Ohio | Department of Medicaid

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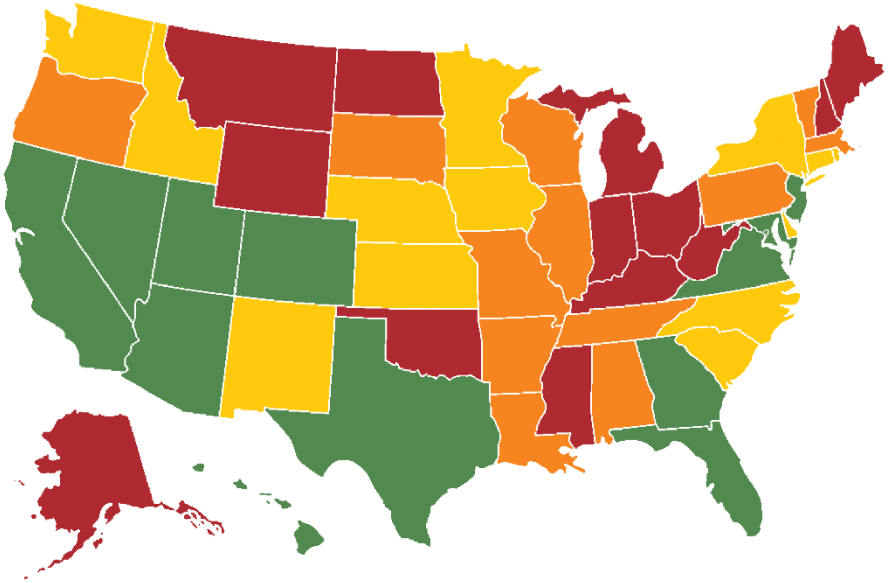
# Improving Performance and Accountability

## Ohio Ranks 46th in the Nation on Health Value

Of the 50 states and D.C.




Source: Health Policy Institute of Ohio. 2017 Health Vale Dashboard. 2018.
Available at: https://www.healthpolicyohio.org/wp-content/uploads/2017/04/2017Dashboard_Snapshot.pdf

*The Department's executive budget introduces policy changes the support improved quality and access to care for Medicaid enrollees while keeping spending at or below national trends.*

### Budget Impact

To improve performance and accountability across the program, Ohio Medicaid proposes increasing its managed care performance withhold, which is estimated to save up to $208.4 million ($62.5 million state GRF) over the biennium. The Department is using the lower end of actuarial trend assumptions, reducing Medicaid's overall spending forecast by $331.4 million ($99.6 million state GRF) for SFY 2020-2021. Additionally, an initiative to ensure managed care plans are paying all member month fees will reduce overall GRF by $113.0 million (33.9 million state GRF) over the biennium, and efforts to close program integrity loopholes will decrease costs by $15.0 million ($4.5 million state GRF) over the biennium.

### Background

As the map above shows, Ohio ranks 46 out of 50 states and the District of Columbia on health value. This indicates Ohioans spend more on health care than people in most other states but are less healthy.

### Managed Care Performance

Nearly 90% of the Medicaid population is enrolled in a managed care plan, and Ohio Medicaid incentivizes the managed care plans to improve health care quality and outcomes while lowering costs. Currently, Ohio Medicaid withholds 2% of managed care plans' monthly capitation rates and allows plans to earn back all withheld funds by meeting standards for a set of clinical quality metrics. Plans can recoup withheld payments if they improve their performance in areas including completing well child visits for pediatric populations, initiating substance use treatment for members who have appropriate diagnoses, following-up with members after they are hospitalized for mental illness, and controlling diabetes and high-blood pressure for enrolled members.

In recent years, the managed care plans' performance has varied across the broad spectrum of populations they serve, including children, adults, those with chronic conditions, and individuals with behavioral health needs. Despite positive trends in many measures, there is room for improvement. For example, only half of adolescents enrolled in managed care received the well care they needed last year. Ohio Medicaid must continue to raise its standards as it works to improve the value of health care for enrollees.

### Program Accountability

Medicaid's program integrity unit ensures appropriate payments are made to eligible providers while reducing fraud, waste, and abuse across the Department. Despite two existing statutes (ORC 5164.36 and 5164.37) that guide Medicaid's work in suspending providers suspected of fraud or abuse, the Department cannot immediately stop a provider from rendering services when Medicaid becomes aware of credible allegations of health and safety violations without seeking a temporary restraining order in court or seeking to terminate the provider, which could require a hearing process that lasts longer than a year. Ohio Medicaid's inability to suspend suspected providers leaves both enrollees and the Department at risk.

## Policy Proposal

The Department of Medicaid proposes to improve value, performance, and accountability across the program through the following efforts:

### Incentivizing Managed Care Performance Through Increased Withhold Rates:

- Ohio Medicaid has increasing expectations for managed care plans to deliver value to the program. In pursuit of better health for the 2.5 million Ohioans enrolled in Medicaid managed care plans, the Department proposes to increase the amount of money withheld from each plan by an additional 1% on January 1, 2020, moving the total withhold from 2% to 3% of capitation payments. This increase in withheld funds demonstrates Ohio Medicaid's strong expectations for managed care plan performance on clinical quality measures and could result in approximately $208.4 million ($62.5 million state GRF) in reduced expenditures over the biennium.
- Each managed care plan will continue to have full opportunity to earn back all withheld funds if they meet standards for clinical quality metrics for enrolled members. Managed care entities use several tools to work toward these goals, including incentivizing members to make healthy choices, implementing value-based payment models with providers, conducting performance improvement projects, and providing comprehensive care management and coordination across acute, primary, community, and behavioral healthcare.

### Adjusting Budget Forecasts to Account for Lower Growth:

- Medicaid's managed care cost forecast is completed using capitation rate trend assumptions based on projected health care cost inflation. For the coming biennium, Medicaid is proposing to use a lower-growth rate trend, which encourages financial discipline and reduces projected program outlays by $331.4 million ($99.6 million state GRF) in SFY 2020-2021.
- Altering this projection will not have a direct impact on provider rates or capitation rates paid to Medicaid's contracted managed care plans. The change in forecasting simply updates Medicaid's forecast with information closer to historical trend for future spending growth over the biennium.

### Reconciling Managed Care Entities' Member Month Tax Payments:

- The Department proposes to conduct an annual reconciliation process for managed care plans' payment of member month taxes. Currently, the managed care plans use enrollment files to calculate the amount they owe, but because of file cutoff times, underpayment can occur. The proposed reconciliation process will ensure appropriate receipt of all tax dollars due to the state, which is estimated to save $113.0 million (33.9 million state GRF) over the biennium.

### Streamlining Provider Integrity Efforts:

- To close the loophole that prevents the Department from suspending providers suspected of fraud or abuse, Ohio Medicaid is proposing changes to the Ohio Revised Code. The proposed changes would streamline the process for suspending a provider agreement in the event of a credible allegation of fraud or indictment.
- The changes would also give Medicaid the authority to suspend a provider agreement if the Department receives a credible allegation that their continued enrollment in the Medicaid program presents a danger of immediate and serious harm to the health, safety, or welfare of enrollees. Each of these changes would continue to allow for due process for providers. This effort is expected to reduce fraud and waste as well as administrative and legal expenditures by approximately $15 million ($4.5 million state GRF) over the biennium.