issues like infant mortality and opioid abuse. Moving forward, there will be an ongoing focus on innovations to improve prevention and population health that will drive down health care expenditures for years to come.
Ohio has made great progress in controlling Medicaid costs and improving the quality of health care for Ohioans, largely due to the partnerships and innovations made possible through managed care.

Moving forward, Ohio will build on its successes by:

- Adding vulnerable populations and additional services such as behavioral health to managed care
- Implementing new requirements, including comprehensive contract requirements for managed care and provider partnerships
- Expanding initiatives that pay for value to align payment with improved outcomes
As Ohio moves forward with strategic initiatives to improve quality of care and population health, lower costs and streamline administration, Medicaid managed care plans (MCPs) will continue to be a valuable partner for the state. MCPs will build on their successes by:

- Serving additional populations
- Providing additional services
- Implementing new requirements, including comprehensive contract requirements for managed care and provider partnerships
- Expanding value-based purchasing strategies

**New Populations in Medicaid Managed Care**

The success of Medicaid managed care has led to additional populations accessing their benefits through Ohio’s MCPs. In January 2017, new populations entering Medicaid managed care include:

- Individuals enrolled in the Bureau for Children with Medical Handicaps (BCMH)
- Children in custody
- Children receiving adoption assistance
- Breast and Cervical Cancer program recipients
- Individuals enrolled in Developmental Disability (DD) waivers who can voluntarily enroll in Medicaid managed care

Each of these populations were previously covered by traditional FFS Medicaid. The transition to managed care will allow them to take advantage of the innovations that MCPs (in partnership with ODM) has delivered while simultaneously offering additional budget stability for the state. These individuals will have access to services offered through managed care that are not available in FFS, such as:

- Dedicated points of contact for members through a toll-free member services call center and a 24-hour toll-free nurse advice line
- Expanded access to care and provider networks
- Care management and care coordination for members with complex conditions
- Health and wellness programs to optimize health status

Further, each MCP offers a selection of value-added services that provide tremendous value to members. A larger list is included in Chapter 1:

- Wellness and disease management incentive programs (e.g. a member can earn rewards for being active in their health care)
- Enhanced dental and vision benefits
- Pregnancy and prenatal programs
- Additional transportation benefits
Adding Services to Managed Care

Behavioral Health

Ohio has long recognized the need to provide better care coordination for persons with serious and persistent mental health illnesses (SPMI). Individuals with SPMI often have co-occurring chronic medical disorders and complex health needs that necessitate a holistic and coordinated approach to care. While the state piloted a program to better coordinate care for Medicaid adults with SPMI and children with Serious Emotional Disturbances (SED), the results showed that members in most need were difficult to reach and manage.

The need for a global approach to physical and behavioral health integration is recognized by the state, stakeholders and federal policy makers alike. In a report issued in 2015 by the Government Accountability Office, data showed that over half of the costliest Medicaid enrollees had a co-occurring mental health condition. Studies show that mental health drives health utilization, and often members with co-occurring mental health conditions have low quality ratings and have the greatest health care needs. Over the past year, MCPs have been collaborating with the state, providers and stakeholders to ensure a smooth transition of services and identify opportunities and initiatives to address members’ health care needs. Through this initiative, MCPs will leverage their existing care coordination models and look for opportunities to enhance the member experience and better manage both member’s physical and behavioral health care needs under a single consolidated model that will provide the majority of behavioral health services. MCPs will collaborate and coordinate care with community partners that have historically provided specialized mental health services to ensure comprehensive care is provided to members and coordinate with the member’s designated medical home.

Institutions of Mental Disease (IMD)

The State of Ohio is working on a plan to enable access to inpatient care in an IMD for adult members with behavioral health and substance abuse disorders. New federal rules on Medicaid managed care released in 2016 are being leveraged to allow for a short-term stay in IMD for adult members in need of this level of care.

Achieving the ultimate goal of including all behavioral health services in managed care will result in more comprehensive care management through enhanced access to information when a member is admitted to a hospital or facility, allowing for improved transition services. It will also enhance coordination of pharmacy benefits across places of service ensuring improved costs and outcomes. The inclusion of behavioral health services into managed care also aligns with the mental health parity law which went into effect in 2009 and requires mental health (or behavioral health) and substance abuse services to be provided on “parity” or in a manner equal to the provision of medical services. Further, as medical

### Innovation Showcase: Supporting Successful Transition Planning for Children in Custody

Transitioning successfully from foster care to independent living is a daunting challenge faced by thousands of young adults each day, many whom lack critical skills needed for the realities of adult life. One MCP developed an interactive website after conversations with foster youth, foster parents and experts. This website allows young adults to learn and engage with peers and are rewarded with virtual points, badges and messages of encouragement as they progress through the following life tracks:

- Money: Budget and learn about money and taxes
- Housing: Understand and compare housing options
- Work: Create a resume and learn interview tips
- Education: Determine next steps after high school
- Health: Learn important health information and answers to common health questions
- Transportation: Navigate options to get around

### Adding Services to Managed Care

Behavioral Health

Ohio has long recognized the need to provide better care coordination for persons with serious and persistent mental health illnesses (SPMI). Individuals with SPMI often have co-occurring chronic medical disorders and complex health needs that necessitate a holistic and coordinated approach to care. While the state piloted a program to better coordinate care for Medicaid adults with SPMI and children with Serious Emotional Disturbances (SED), the results showed that members in most need were difficult to reach and manage.

The need for a global approach to physical and behavioral health integration is recognized by the state, stakeholders and federal policy makers alike. In a report issued in 2015 by the Government Accountability Office, data showed that over half of the costliest Medicaid enrollees had a co-occurring mental health condition. Studies show that mental health drives health utilization, and often members with co-occurring mental health conditions have low quality ratings and have the greatest health care needs. Over the past year, MCPs have been collaborating with the state, providers and stakeholders to ensure a smooth transition of services and identify opportunities and initiatives to address members’ health care needs. Through this initiative, MCPs will leverage their existing care coordination models and look for opportunities to enhance the member experience and better manage both member’s physical and behavioral health care needs under a single consolidated model that will provide the majority of behavioral health services. MCPs will collaborate and coordinate care with community partners that have historically provided specialized mental health services to ensure comprehensive care is provided to members and coordinate with the member’s designated medical home.

Institutions of Mental Disease (IMD)

The State of Ohio is working on a plan to enable access to inpatient care in an IMD for adult members with behavioral health and substance abuse disorders. New federal rules on Medicaid managed care released in 2016 are being leveraged to allow for a short-term stay in IMD for adult members in need of this level of care.

Achieving the ultimate goal of including all behavioral health services in managed care will result in more comprehensive care management through enhanced access to information when a member is admitted to a hospital or facility, allowing for improved transition services. It will also enhance coordination of pharmacy benefits across places of service ensuring improved costs and outcomes. The inclusion of behavioral health services into managed care also aligns with the mental health parity law which went into effect in 2009 and requires mental health (or behavioral health) and substance abuse services to be provided on “parity” or in a manner equal to the provision of medical services. Further, as medical
homes and health homes have become functional, awareness of the importance of mental health and medical health integration to the overall care of the Medicaid member has increased. Behavioral health comorbidities form strong determinants of a member’s ability to self-manage and their adherence to a medical plan of care. Inclusion of behavioral health services into managed care ensures that holistic care is afforded to members through comprehensive coordination of health care that addresses the mind and body.

Telehealth and Telemedicine

Telehealth and telemedicine are areas of interest for future development. Telemedicine is the delivery of health care services to members using technology to overcome barriers in geographic access. Telehealth tends to reference a larger category of services including remote monitoring of chronic conditions and remote connectivity to other services such as care management. Telehealth and telemedicine hold potential promise for Ohio members to receive services that would otherwise be unavailable due to lack of provider availability or transportation.

Current barriers to the broad use of telemedicine include limitations in provider prescribing rules and the absence of established payment mechanisms for telemedicine and telehealth services as well as availability of telemedicine technology. Moving forward, Ohio is collaborating with the Ohio State Medical Board to work through current rules that limit prescribing by physicians who have not physically examined the patient.

The issues are complex and center around balancing patient access to services with risks to patient safety. MCPs are engaged in these issues and are collaborating with ODM to establish expectations and rules around compensation for telemedicine and telehealth services.

MyCare Ohio

Engagement has been high in the MyCare Ohio demonstration, with a monthly enrollment of around 97,500 members. However, the demonstration project is limited to selected counties. Ohio MCPs are excited about the opportunity to build on the pilot’s success and expand the program statewide. More information on the MyCare demonstration is referenced in Chapter 1—A History of Medicaid Managed Care in Ohio.

Implementing New Requirements

Medicaid managed care plans in Ohio are held to the requirements set forth in the contract with ODM as well as the rules established in Ohio Administrative Code Chapter 5160-26. ODM revises the contract with the MCPs bi-annually. These requirements aim to monitor and drive quality and in turn lower costs.

Care Management/Care Coordination: The rules provide a comprehensive list of care management activities including utilization management and the ability to identify and stratify populations based on risk and cost of care. Care coordination requirements specify that each member must be assigned a primary care provider (PCP) and defines the role of the PCP within the MCP’s network. The rule stipulates triage requirements that define how quickly a Medicaid member must be seen by the PCP.

1. Members with emergency care needs must be triaged and treated immediately on presentation at the PCP site

Member Spotlight: Ron, a MyCare Ohio Member

Ron was experiencing debilitating health challenges, including depression, eyesight difficulty, and foot problems. He also needed new glasses and hearing aids. While he was regularly going to a local hospital for help with his health problems, at one time, Ron was on the brink of suicide.

When he became a member of a MCP, his Care Manager, Christy, became his main point of contact. She coordinated with Ron, his doctors and specialists to make sure Ron’s needs were met. In addition, Christy helped Ron move into a facility that offered assisted living — a better living solution for him that provided a high level of independence.

Ron took responsibility for his health care with help from his Care Manager. With the services offered by his MCP, he has reported that he is content and improving his health.
2. Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site.

3. Members with requests for routine care must be seen within six weeks.

The rule also stipulates the requirements for primary care providers’ accountability for care coordination.

1. Assist with coordination of the member’s overall care, as appropriate for the member.
2. Serve as the ongoing source of primary and preventive care.
3. Recommend referrals to specialists, as required.
4. Triage members per the access standards.
5. Participate in the development of care plans.
6. Notify the MCP of members who may benefit from care management.

The MCPs are required to have a care management system in which there is 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 appropriate to their needs.

These rules underscore the importance of care coordination for the future of Ohio Medicaid. MCPs have extensive experience in care management and coordination.

**Evidence-Based Practice Guidelines:** In keeping with Ohio’s desire to implement evidence-based practice standards and to improve outcomes, the Administrative Rule requires that MCPs must adopt practice guidelines and disseminate the guidelines to all affected providers and upon request to members and pending members. These guidelines must:

1. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
2. Consider the needs of the MCP’s members.
3. Be adopted in consultation with contracting health care professionals.
4. Be reviewed and updated periodically, as appropriate.

The MCPs must then establish ongoing venues for updating the guidelines with evolving medical evidence and communicating the results to their provider networks. MCPs are currently preparing to implement these guidelines.

**Moving to Value-Based Purchasing**

Moving forward, Ohio intends to focus on refining payment initiatives that result in better value for the healthcare dollar. Ohio’s pay for value strategy is built around two initiatives: the advancement of comprehensive primary care (CPC) and episodes of care payment, both of which require strong partnerships with MCPs. These two initiatives are discussed at greater length in the Innovations chapter. ODM envisions growing their pay for value initiatives which will result in MCPs and providers taking greater accountability for the outcomes of care. By 2020 at least 50 percent of the plans’ provider contracts must be value-based. Figure 5.1 shows the current status of MCPs’ value-based purchasing arrangements.
Opportunities and Challenges

CPC and episodes of care will increase the amount of spending under value-based purchasing arrangements. However, some challenges will remain. Providers must be willing to accept increasing risk and many providers are reluctant to assume downside risk. Provider reluctance can be attributed to a variety of reasons, some of which are:

- The administrative burden required to implement such arrangements. The value-based purchasing arrangements can vary by payer or even within payer or by population.
- A certain size is necessary to be an incentive to providers. Providers need a certain panel size to effectively manage risk.
- Concerns about costs that may be attributable to them, but not in their control.
- Challenges with access to timely, accurate data to manage risks and opportunities.
- Member attribution since members may still see multiple providers.

There are opportunities to further support the transition to value-based purchasing arrangements. A centralized claims data base would provide a significant boon to the system. Ohio does not currently have a data warehouse or repository to aggregate Medicaid claims and encounter data across health plans, providers, and populations. A centralized repository coupled with analytic services would assist Ohio in paying for value by providing a comprehensive view of health plan and provider performance on VBP metrics, informing areas for improvement at the practice level, and providing evidence with which to negotiate with plans for the purposes of paying for value.

Further support relative to the electronic exchange of medical records could strengthen the critical, meaningful exchange of data to assist health plans and provider practices on achieving value-based purchasing and quality goals. The lack of standardization in data is a barrier for its timely exchange.
Maintaining the Ability to Innovate

Managed care cultivates an environment of innovation that is not possible under FFS. Ohio’s MCPs have a track record of innovation through their partnership with ODM to enhance the health status of Ohioans and bring down the total cost of care. The future health of Ohio depends on the ongoing innovations in health care delivery as well as payment innovations that align with the incentives of Ohio stakeholders. It will be important to consider avoiding future legislation and policy changes that would limit the MCPs’ ability to innovate and work creatively in the areas of payment reform and health care delivery improvements.

Expansion of Managed Care

In the short term, the State of Ohio will be expanding the population that will be served by managed care to include individuals enrolled in the Bureau for Children with Medical Handicaps (BCMH), children in state conservatorship, children receiving adoption assistance, and Breast and Cervical Cancer program recipients.

Individuals who are eligible for the DD waiver may also voluntarily enroll in managed care beginning in January 2017. This initiative will serve to better integrate and coordinate care for medically complex populations and better manage cost. As the state moves forward with implementation of this initiative, it is imperative that the regulatory environment and federal and state Medicaid policies are aligned to support key managed care principles.

Integration of Behavioral Health

Beginning in 2018, Ohio will integrate behavioral health services into managed care. This is a critical and important step to achieving physical and behavioral health integration and improving outcomes. Through this initiative, adult members can receive services in health care settings not otherwise covered in FFS due to federal restrictions. All members can receive greater coordination and supports for transition planning to ensure access to timely follow-up care, subsequent to a hospital admission. This initiative also provides a great opportunity for care coordinators to work with members to ensure that supports are available to assist with medication adherence and access to care.

Long-Term Care Services and Supports

Further service integration within managed care will reduce Ohio Medicaid costs and increase quality. There is a large body of evidence showing that individuals fare better when their physical, behavioral health and LTSS are coordinated in a single delivery system. In the future, consideration should be given to the inclusion of Home and Community Based Services (HCBS), currently provided to waiver populations, to achieve comprehensive integration of care. The addition of these benefits in managed care could greatly increase coordination of care as seen in the MyCare Ohio initiative. By having all benefits administered by a single managed care plan, members are able to receive all their healthcare and support needs through one individualized plan of care.

Administrative Simplification

While Medicaid is a complex program, those complexities should not translate into administrative burdens for providers, consumers and health plans. Over the last several years, regulation has increased tremendously in the MCP regulatory environment. Although some of the new regulations have been welcomed, some may have unintended consequences. What makes the MCP model effective is its ability to move from the heavily controlled federal Medicaid rules to provide benefits and services that recognize the needs and personal choices of the consumer. The State of 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.
Health Care Transformation

Finally, the ability to innovate is critical to providing the best services to Medicaid members while simultaneously being responsible partners with the Ohio Medicaid program. Ohio’s MCPs have a track record of innovation and partnership with ODM to enhance the health status of Ohioans and reduce the total cost of care. Ohio’s health plans continue to test, develop, and implement programs and payment modalities with the goal of enhancing care, increasing access and accountability, improving health outcomes and paying for quality. It will be important in considering future legislation to avoid policy changes that would have the effect of limiting the MCPs’ ability to innovate and be creative in the areas of payment reform and health care delivery improvements.

Moving forward, it will be paramount for the health plans, stakeholders, and state leadership to continue to work together on opportunities to redesign the system. They should seek opportunities to leverage the flexibility made available through the newly adopted managed care regulations by the Centers for Medicare and Medicaid, and to identify opportunities to address health care shortages through technology or other innovations, while working collaboratively to address any limitations in state policy or rule.

Ongoing efforts are needed to simplify processes for members and providers, but these efforts should not stifle the health plans’ ability to create marketplace competition that is needed to continue to drive innovation. While necessary to manage costs, MCPs recognize the need to streamline and simplify these requirements for both providers and members by applying best practices. In order to further innovate the delivery system using population health-based strategies, more work is needed to better understand, measure, and assess the social determinants of health of members. To enhance payment innovations, MCPs and ODM will further align incentives around cost and quality and implement more evidence-based standards to help decrease the variation in care provided, offer better patient experience, and improve outcomes of care for Ohioans across the state.
End Notes

Executive Summary

1 http://healthinsuranceratings.ncqa.org/2016/search/Medicaid

Chapter 1 | History of Managed Medicaid in Ohio

1 Source: Ohio Medicaid (2013); 2015 Executive Budget as proposed. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=LQXG6TYOk9w%3d&tabid=136

2 Eligibility and Enrollment Tables. http://www.medicaid.ohio.gov/RESOURCES/ReportsandResearch/MedicaidManagedCarePlanEnrollmentReports.aspx#1465550-2016-monthly-enrollment


4 Managed Medicaid Eligibility. http://www.medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/MedicaidManagedCareEligibility.pdf

Chapter 2 | Managing Medicaid’s Impact on Cost

1 According to the Kaiser Family Foundation, the Ohio Federal Medical Assistance Percentages were 63.58% in 2013, 63.02% in 2014, and 62.64% 2015.

2 During the 2008-2015 rating periods the assumed annual trend used in setting the Ohio Medicaid capitation rates was generally lower than the trend rates we would expect to see in an unmanaged FFS population. We believe that it is reasonable, and possibly conservative, to assume that annual FFS trends would be 0.5% higher.

3 Each capitation rate development used historical Encounter and/or FFS data from earlier periods. Appendix C summarizes the historical data underlying each capitation rating period relevant to this analysis. CY 2011 is not included as it was not used as base experience in the development of subsequent rates.

4 Wakely was able to obtain rating documentation beginning with the CY 2008 rating period. We were not able to obtain the rate development for the 2006 and 2007 rating periods.

5 We did not consider the impact of potential matching federal dollars on premium or other taxes, assuming that similar taxes could be levied on providers under the FFS program (and vice versa).

6 We included the same MCP/Hospital Incentive PMPMs for all baseline FFS cost estimates as were included in the managed Medicaid program. This assumes that these costs represented provider funding that would also have been included in a FFS environment.

7 The 0.5% trend differential was assumed to have been achieved starting with CY 2008 for CFC non-delivery, CY 2009 for ABD 21+, July 2013 for ABD <21, and CY 2014 for Extension non-delivery (i.e. for CY 2013 savings the 0.5% annual trend differential was compounded for 6 years for CFC non-delivery). No trend differential was assumed for the Delivery rates.

8 As calculated by the state actuary.
Chapter 3 | Managing Medicaid’s Impact on Quality

1 http://medicaid.ohio.gov/Portals/0/Resources/Reports/ModernizeHospPmt/MCP-PPR.pdf
Appendix
January 20, 2017

Miranda Motter
President and CEO
Ohio Association of Health Plans
230 East Town Street, Suite 200
Columbus, OH 43215

Ohio Medicaid Managed Care Savings Analysis – January 2013 through December 2015

Dear Miranda:

Wakely Consulting Group, Inc. (Wakely) has been retained by the Ohio Association of Health Plans (OAHP) to assist in an evaluation of the programmatic savings that the Managed Care Plans (MCPs) achieved for the State of Ohio’s Managed Medicaid program under oversight by the Ohio Department of Medicaid (ODM) during the Calendar Years (CY) 2013 through 2015. The original January 2013 capitation rates were adjusted in July 2013. The CY 2014 and CY 2015 rates were not adjusted during the course of their respective years. We have accounted for the July 2013 rating changes in our estimates for the CY 2013 period. This report includes a comparison of capitation rates for members enrolled with participating MCPs to estimated costs if those same members were enrolled in the State of Ohio’s Fee for Service (FFS) program.

Wakely relied on data provided by each of the MCPs as well as capitation rates and rating documentation from ODM in performing this analysis. We relied on the accuracy of this documentation and the assumptions imbedded in the rate development. If those assumptions differ from actual experience, then our estimates will be affected. Actual results will likely vary from our estimates. This report was prepared to assist OAHP in estimating savings achieved by MCPs participating in the Ohio Managed Medicaid program during Calendar Years 2013 through 2015, and satisfies Actuarial Standard of Practice 41 reporting requirements. Other uses may be inappropriate.

We understand this report may be shared with outside parties. When it is shared, it should be shared in its entirety. This document and the supporting exhibits/files constitute the entirety of the report and supersede any previous communications on the project. Wakely does not intend to create a reliance by outside parties receiving this report. Outside parties receiving this report should retain their own qualified experts in interpreting the results. It is the responsibility of the organizations receiving this report to review the assumptions carefully and notify Wakely of any potential concerns.

Executive Summary

This report compares MCP capitation rates to estimated costs for those same members if they had been covered by traditional FFS Medicaid. MCPs achieve programmatic savings by promoting efficient use of the health care system and eliminating wasteful or inefficient spending by placing an
emphasis on preventative care, managing chronic patients, and detecting and treating serious illnesses early.

In states where recent FFS data is used to set managed care rates, the comparison of estimated FFS costs to MCP capitation rates is relatively straightforward. When plan encounter data is the primary data source, it is more difficult to develop comparable FFS cost estimates. While this exercise necessarily incorporates review of older FFS experience, it uses all of the available information and, in our opinion, is reasonable and actuarially sound. The estimates in this report include all MCP dollars associated with the Medicaid program, except those associated with the MyCare dual-eligible demonstration program, inclusive of both state and federal funding components.

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

The low end of the estimated range assumes that the trend assumptions used by the state’s actuaries in the capitation rate development are representative of FFS trends, and the high end assumes that annual FFS trends would have been 0.5% higher than the state actuaries’ trend assumptions.

The following table shows additional detail regarding the range above:

<table>
<thead>
<tr>
<th>Table 1 – Estimated Savings Relative to Fee For Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on no assumed trend differential CY 2013 – CY 2015</td>
</tr>
<tr>
<td>Estimated FFS Costs</td>
</tr>
<tr>
<td>Calculated MCO Revenue [1]</td>
</tr>
<tr>
<td>Total Dollars Saved</td>
</tr>
<tr>
<td>Total Percentage Saved</td>
</tr>
</tbody>
</table>

Based on 0.5% annual trend differential CY 2013 – CY 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 (HIC) tax and Sales and Use tax.

Definitions and Programmatic History

The following definitions and information may be helpful in understanding the various assumptions and methodology used in our analysis:

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1 According to the Kaiser Family Foundation, the Ohio Federal Medical Assistance Percentages were 63.58% in 2013, 63.02% in 2014, and 62.64% 2015.

2 During the 2008-2015 rating periods the assumed annual trend used in setting the Ohio Medicaid capitation rates was generally lower than the trend rates we would expect to see in an unmanaged FFS population. We believe that it is reasonable, and possibly conservative, to assume that annual FFS trends would be 0.5% higher.
Capitation rates – Capitation rates are the monthly payments made to each MCP for Medicaid enrollees. They are published by the state’s actuary and vary by rate cell and geographic region. We have not risk adjusted plan-level capitation rates, as the composite risk level across all plans is 1.0.

Fee for Service Administrative Costs – We have assumed that ODM administrative costs to operate the FFS program are 2% higher than ODM administrative costs to operate the managed care program. This assumption is consistent with assumptions used in other states. Therefore, our savings estimates are approximately 2% higher than they would be otherwise in recognition of decreased state administrative costs for the managed care program.

Managed care has a long history in Ohio’s Medicaid program. A review of the rate setting methodology from historical rating periods was necessary as the actuarial assumptions used to set those rates include the managed care savings necessary for MCPs to achieve targeted financial performance. To develop comparable FFS cost estimates for CY 2013 through 2015, we used rate setting information underlying the CY 2008 through CY 2010 and CY 2012 through CY 2015 capitation rates.

From CY 2006 through CY 2008 the state of Ohio transitioned the majority of the Covered Families and Children (CFC) and Aged, Blind and Disabled (ABD) 21+ populations into the managed Medicaid program. As a result, the CY 2008 through CY 2010 rate developments for these populations relied on a blend of FFS, Encounter, and Cost Report base data. The following tables illustrate the transition from FFS base data to encounter and cost report base data that occurred from CY 2008 through CY 2010 for each population.

### Table 2 – CFC FFS, Encounter, and Cost Report Data Weight by Rating Period

<table>
<thead>
<tr>
<th>Rating Period</th>
<th>FFS Data Weight</th>
<th>Encounter Data Weight</th>
<th>Cost Report Data Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2008</td>
<td>14.5% to 100%*</td>
<td>0% to 42.75%*</td>
<td>0% to 42.75%*</td>
</tr>
<tr>
<td>CY 2009</td>
<td>10.8% to 29.4%*</td>
<td>35.3% to 44.6%*</td>
<td>35.3% to 44.6%*</td>
</tr>
<tr>
<td>CY 2010</td>
<td>0%</td>
<td>60%</td>
<td>40%</td>
</tr>
</tbody>
</table>

*The weights applied to the FFS, Encounter, and Cost Report components vary by region

### Table 3 – ABD 21+ FFS, Encounter, and Cost Report Data Weight by Rating Period

<table>
<thead>
<tr>
<th>Rating Period</th>
<th>FFS Data Weight</th>
<th>Encounter Data Weight</th>
<th>Cost Report Data Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2008</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>CY 2009</td>
<td>34.6% to 100%*</td>
<td>0% to 32.7%*</td>
<td>0% to 32.7%*</td>
</tr>
<tr>
<td>CY 2010</td>
<td>0% to 55.6%*</td>
<td>44.4% to 60%*</td>
<td>0% to 40%*</td>
</tr>
</tbody>
</table>

*The weights applied to the FFS, Encounter, and Cost Report components vary by region

The pharmacy benefit was carved-out of the managed Medicaid program for CY 2010 and thus was not included in the rate development for that period. Pharmacy was again included as a managed

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3 Each capitation rate development used historical Encounter and/or FFS data from earlier periods. Appendix C summarizes the historical data underlying each capitation rating period relevant to this analysis. CY 2011 is not included as it was not used as base experience in the development of subsequent rates.

4 Wakely was able to obtain rating documentation beginning with the CY 2008 rating period. We were not able to obtain the rate development for the 2006 and 2007 rating periods.
care benefit for the CY 2012 and CY 2013 rating periods. The prospective development of pharmacy costs for CY 2012 and CY 2013 were based on one month of managed care data (January 2010) and eleven months of FFS data (February through December 2010). During that time, non-pharmacy rates were developed using a blend of managed care Encounter and Cost Report data. Pharmacy and non-pharmacy components of the CY 2014 and CY 2015 CFC and ABD 21+ capitation rates were based exclusively on managed care data from CY 2012 and CY 2013, respectively.

Beginning July 2013 Ohio expanded the managed Medicaid program to include the ABD <21 population. A blend of CY 2009 and CY 2010 FFS base data was used to set the July 2013 rates for this population. CY 2012 FFS base data was used to develop ABD <21 capitation rates for CY 2014 and CY 2015.

Effective January 2014 Ohio again expanded its managed Medicaid program to cover the ACA Extension population. Since no historical experience previously existed for this population, both the CY 2014 and CY 2015 rates were developed based on a blend of ABD adult and CFC adult managed care experience.

Methodology, Assumptions, and Results

Wakely estimated savings produced by the MCPs by comparing capitation payments from ODM for the managed Medicaid populations to estimated costs for those same populations if they had been enrolled in the FFS program. In developing these estimates, we performed the following steps:
### Table 4 - Overview of Savings Estimate Methodology

**Calculate managed Medicaid program costs (A)**

**Step 1:** Determine aggregate capitation payments made to participating MCPs during the CY 2013, CY 2014 and CY 2015 rating periods. This step consisted of multiplying total managed Medicaid monthly enrollment by the published capitation rates for each region and rate cell. The capitation rates used in this analysis excluded the Health Insuring Corporation (HIC) tax and the Sales and Use tax, as taxes represent offsetting cost and revenue items for the managed Medicaid program.

**Estimate FFS costs for managed Medicaid enrollees (B)**

**Step 2:** Determine estimated baseline FFS costs by rate cell. Due to the current reliance on the encounter data for the ABD 21+ and CFC populations, comparative FFS data is no longer available. Historical FFS to managed care cost differentials were assumed to continue going forward. This includes adjusting implied FFS costs to remove the impact of MCP savings, MCP administrative costs, and taxes.

**Step 3:** Compare the composite MCP medical loss ratios for the historical periods to the loss ratios originally estimated by the state’s actuaries for the same periods. Composite MCP loss ratios were calculated based on a review of audited financial statements for each plan. If the observed MCP loss ratio is lower than estimated by the state actuary, additional costs savings are accrued since prospective rates will be reduced. If the MCP loss ratio is higher than expected, managed care cost savings will be lower than implied in the rate setting methodology.

**Step 5:** Incorporate additional cost savings for new populations (ABD <21 – July 2013, Extension – CY 2014).

**Step 6:** Add FFS administrative cost difference of 2% to estimated FFS costs.

**Step 7:** Apply FFS versus managed care trend differential.

**Final Savings Estimate**

Compare results of managed Medicaid program cost calculation (A) to estimated FFS costs for managed Medicaid plan enrollees (B). Subtracting (A) from (B) results in estimated dollar savings.

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5 We did not consider the impact of potential matching federal dollars on premium or other taxes, assuming that similar taxes could be levied on providers under the FFS program (and vice versa).

6 We included the same MCP/Hospital Incentive PMPMs for all baseline FFS cost estimates as were included in the managed Medicaid program. This assumes that these costs represented provider funding that would also have been included in a FFS environment.

7 The 0.5% trend differential was assumed to have been achieved starting with CY 2008 for CFC non-delivery, CY 2009 for ABD 21+, July 2013 for ABD <21, and CY 2014 for Extension non-delivery (i.e. for CY 2013 savings the 0.5% annual trend differential was compounded for 6 years for CFC non-delivery). No trend differential was assumed for the Delivery rates.
and cost report data used to develop those rates already reflected estimated MCP historical FFS to managed care cost differentials. This is based on aggregate MCP financial results for 2008 through 2010, 2012, and 2013 that generally conformed to the state actuaries’ assumptions regarding expected loss ratios. CY 2008 was not directly used in developing the CY 2013 through CY 2015 capitation rates. However, it was used to develop the CY 2010 rates and therefore had an indirect impact on CY 2013 through CY 2015 savings. The table below summarizes the observed and estimated loss ratios for each of these base period years:

<table>
<thead>
<tr>
<th>Rating Period</th>
<th>Expected Loss Ratio</th>
<th>Observed Loss Ratio</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2008</td>
<td>90.2%</td>
<td>95.9%</td>
<td>6.3%</td>
</tr>
<tr>
<td>CY 2009</td>
<td>90.3%</td>
<td>95.4%</td>
<td>5.6%</td>
</tr>
<tr>
<td>CY 2010</td>
<td>88.8%</td>
<td>85.3%</td>
<td>-4.0%</td>
</tr>
<tr>
<td>CY 2012</td>
<td>89.5%</td>
<td>87.5%</td>
<td>-2.2%</td>
</tr>
<tr>
<td>CY 2013</td>
<td>89.3%</td>
<td>87.1%</td>
<td>-2.5%</td>
</tr>
</tbody>
</table>

We were not able to obtain rating documentation for CY 2007 and instead assumed the FFS to managed care cost differential for this period was similar to our estimate for CY 2008. Since pharmacy was carved out for CY 2010, we made adjustments to the CY 2008 through CY 2010 MCP financials to estimate the non-pharmacy loss ratios for comparison to the expected non-pharmacy loss ratios implied by the rate setting documents.

As illustrated in Table 5, the observed non-pharmacy loss ratios for CY 2008 and CY 2009 were higher than the state actuaries’ expected loss ratio. This deviation resulted in lower estimated managed care cost savings than were implied by the rate setting documents. The observed non-pharmacy loss ratio for CY 2010 and the observed total loss ratios (pharmacy and non-pharmacy combined) for CY 2012 and CY 2013 were lower than the state actuaries’ expected loss ratios. This deviation resulted in higher estimated managed care cost savings than were implied by the combination of the rate setting methodology and the historical FFS to managed care cost differentials that were carried forward from the prior base periods. Favorable MCP loss ratio deviation does not necessarily indicate a higher level of MCP profits. Such results may have been driven by more intensive medical management and efficiencies and associated additional administrative costs not reflected in the favorable loss ratio.

Beginning with CY 2014, the Extension population was included in the managed Medicaid program. The CY 2014 and CY 2015 Extension rates were based on a blend of ABD adult and CFC adult managed care experience. The employed rating methodology results in the same expected net managed care savings percentage as was achieved by the other populations (ABD <21, ABD 21+ and CFC). This estimated savings percentage was reduced by explicit adjustments made by the state actuaries’ during rate development. These adjustments were made to account for the Extension population being new to the managed care environment.

Table 6 summarizes the results of our savings analysis by year and Table 7 illustrates the various components that result in our final savings estimates.

---

8 As calculated by the state actuary.
Table 6 – Estimated Savings Relative to Fee For Service

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Estimated FFS Costs</td>
<td>$6,807,035,000</td>
<td>$9,325,294,000</td>
<td>$11,609,055,000</td>
<td>$27,741,384,000</td>
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<tr>
<td>Calculated MCO Revenue [1]</td>
<td>$6,442,694,000</td>
<td>$8,473,027,000</td>
<td>$10,366,771,000</td>
<td>$25,282,492,000</td>
</tr>
<tr>
<td>Total Dollars Saved</td>
<td>$364,341,000</td>
<td>$852,267,000</td>
<td>$1,242,284,000</td>
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<tr>
<td>Total Percentage Saved</td>
<td>5.4%</td>
<td>9.1%</td>
<td>10.7%</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Based on 0.5% annual trend differential</th>
<th>CY 2013</th>
<th>CY 2014</th>
<th>CY 2015</th>
<th>CY 2013 - CY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical FFS Costs</td>
<td>$6,986,636,000</td>
<td>$9,575,544,000</td>
<td>$11,929,306,000</td>
<td>$28,491,486,000</td>
</tr>
<tr>
<td>Calculated MCO Revenue [1]</td>
<td>$6,442,694,000</td>
<td>$8,473,027,000</td>
<td>$10,366,771,000</td>
<td>$25,282,492,000</td>
</tr>
<tr>
<td>Total Dollars Saved</td>
<td>$543,942,000</td>
<td>$1,102,517,000</td>
<td>$1,562,535,000</td>
<td>$3,208,994,000</td>
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<tr>
<td>Total Percentage Saved</td>
<td>7.8%</td>
<td>11.5%</td>
<td>13.1%</td>
<td>11.3%</td>
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</table>

[1] Excludes Health Insuring Corporation (HIC) tax and Sales and Use tax.

Table 7 – Summary of Estimated Savings by Component

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<th>CY 2013</th>
<th>CY 2014</th>
<th>CY 2015</th>
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<tbody>
<tr>
<td>Claim Cost Savings versus FFS Implied in Base Period Rate Development</td>
<td>-7.8%</td>
<td>-10.9%</td>
</tr>
<tr>
<td>Base Period MCP Financial Savings (MLR)</td>
<td>-2.1%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>State Administrative Savings</td>
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<tr>
<td>Prospective Additional Managed Care Savings</td>
<td>-4.5%</td>
<td>-4.1%</td>
</tr>
<tr>
<td>MCO Administrative Allowance</td>
<td>10.1%</td>
<td>8.9%</td>
</tr>
<tr>
<td><strong>Total Estimated Savings (no trend differential)</strong></td>
<td><strong>-5.4%</strong></td>
<td><strong>-9.1%</strong></td>
</tr>
<tr>
<td>Impact of Annual 0.5% Trend Differential</td>
<td>-2.6%</td>
<td>-2.6%</td>
</tr>
<tr>
<td><strong>Total Estimated Savings (0.5% annual trend differential)</strong></td>
<td><strong>-7.8%</strong></td>
<td><strong>-11.5%</strong></td>
</tr>
</tbody>
</table>

In performing this analysis, we have not attempted to adjust for any potential errors or inconsistencies included in the rate setting processes. In our opinion, any differences arising from such issues would be more likely to increase the savings estimates than decrease them. Based on our review of the financial results for MCPs, we assumed that no pay for performance funds were paid out in any year. If pay for performance funds were paid out they would represent an offset to these savings.

**Conclusion**

The estimated range of savings indicates that the MCPs are operating efficiently and producing significant savings compared to costs of those members in the FFS program.

Taylor Pruisner and Ryan Link are responsible for this communication. We are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to issue this report. We completed the analysis using sound actuarial practice. To the best of our knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice with no known deviations. We are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to OAHP.
The assumptions and resulting estimates included in this report are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. There are no known relevant events subsequent to the date of information received that would impact the results of this report. Wakely and the undersigned actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to OAHP.

Please do not hesitate to call us if you have any questions or if we may be of additional assistance. Thank you for the opportunity to work on this important project.

Sincerely,

Taylor Pruisner, FSA, MAAA
Senior Consulting Actuary
Wakely Consulting
9777 Pyramid Court
Suite 260
Englewood, CO 80112
(720) 226-9808

Ryan Link, FSA, MAAA
Consulting Actuary
Wakely Consulting
9777 Pyramid Court
Suite 260
Englewood, CO 80112
(720) 226-9817
### Appendix A

#### Regional Capitation Rates – January 2013 through June 2013

<table>
<thead>
<tr>
<th>Category of Aid</th>
<th>Rate Group</th>
<th>Central</th>
<th>East Central</th>
<th>Northeast</th>
<th>Northeast Central</th>
<th>Northwest</th>
<th>Southeast</th>
<th>Southwest</th>
<th>West Central</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFC</td>
<td>HF/HST M+F &lt;1</td>
<td>$798.04</td>
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<td>$616.76</td>
<td>$731.27</td>
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<td>$705.60</td>
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<tr>
<td>CFC</td>
<td>HF/HST M+F 1</td>
<td>$163.66</td>
<td>$180.37</td>
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<td>$168.40</td>
<td>$172.12</td>
<td>$211.94</td>
<td>$194.35</td>
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<td>HF/HST M+F 2-13</td>
<td>$117.98</td>
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<td>$122.93</td>
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<td>$121.33</td>
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<tr>
<td>CFC</td>
<td>HF/HST M 14-18</td>
<td>$162.20</td>
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<td>$172.12</td>
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<td>HF/HST F 14-18</td>
<td>$196.82</td>
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<td>CFC</td>
<td>HF M 19-44</td>
<td>$305.90</td>
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<td>$289.23</td>
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<tr>
<td>CFC</td>
<td>HF/HST M+F 45-64</td>
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<td>$551.28</td>
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<td>$716.70</td>
<td>$601.37</td>
<td>$623.73</td>
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<td>$5,352.32</td>
<td>$6,582.72</td>
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<td>ABD</td>
<td>21+</td>
<td>$1,518.25</td>
<td>$1,437.30</td>
<td>$1,535.62</td>
<td>$1,396.11</td>
<td>$1,445.01</td>
<td>$1,258.37</td>
<td>$1,373.00</td>
<td>$1,545.32</td>
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#### Regional Capitation Rates – July 2013 through December 2013

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<tr>
<th>Category of Aid</th>
<th>Rate Group</th>
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<th>Northwest</th>
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<th>South Central</th>
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<th>Northeast</th>
<th>Northeast Central</th>
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</thead>
<tbody>
<tr>
<td>CFC</td>
<td>HF/HST M+F &lt;1</td>
<td>$688.99</td>
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<td>$788.89</td>
<td>$927.89</td>
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<td>$911.18</td>
<td>$558.23</td>
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<tr>
<td>CFC</td>
<td>HF/HST M+F 1</td>
<td>$170.33</td>
<td>$142.19</td>
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<td>$170.47</td>
<td>$163.82</td>
<td>$179.50</td>
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</tr>
<tr>
<td>CFC</td>
<td>HF/HST M+F 2-13</td>
<td>$124.01</td>
<td>$112.41</td>
<td>$129.92</td>
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<td>$123.62</td>
<td>$113.89</td>
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<td>CFC</td>
<td>HF/HST M 14-18</td>
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<td>HF/HST F 14-18</td>
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<td>$200.66</td>
<td>$196.87</td>
<td>$180.51</td>
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<tr>
<td>CFC</td>
<td>HF M 19-44</td>
<td>$294.32</td>
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<tr>
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<td>HF F 19-44</td>
<td>$423.86</td>
<td>$395.09</td>
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<tr>
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<td>HF M+F 45-64</td>
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<td>$612.86</td>
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<td>$1,008.23</td>
<td>$795.93</td>
<td>$715.73</td>
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*All capitation rates shown in Appendix A include Health Insuring Corporation Tax and Sales and Use Taxes*
### Regional Capitation Rates – CY 2014

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<th>Category of Aid</th>
<th>Rate Group</th>
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<th>South Central</th>
<th>Southeast</th>
<th>Northeast</th>
<th>Northeast Central</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFC</td>
<td>HF/HST M+F &lt;1</td>
<td>$713.44</td>
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<td>$990.37</td>
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<td>HF/HST M+F 1</td>
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<td>$154.12</td>
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<td>HF/HST M+F 2-13</td>
<td>$117.90</td>
<td>$110.28</td>
<td>$142.52</td>
<td>$126.31</td>
<td>$142.03</td>
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<tr>
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<td>HF/HST M 14-18</td>
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<td>$137.80</td>
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<td>$150.65</td>
<td>$177.88</td>
<td>$153.86</td>
<td>$136.81</td>
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<td>$188.24</td>
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<td>$5,965.90</td>
<td>$5,598.86</td>
<td>$5,841.55</td>
<td>$5,201.02</td>
<td>$5,600.65</td>
<td>$4,710.04</td>
</tr>
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<td>ABD</td>
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### Appendix A (continued)

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<th>Rate Group</th>
<th>Regional Capitation Rates – CY 2015 $</th>
</tr>
</thead>
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<tr>
<td></td>
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### Appendix B

#### MMs / Deliveries by Region – January 2013 through June 2013

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#### MMs / Deliveries by Region – July 2013 through December 2013

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## Appendix B (continued)

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## Appendix C

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<th>Base Information Used to Develop Capitation Rates</th>
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| Calendar Year 2008       | **ABD 21+:** Included FFS data from CY2005 and CY2006  
**CFC:** Included a blend of FFS, Encounter and Cost Report data from CY2005 and CY2006 |
| Calendar Year 2009       | **ABD 21+:** Included FFS data from CY2006 and a blend of FFS, Encounter and Cost Report data from CY2007  
**CFC:** Included a blend of FFS, Encounter and Cost Report data from CY2006 and CY2007 |
| Calendar Year 2010       | **ABD 21+:** Included a blend of FFS, Encounter and Cost Report data from CY2007 and CY2008  
**CFC:** Included a blend of Encounter and Cost Report data from CY2007 and CY2008 |
| Calendar Year 2012       | **ABD 21+ / CFC:** Included a blend of Encounter and Cost Report data from CY2009 and CY2010 for non-pharmacy; included 1 month of managed care (January 2010) and 11 months of FFS (February through December 2010) for pharmacy. |
| January – June 2013      | **ABD 21+ / CFC:** Included a blend of Encounter and Cost Report data from CY2009 and CY2010 for non-pharmacy; included 1 month of managed care (January 2010) and 11 months of FFS (February through December 2010) for pharmacy. |
| July to December 2013    | **ABD 21+ / CFC:** Included a blend of Encounter and Cost Report data from CY2010 for non-pharmacy; included 1 month of managed care (January 2010) and 11 months of FFS (February through December 2010) for pharmacy.  
**ABD <21:** Included FFS data from CY2009 and CY2010 |
| Calendar Year 2014       | **ABD 21+ / CFC:** Included CY2012 Cost Report data as the rate base, supplemented with the January through June 2012 Encounter data to support member-level rate adjustments.  
**ABD <21:** Included FFS data from CY2012.  
**Extension:** Used rate base established from estimated claim costs for the CFC and ABD 21+ populations. |
| Calendar Year 2015       | **ABD 21+ / CFC:** Included CY2013 Cost Report data as the rate base, supplemented with CY2013 Encounter data to support member-level rate adjustments.  
**ABD <21:** Included FFS data from CY2012.  
**Extension:** Used rate base established from estimated claim costs for the CFC and ABD 21+ populations. |
Sellers Dorsey is a national healthcare consulting firm composed of an industry-leading team of consultants and thought leaders from the worlds of policy, government, business, and industry, allowing the firm to provide a fully integrated suite of services to clients. Sellers Dorsey has a deep understanding of Medicaid, having consulted in over 30 states on a range of financing, policy and operational projects, and Medicare financing and policy. Its reputation is one of creativity, collaboration, and accomplishment.

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