Ohio Department of Medicaid
Population Health & Quality Strategy

Jon Barley PhD
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Ohio Department of Medicaid

Ohio Department of Medicaid's New Population Health and Quality Strategy

Jon Barley, PhD, Chief,
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Learning Objectives

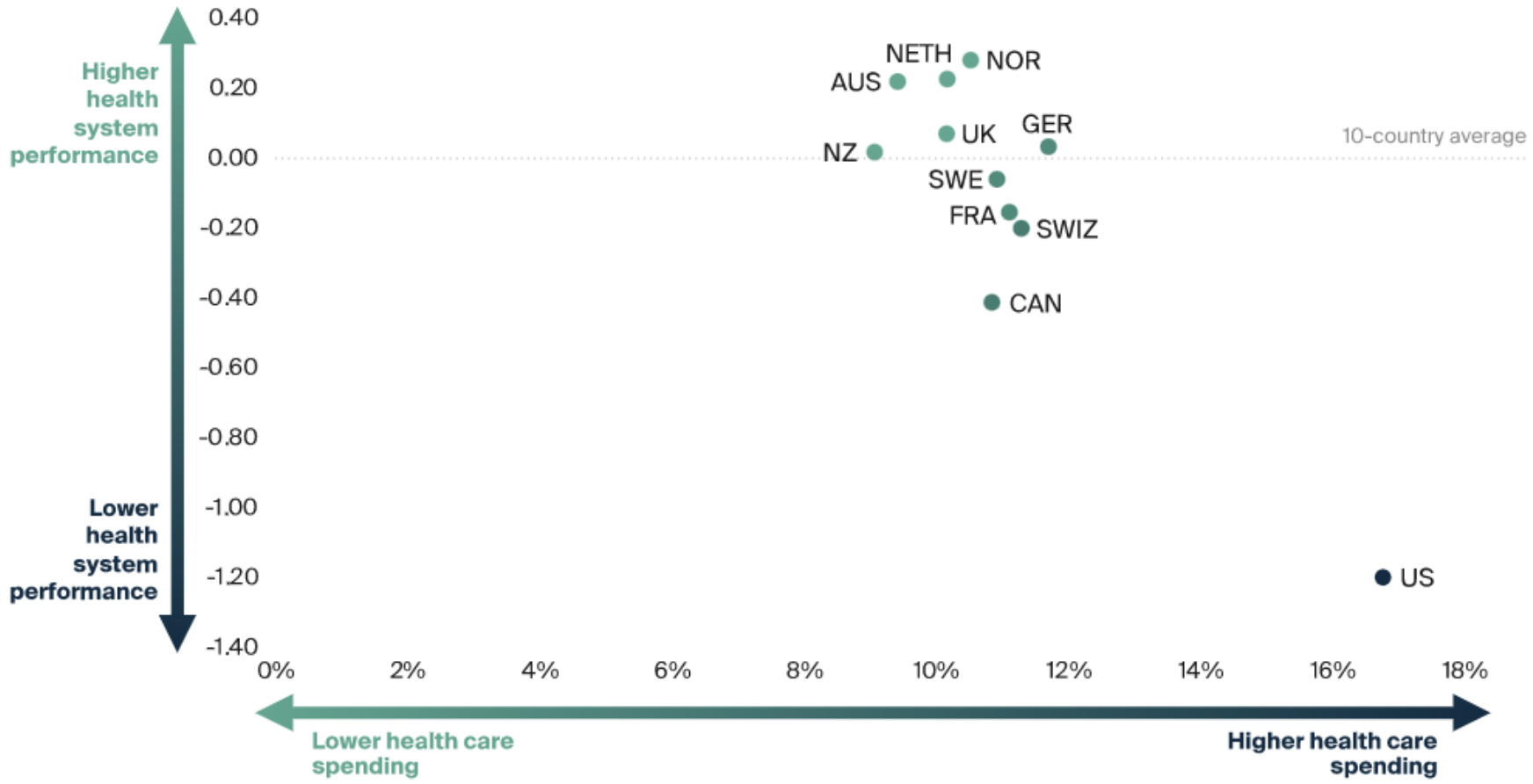
- How the Ohio Department of Medicaid (ODM) is recalibrating expectations of managed care plans to focus first on the individual rather than the business of managed care in an effort to meaningfully improve the health outcomes of members who have entrusted their care to the Medicaid program
- ODM's focus populations and their respective health outcome goals outlined in ODM's Quality Strategy
- How ODM aims to apply a population health strategy to reduce disparities and improving health outcomes

Conflicts of Interest

- I have no financial relationships with any commercial interest related to the content of this activity.

EXHIBIT 4

Health Care System Performance Compared to Spending



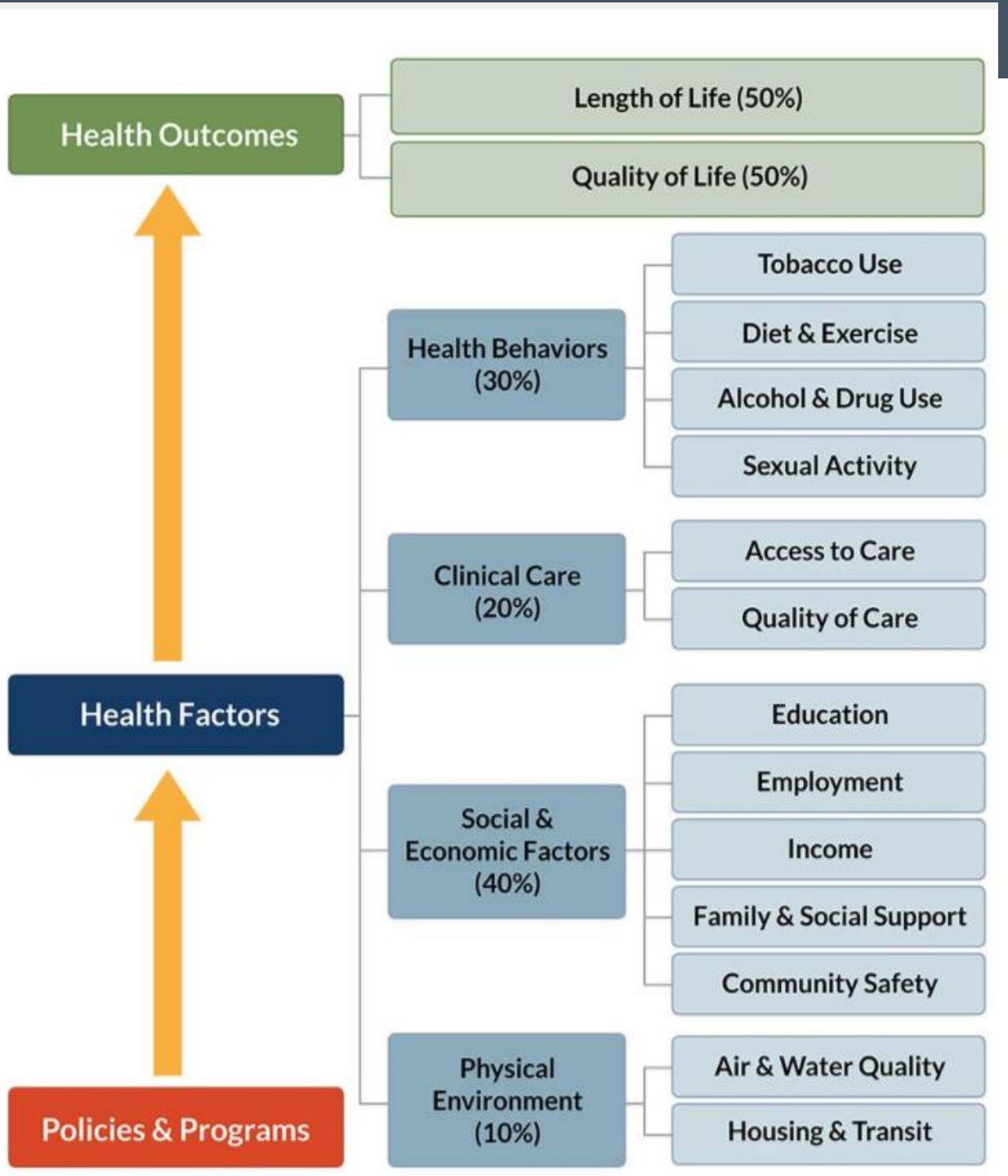
Note: Health care spending as a percent of GDP. Performance scores are based on standard deviation calculated from the 10-country average that excludes the US. See How We Conducted This Study for more detail.

Data: Spending data are from OECD for the year 2019 (updated in July 2021).

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021).

CommonWealth Fund (2021)
71 Perf. Measures across 5 Domains

- Access to Care
- Care Process
- Admin Efficiency
- Equity
- Health Outcomes



From the University of Wisconsin Population Health Institute County Health Rankings

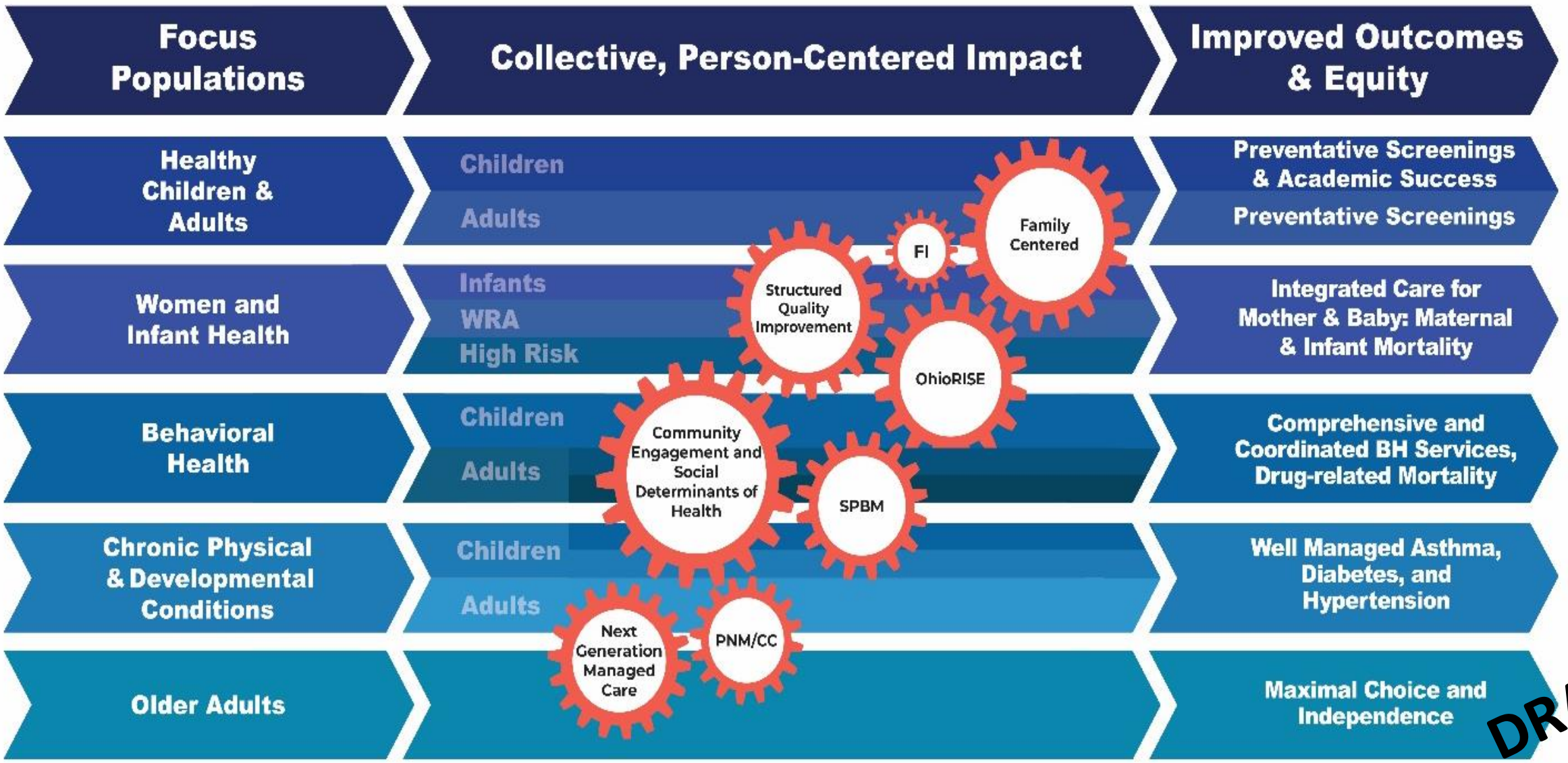
Albert Einstein

"We cannot solve our problems with the same thinking we used when we created them."

The Next Generation of Managed Care

Goals of Ohio's Future Managed Care Program

Ohio Medicaid's Population Health and Quality Strategy



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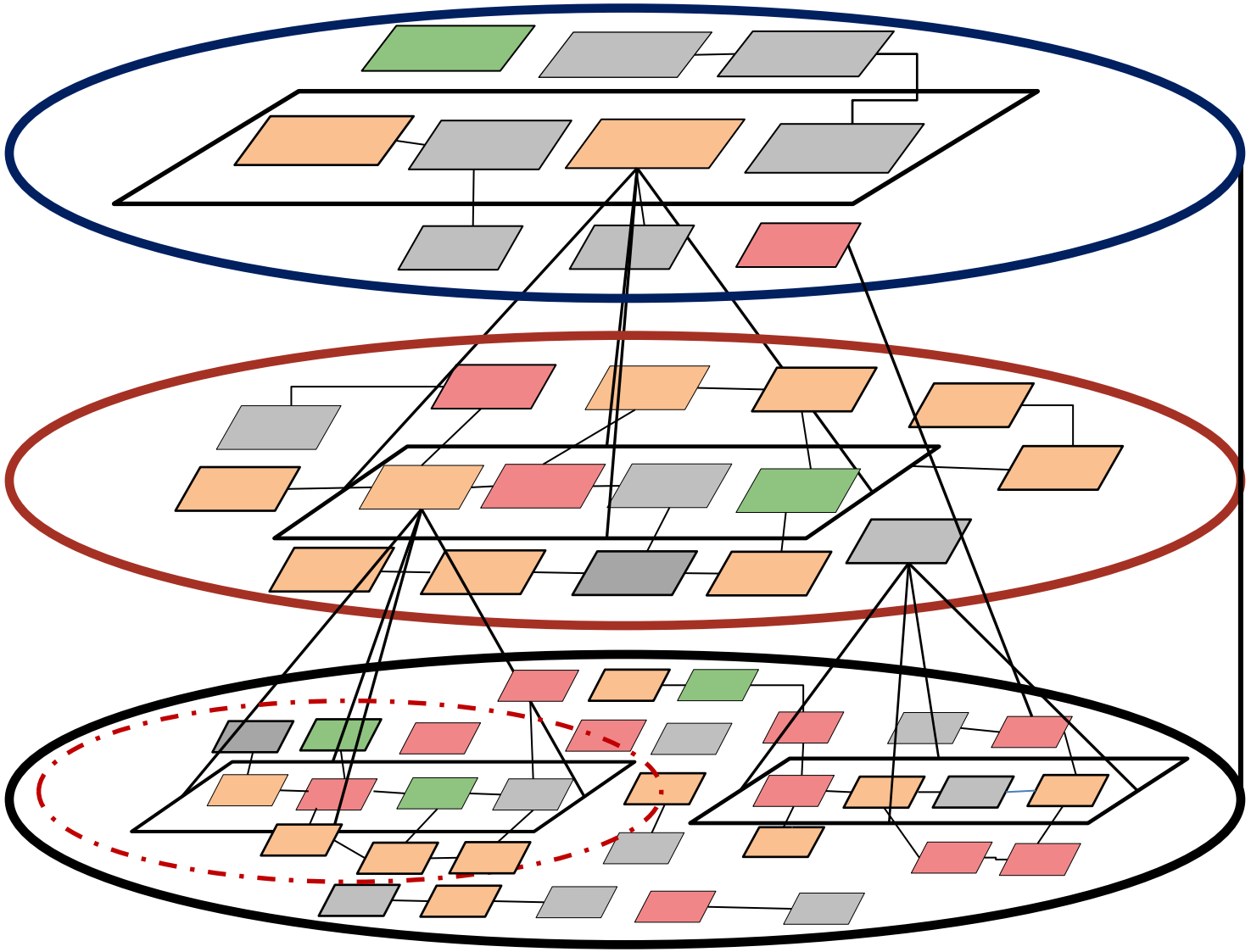
Alignment Framework to Improve Population Outcomes

Ohio | Department of Medicaid

Macrosystem-
State and Federal

Role-
Set priorities;
Direct resources;
Regulation;
Financing



Mesosystem-
Managed Care Entities, Large Health Systems

Role-
Manage delivery of evidence-based care across systems

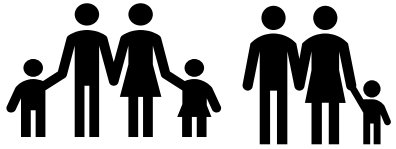
Microsystem-
Local (e.g., Community & Providers)

Role-
Give health guidance, diagnosis;
Provide evidence-based treatment & services

Simplified "Stairstep" Framework for Population Health Management

Develop System

Get/Keep Individuals in the System

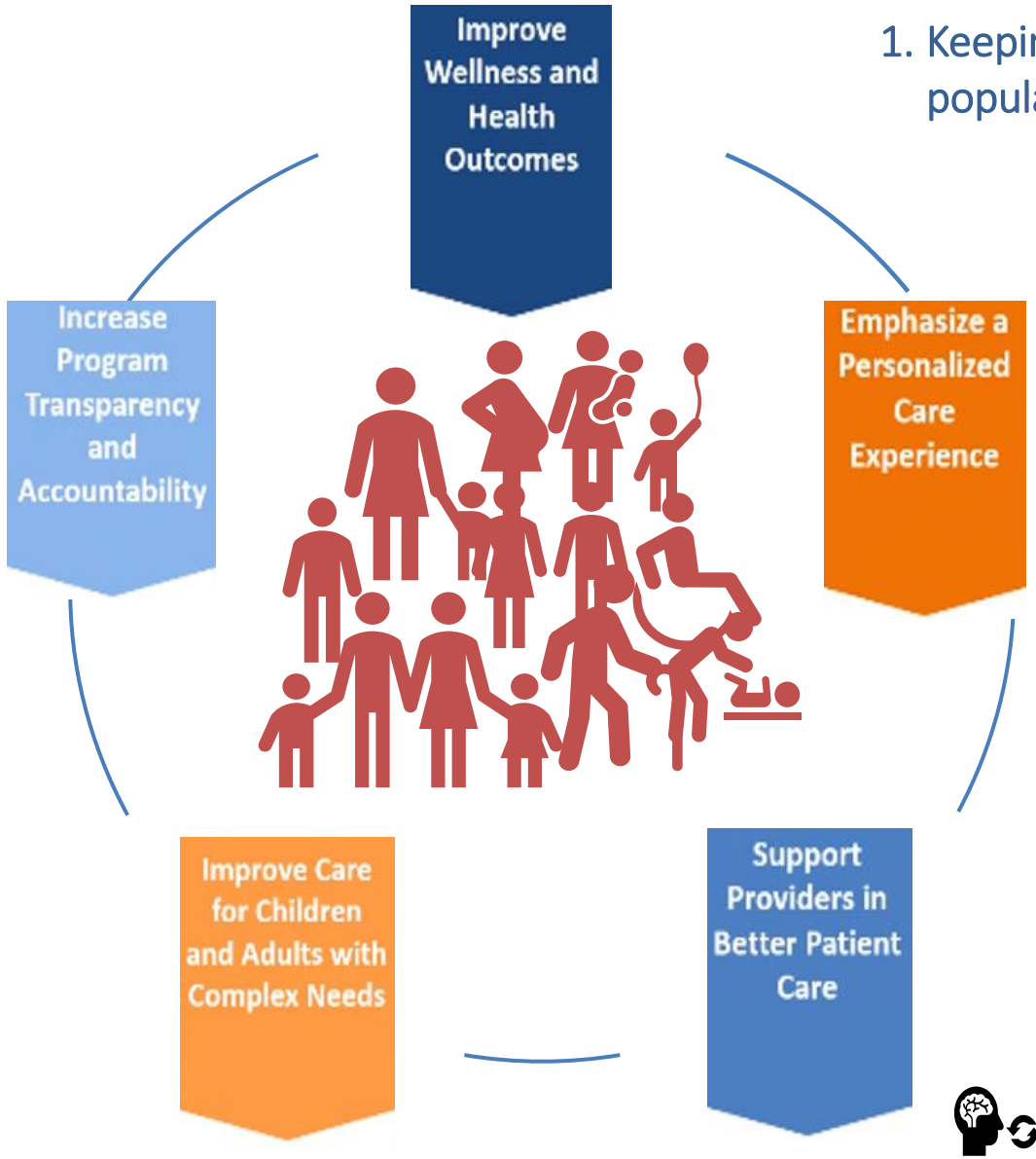


Identify Higher Risk (sub) Populations

Provide Best-evidenced Care & Enhanced Services

Maintain and Support Lifecourse Continuity

Person-centered Goals



Population Health Principles

1. Keeping individuals & their families at the center of all efforts to identify and meet population needs by:

   - Removing barriers to care
   - Using information to optimize collaboration & coordination, ensure consistent coverage, & tailor initiatives
   - Connecting with & having a physical presence within members' communities

2. Valuing wellness by:

   - Investing in preventive, health promotion, wellness services, & primary care

3. Ensuring health equity in all policies, practices, & operations;

4. Emphasizing strengths-based integration of physical and behavioral health care.

Optimal Delivery System:
- Best Payer Practice
- Clinical Best Practice

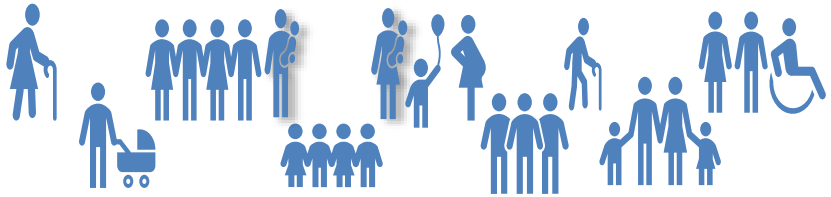
Health Equity

Quality Improvement

Population Health Improvement Approaches

Population Health Improvement Approaches

Population Identification & Segmentation



Care Coordination: Providing support and resources across the continuum of need

Utilization Management: Assessing Utilization for Best Outcomes

Specialized Services & Resources: Enhanced & tailored services for high Need & Disparate Populations

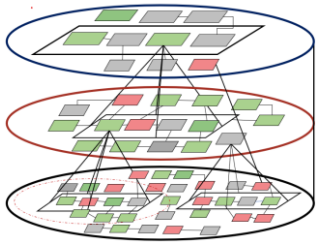
Community Reinvestment Partnering with community-based organizations

High Impact Leadership

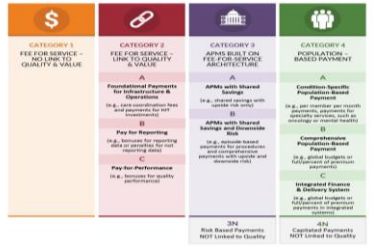
Staffing Resource Allocation

Population Health Information System

Foundational Infrastructure



Cross-system Collaboration



Supportive Payment Structures

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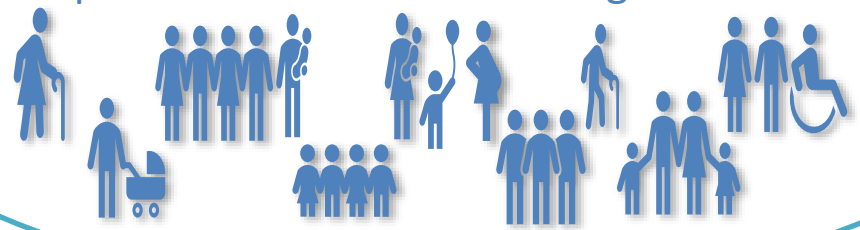

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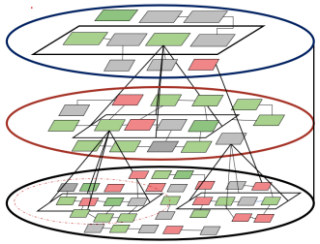

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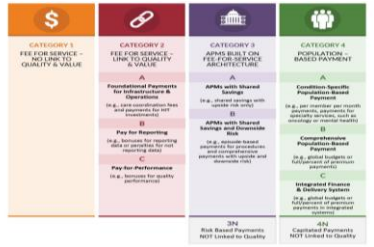


Supportive Payment Structures

Population Identification and Segmentation

- Alignment with ODM population streams
- Incorporation of multiple data sources
- Consideration of medical, behavioral, SDoH-related needs
- Ongoing monitoring
- Special attention to high-risk groups
- Informs population health improvement efforts
- Aim to find and address disparities

Ohio's Opportunity Index

Education

- Educational attainment
- School performance
- Free & reduced lunch participation
- High school graduation rate
- Residential internet connectivity

Employment

- Low wage job access
- Access to workforce or job training sites
- Unemployment
- Poverty

Transportation

- Access to public transit
- Average commute to work time
- Households without vehicle access
- Traffic proximity

Housing

- Median rent
- Median home value
- Concentration of existing Low-Income Housing Tax Credit (LIHTC) units
- Housing stock built pre-1960s
- Residential overcrowding
- Residential mobility

Health

- Age-adjusted mortality
- Preventable ED visits
- Diabetes admits/diagnoses
- Access to grocery stores
- Access to medical providers

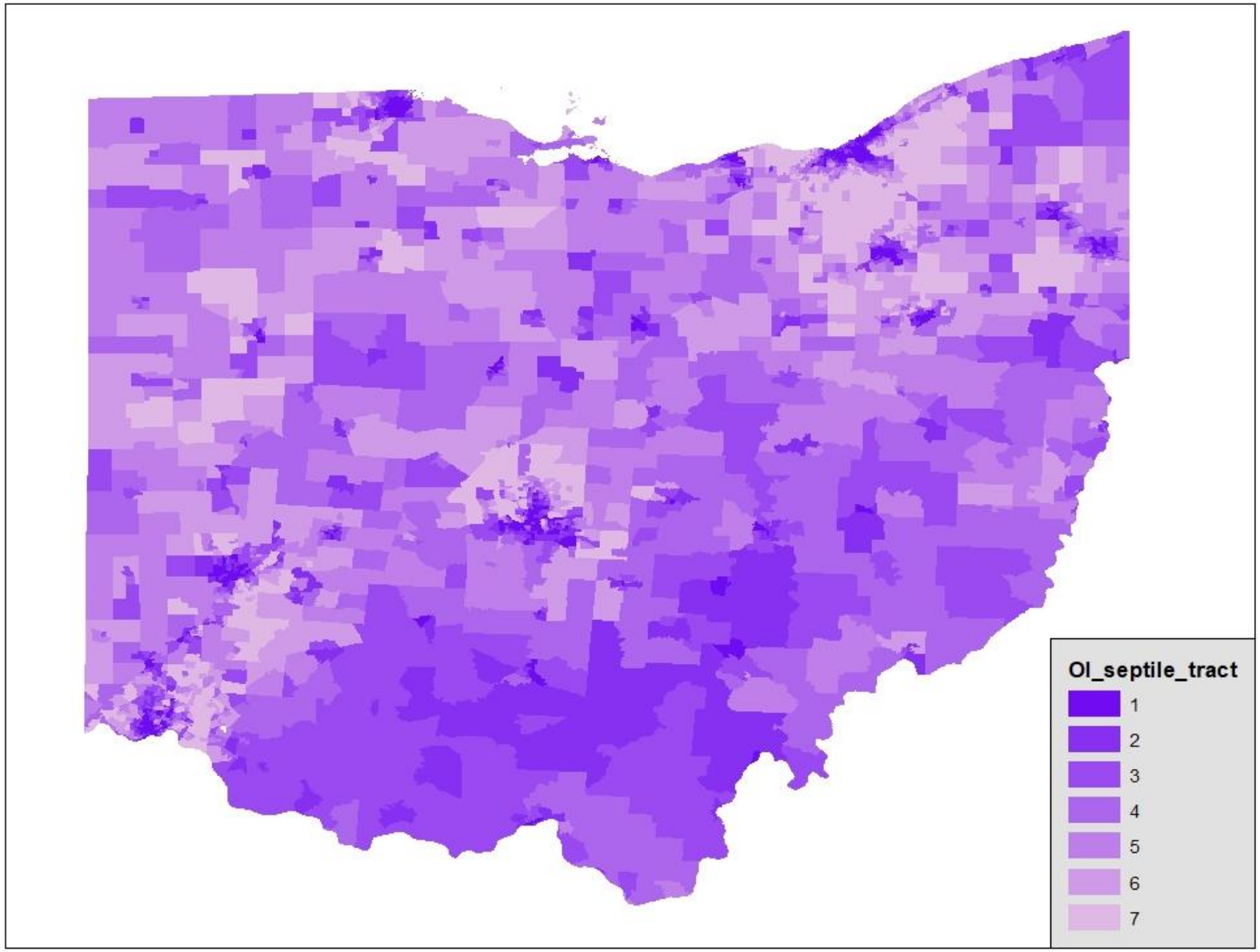
Environment

- Access to green space
- PM2.5 (air pollutant) levels in air
- Walkability
- Urban landcover

Crime

- Homicide, aggregated assault & sexual assault
- Robbery
- Burglary, larceny-theft and motor vehicle theft
- Public drunkenness and DUI
- Drug involved crimes

Ohio Medicaid's Opportunity Index Census Tracts



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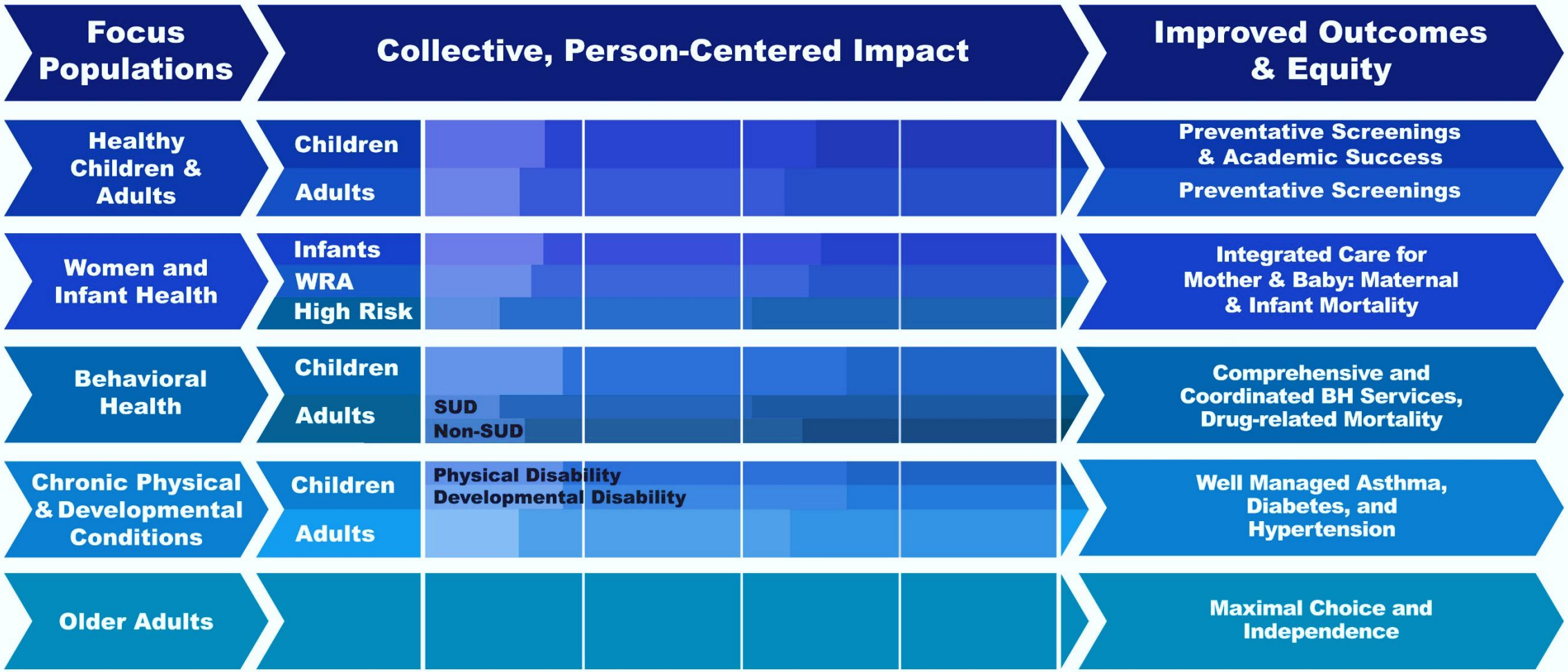

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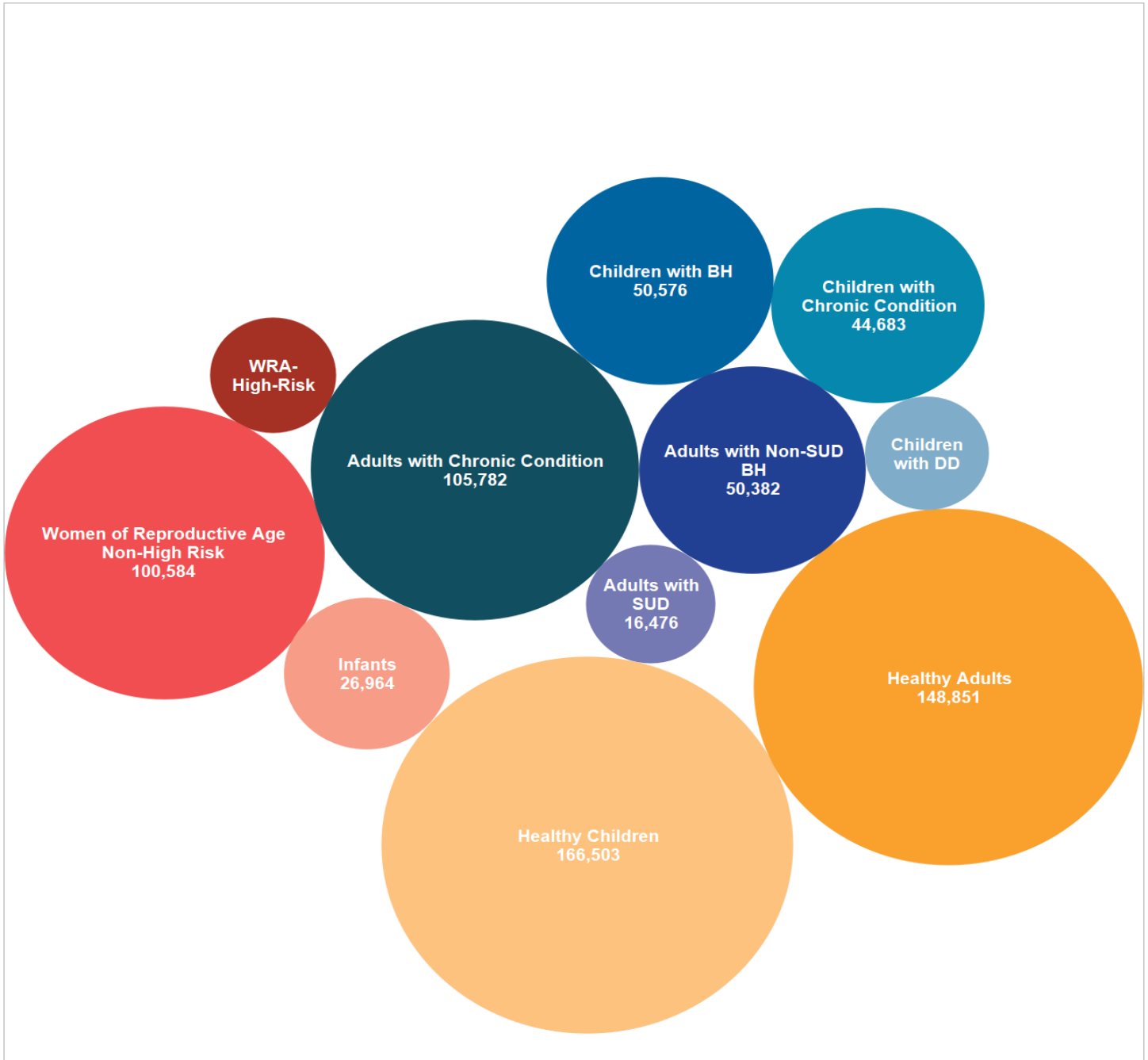
Population Health Streams, Medicaid Managed Care, SFY 2021*

*Not mutually exclusive



Population Stream
- Adults with Chronic Condition
- Adults with Non-SUD BH
- Adults with SUD
- Children with BH
- Children with Chronic Condition
- Children with DD
- Healthy Adults
- Healthy Children
- Infants
- Women of Reproductive Age Non-High Ri..
- WRA- High-Risk

Population Stream	Total
Adults with Chronic Condition	750,561
Adults with Non-SUD BH	332,351
Adults with SUD	158,044
Children with BH	241,086
Children with Chronic Condition	219,530
Children with DD	71,817
Healthy Adults	994,601
Healthy Children	866,519
Infants	148,579
Women of Reproductive Age Non-High Risk	619,141
WRA- High-Risk	144,164

MCO and OhioRISE Collaboration
High Risk Children with Multi-System Needs

OhioRISE

Resilience through Integrated Systems and Excellence

A specialized managed care program for youth with complex behavioral health and multi-system needs

Specialized Managed Care Plan

Aetna Better Health of Ohio will serve as the single statewide specialized managed care plan.

Shared Governance

OhioRISE features multi-agency governance to drive toward improving cross-system outcomes – we all serve many of the same kids and families.

Coordinated and Integrated Care & Services

OhioRISE brings together local entities, schools, providers, health plans, and families as part of our approach for improving care for enrolled youth.

Prevent Custody Relinquishment

OhioRISE will utilize a new 1915c waived to target the most in need and vulnerable families and children to prevent custody relinquishment.

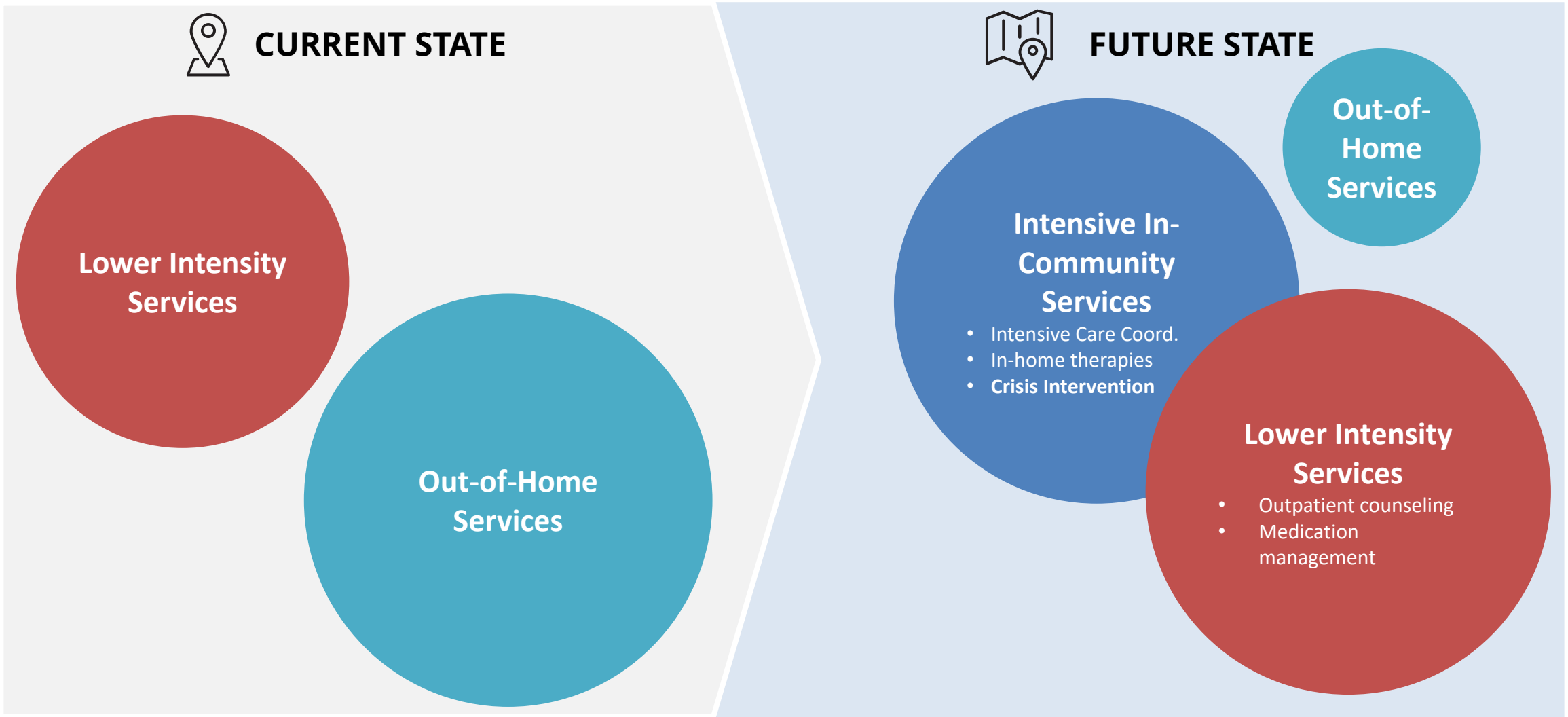
OhioRISE Enrollment

- ✓ Enrolled in Medicaid (managed care or fee for service)
- ✓ Up to age 21
- ✓ **In need of significant behavioral health service**
- ✓ Require significant functional intervention, as assessed by the Child and Adolescent Needs and Strengths (CANS)
- ✓ Estimate 55-60,000 children & youth by end of year 1

OhioRISE Services

- ✓ All existing behavioral health services
- ✓ Intensive and Moderate Care Coordination **NEW**
- ✓ Intensive Home-Based Treatment (IHBT) **ENHANCED**
- ✓ Psychiatric Residential Treatment Facility (PRTF) **NEW**
- ✓ Behavioral health respite **ENHANCED**
- ✓ Flex funds to support implementing a care plan **NEW**
- ✓ 1915(c) waiver that runs through OhioRISE **NEW**
  - ✓ Unique waiver services & eligibility
- ✓ Mobile Response and Stabilization Service (MRSS) **NEW**
  - ✓ Also covered outside of OhioRISE (MCO and FFS)

Shifting the System - Building Capacity for Intensive In-Community Services



Approaches to Population Health Improvement

Optimal Delivery System:
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- Clinical Best Practice

Health Equity

Quality Improvement

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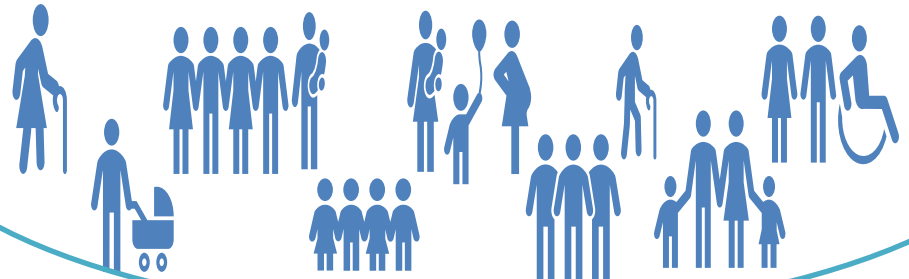
Population Identification & Segmentation



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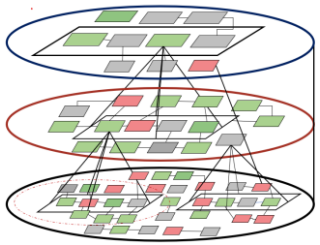

Cross-system Collaboration

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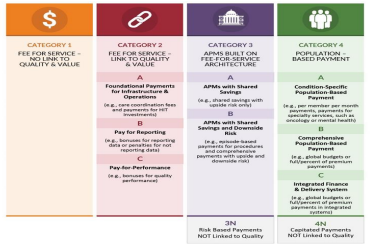

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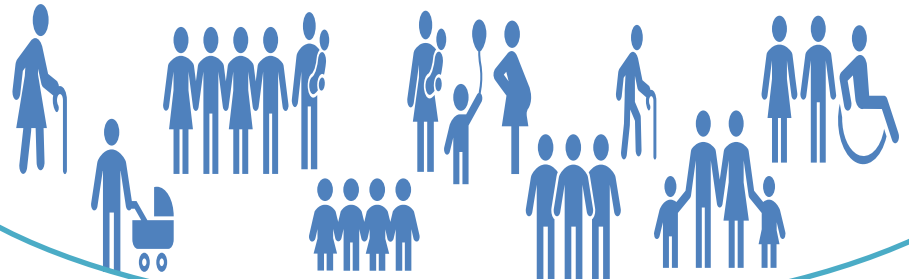

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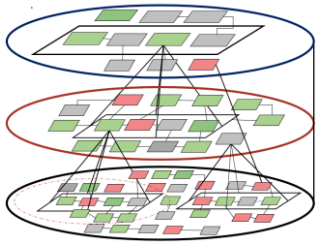

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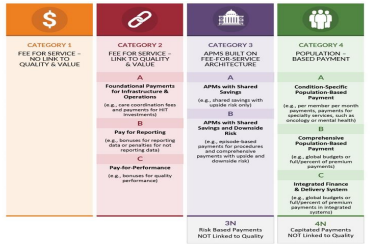


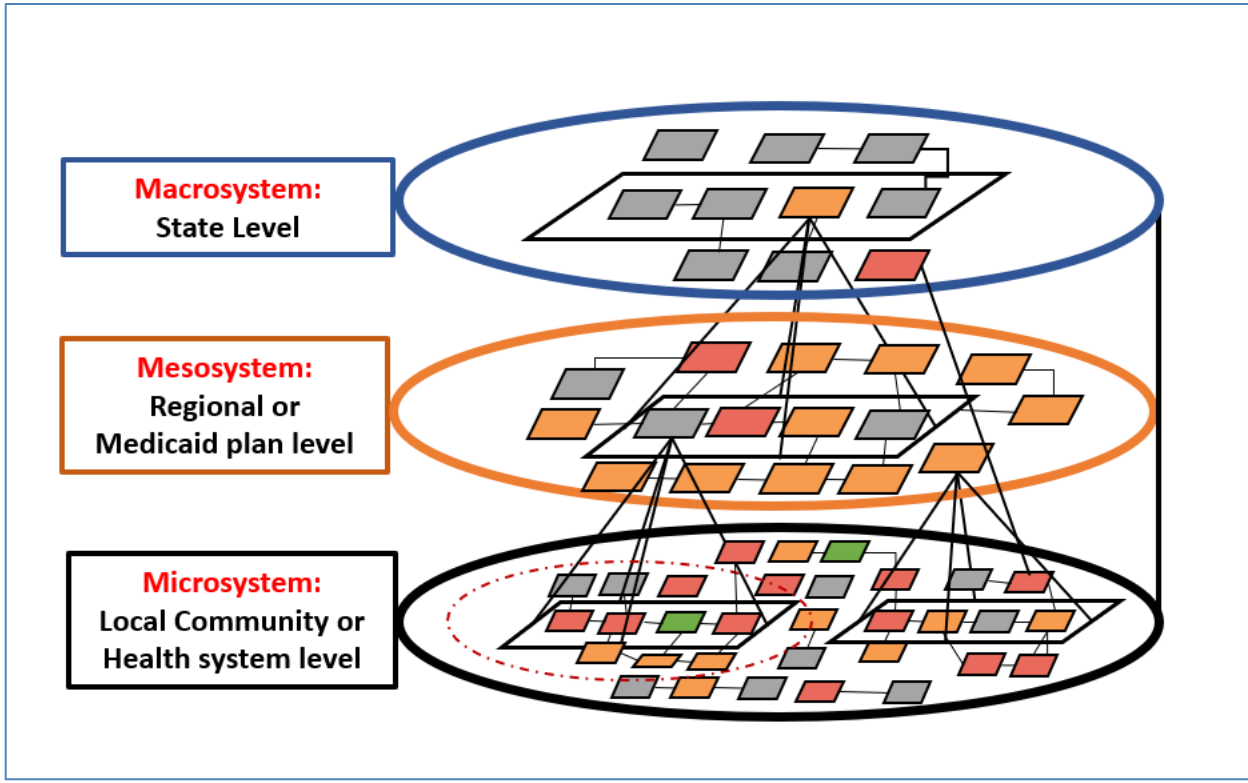
Supportive Payment Structures

Optimal Delivery System

Continuously improving ALL aspects of the care delivery system to optimize the health of members through **inclusion of input from members, providers, and other partners** across the care continuum into the **design, execution, evaluation, and refinement of MCO service delivery policy and practice.**

Key Mechanisms:

- **Clinical Best Practice Guidelines** to ensure quality care
- **Best Payer Practice** that optimizes member and provider experience.



Clinical Best Practice Guidelines

- Ohio Cardiovascular and Diabetes Health Collaborative, Cardi-OH
  - » Improve cardiovascular and diabetes care and eliminate disparities
  - » Focused on the primary care team capacity to manage cardiovascular health and diabetes
  - » Includes experts from across Ohio's seven medical schools
  - » Disseminate best practices
- Ohio Minds Matter
  - » Website serving as a Behavioral Health resource to help families, teachers, and healthcare professionals managed childhood mental health needs
  - » Developed by a panel of clinical childhood behavioral health experts
  - » Includes treatment modules, screening tools, prescribing guides, prevention resources, how to get help, etc.
- Regional QI HUB
  - » More reliably translate best evidenced care into clinical practices
  - » Structure to collectively support health improvements that can be measures al the levels of Ohio's populations
  - » Build off success of cardiovascular and diabetes efforts
  - » Ohio medical schools in partnership with select hospital systems to serve as the Regional QI HUB

Health Equity

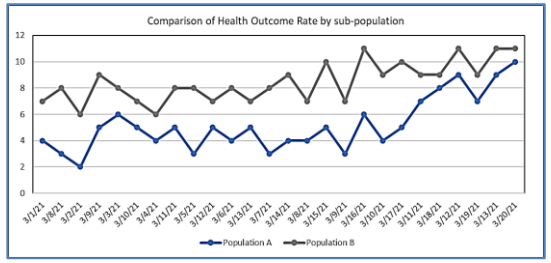
Use data to identify disparities in health care and health outcomes

Engage members, families & communities in service design

Broad Strategies

- Promote cultural humility
- Awareness of implicit bias
- Physical & behavioral healthcare integration
- Culturally appropriate service delivery & communications
- Address social risk factors (transportation, housing, food insecurity)

Health disparity reduction

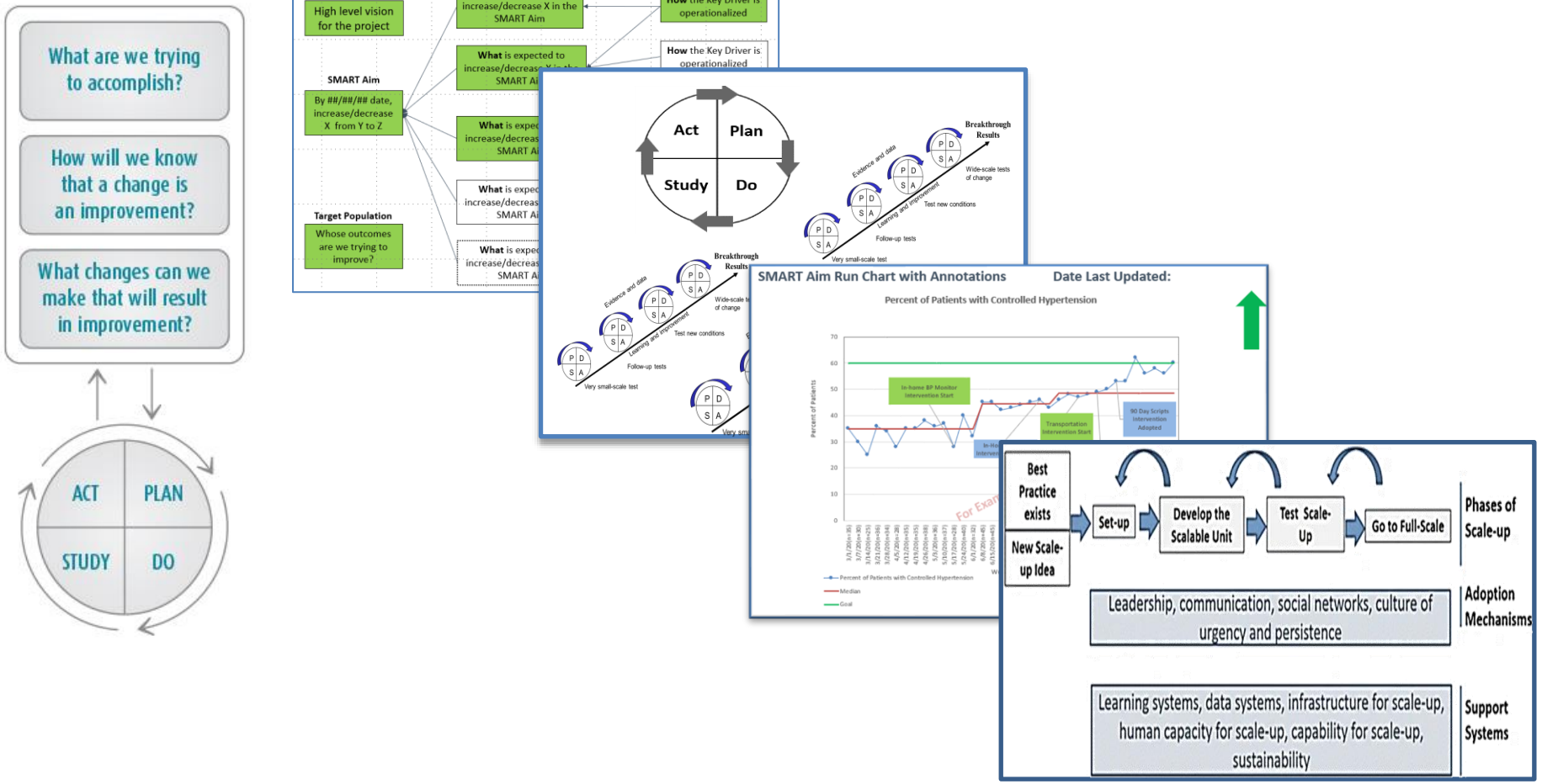


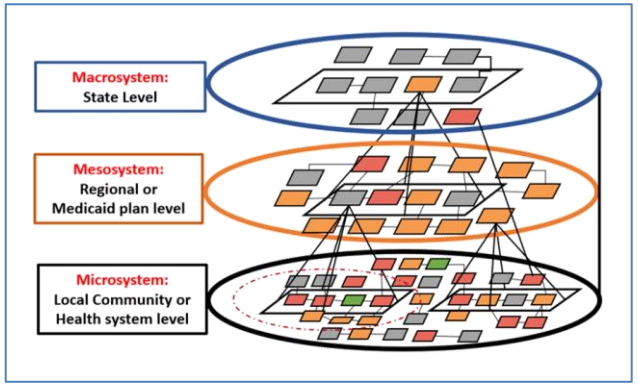
Equitable Healthcare & Outcomes

Metrics for assessing intervention success & disparity reduction

Accountability through active member involvement & feedback

Quality Improvement





The Model for Improvement can be used at all system levels to improve:

- Member Experience
- Member Outcomes
- Clinical Teamwork Satisfaction
- Community Health
- Healthcare Quality
- Lower Costs (e.g., decreased ER visits)
- National Targets

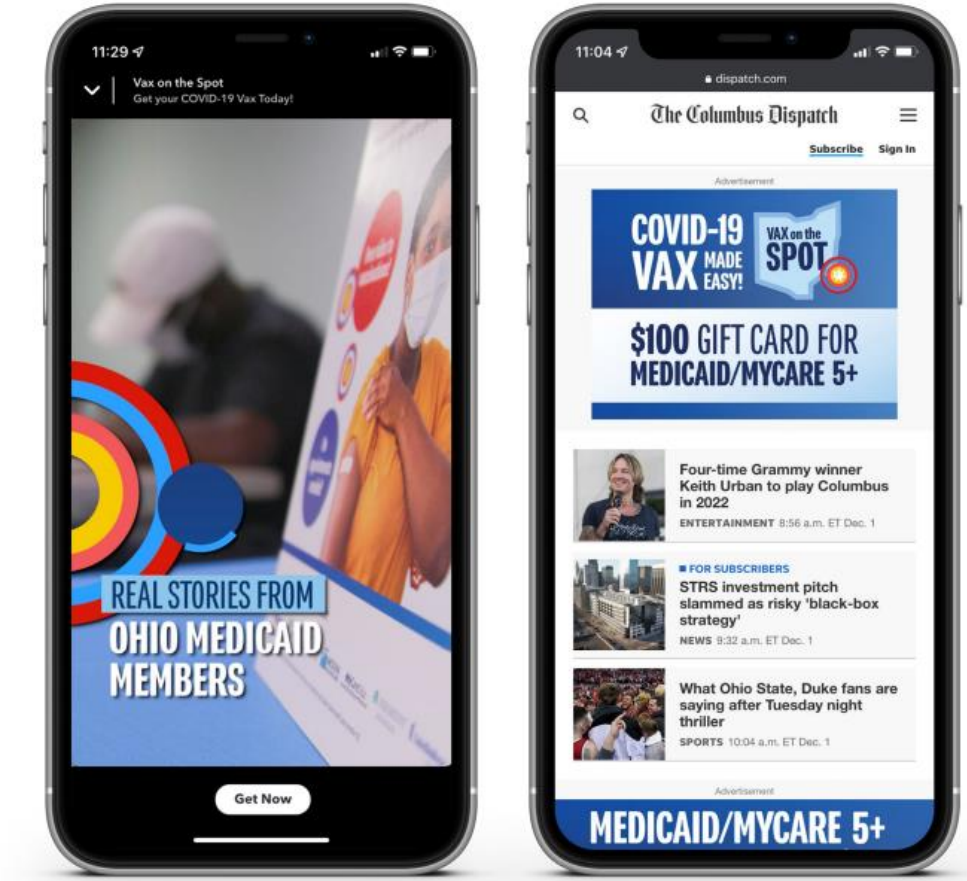
2021 COVID Vaccine Campaign

Challenge: Help Ohio Medicaid members to reach vaccine rates on par for the Ohio population

Vaccine effort was one of the quality withhold initiatives for 2021.

Collective Impact: Aligning MCOs, providers, pharmacies, Governor's Office and ODM to achieve a common, measurable goal can and does make a difference.

Today more than **ONE MILLION** Ohioans served by Medicaid are on their way to COVID protection.



COVID-19 Vaccinations KDD

LEGEND
Potential Intervention
Actively Testing Intervention
Adopted Intervention
Abandoned Intervention

Maximize the number of Ohio Medicaid members who are fully vaccinated against COVID-19

SMART Aim: by December 31, 2021

MMC SMART Aim 1: Increase the number of MMC adult members (age 18+) with COVID-19 vaccinations initiated from 350,000 to at least 583,000 (900,00 stretch goal)

MMC SMART Aim 2: For MMC members (age 18+) residing in neighborhoods with low (septile 1 or 2) Opportunity Index (OI) Scores , increase the number of members with initiated COVID-19 vaccinations from 75,000 to at least 200,000 (388,000 stretch goal)

MyCare SMART Aim 1: Increase the number of initiated COVID-19 vaccinations for MyCare members age 18-64 from 19,000 to at least 38,000

MyCare SMART Aim 2: Increase the number of initiated COVID-19 vaccinations among MyCare members enrolled in the MyCare Waiver, age 18-64, from 3,300 to at least 5,400.

MyCare SMART Aim 3: Increase the number of initiated COVID-19 vaccinations for MyCare members age 65+, from 38,000 to at least 47,000

MyCare SMART Aim 4: Increase the number of initiated COVID-19 vaccinations for MyCare members enrolled in the MyCare Waiver, age 65+, from 13,000 to at least 16,000

Population

Ohio Medicaid (including Mycare) members, 18+ who are eligible to receive COVID-19 vaccines

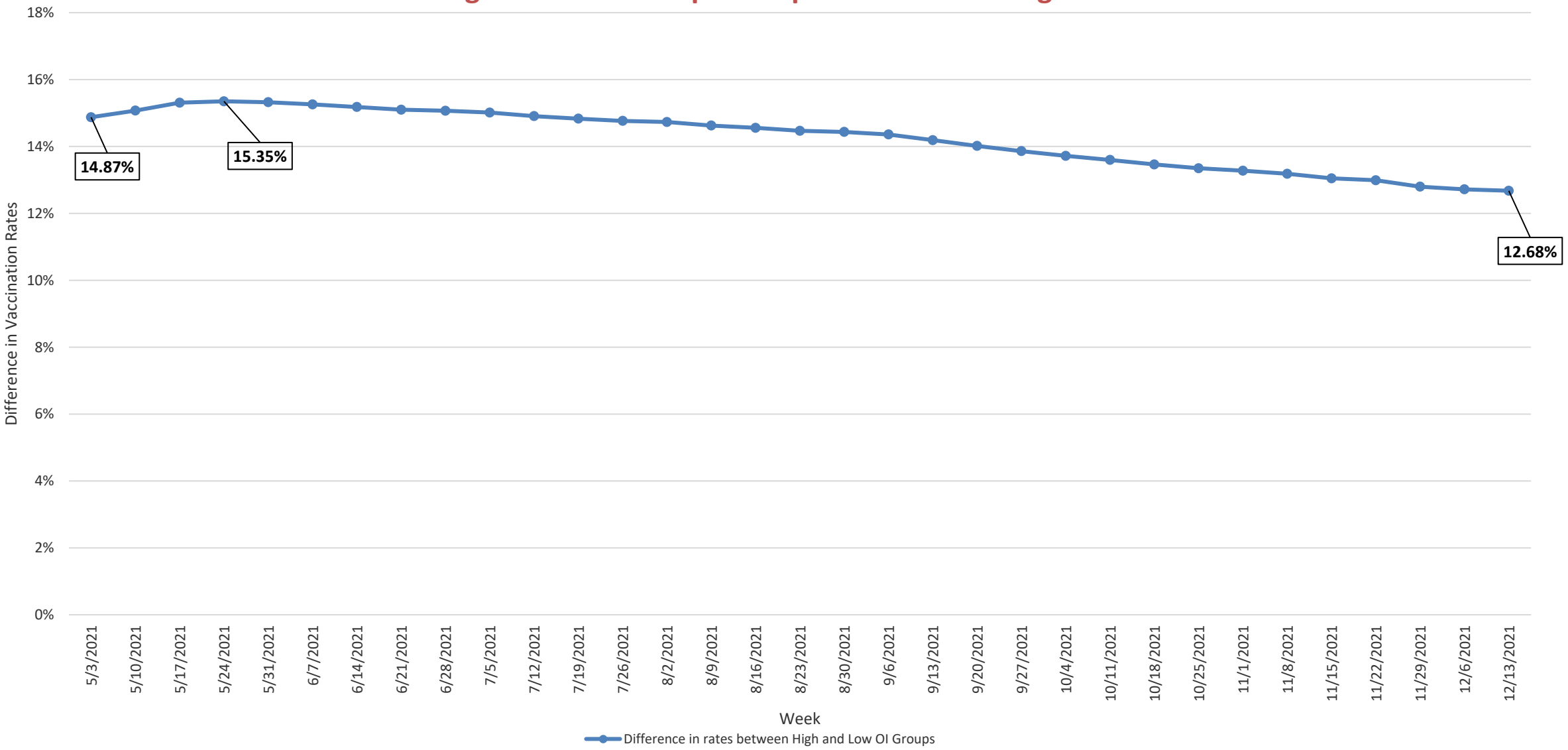
Key Drivers

- Convenient access to vaccination by **pharmacies**
- Convenient access to vaccination by **Doctor's offices/providers**
- Convenient access to vaccination by **community events**
- Increased member trust in vaccine efficacy and safety
- Reduce barriers (SDOH) to getting to vaccination appt (childcare, missing work, etc.)
- Special population efforts (Lowest OI/Homebound)

Interventions

- Pharmacy bonus program
- MTM pharmacy program
  Timely data targeting unvaccinated members and additional reimbursement (e.g., Discount Drug Mart, CSS, Kroger partnerships) + Engagement of Pharmacy CEOs
- Enhanced vaccine reimbursement for pharmacists (admin fee)
- Promote community, school-based and retail-based vaccination events
- Support LHDs, Schools, foodbanks, etc. with plan personnel and marketing
  Partnership with Dollar General/Rite Aid
- Use of trusted messengers within the community (e.g., CHW)
- Gift cards for members to receive their vaccine
- MCP assistance for providers (e.g., vaccination lists, transportation)
- Use of in-home vaccination providers (e.g., Sterling/OFFOR)
- Member information and incentives to Restored Citizens

Difference in Rates for COVID-19 Vaccinations Initiated
High and Low OI Septile Populations - MMC Age 18+



Care Coordination

Current State of Care Management

- A “one size fits all approach”
- Full Care Management benefits are only available to those who “engage” in Care Management

Future State of Care Coordination

- A more customizable approach
- Provides a variety of options for individualized/ person-centered care
- Offers “short-term” assistance and/or “long term” support based upon needs or requests

Key Components of MCO Community Reinvestment Requirement

- Support population health strategies
- Contribute a percentage of annual profits*
  - 3% for CY 2022
  - 4% for CY 2023
  - 5% for CY 2024
- Maximize the collective impact by working collaboratively with other MCOs
- Use available population health data and consider existing local community health assessments
- Prioritize community reinvestment opportunities generated from community partners
- MCOs must submit a *Community Reinvestment Plan and Evaluation* annually

*after-tax underwriting margin

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- Clinical Best Practice

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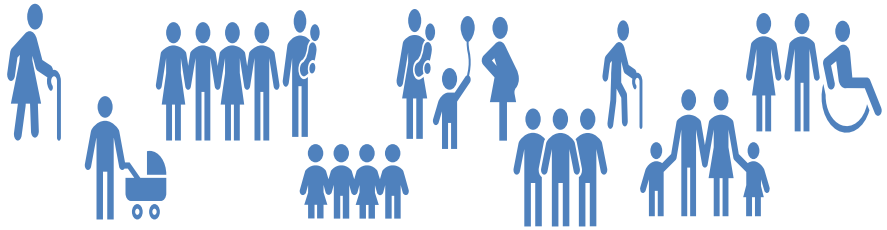

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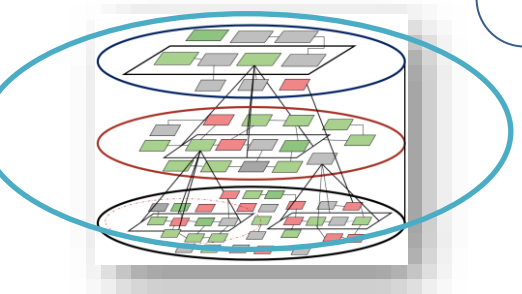
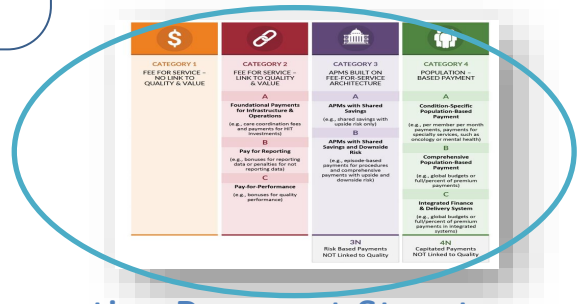


Cross-system Collaboration

Foundational Infrastructure



Supportive Payment Structures

Cross-System Collaboration

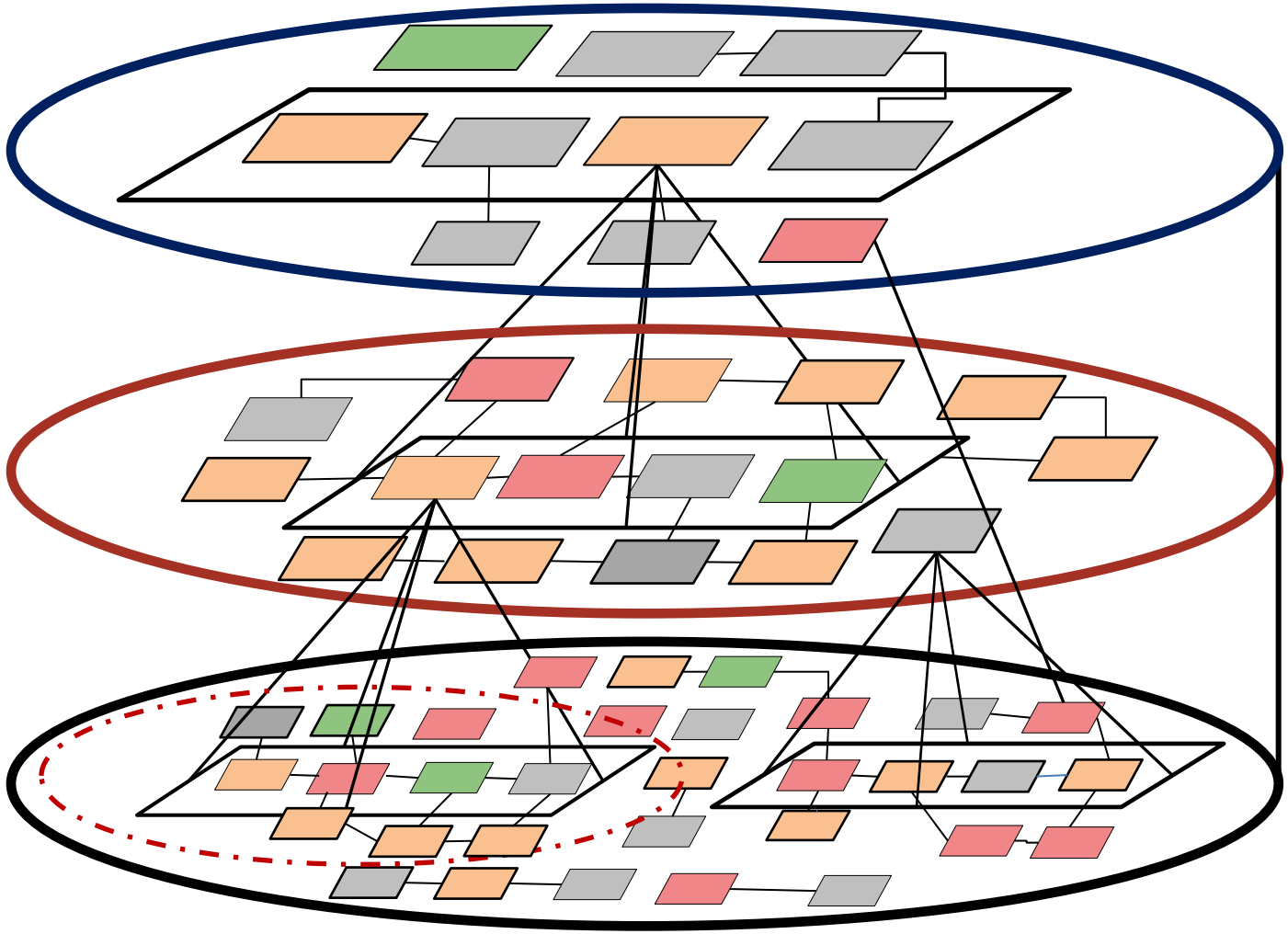
Cross-System Collaboration

Alignment Framework to Improve Population Outcomes

Macrosystem-
State and Federal

Mesosystem-
Managed Care Entities, Large Health Systems

Microsystem-
Local (e.g., Community & Providers)



Role-
Set priorities;
Direct resources;
Regulation;
Financing

Role-
Manage delivery of evidence-based care across systems

Role-
Give health guidance, diagnosis;
Provide evidence-based treatment & services

Cross-System Collaboration

- Care Innovation and Community Improvement Program (CICIP)
  - » 4 Public Hospitals partnered with MCOs
  - » QI projects focused on OUD
- Regional QI HUB
  - » Medical Schools + Hospital Systems partnered with MCOs
  - » Disseminate Best Practices
- School-Based Health Care
  - » Schools Partnered with MCOs
  - » Improve Well-Child Visits

Supportive Payment Structure

Goals of Alternative Payment Models (APMs) Implementation

ADDRESSING SOCIAL DETERMINANTS OF HEALTH (SDOH)

Reducing disparities and improving health equity through reallocation of resources to address SDOH (e.g., housing, food insecurity, transportation).

REDUCING INEFFECTIVE CARE AND INAPPROPRIATE UTILIZATION OF SERVICES

Focusing on appropriateness, care variation, and person-centered care for all patients through dissemination of best practices.

INCREASING DATA TRANSPARENCY AND INTEROPERABILITY

Providing patients and caregivers with cost, quality, and appropriateness of care data in an actionable, easily understood, and accessible manner. Ensuring that electronic data can be easily shared meeting advanced technology standards (e.g., HL7 FHIR) to improve care delivery.

ENSURING TIMELY DATA AND ANALYTICS CAPABILITIES

Ensuring providers adopt timely data and analytics capabilities, combining multiple data sources (e.g., electronic health record and claims data), to enable successful participation in value-based payment models.

FACILITATING MARKET SHIFTS TO VALUE

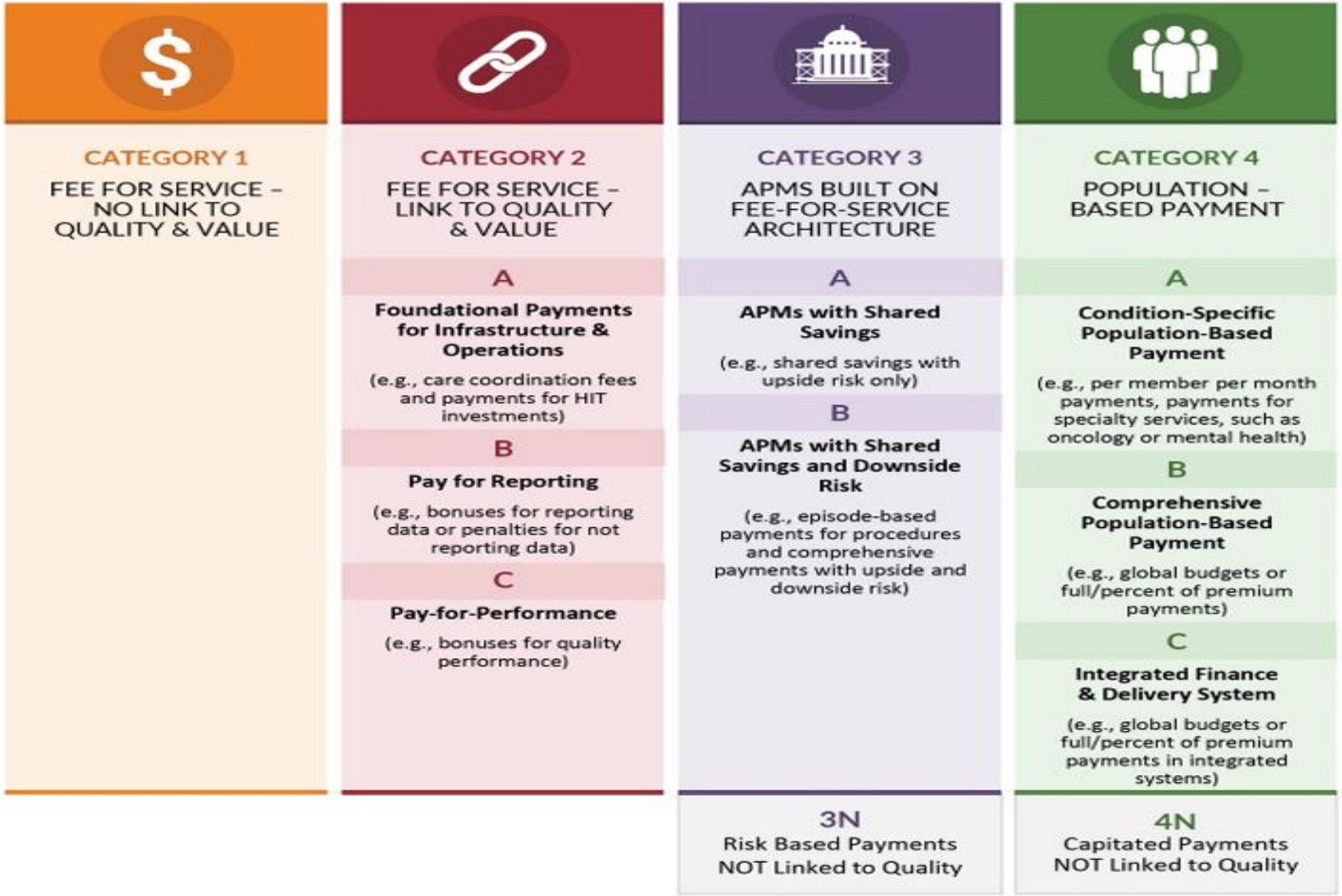
Providers who are successful in FFS may lack a compelling reason to transition to APMs, but may be unable to compete with the person-centered care delivered by providers in APMs. Introducing APMs through multi-payer pilots in these markets (particularly for independent and smaller providers) may increase competition and reduce FFS entrenchment.

PROMOTING POPULATION-SPECIFIC APPROACHES

Improving predictability for providers through improved risk adjustment for complex patients, offering stronger incentive structures for Medicaid beneficiaries, and flexibility on waivers.

Source: hcp-lan.org

HCP-LAN APM Framework



"I didn't recognize opportunity when it knocked. It was disguised as hard work."

Questions?