Testimony of
Miranda Motter
President and CEO
Ohio Association of Health Plans
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Mr. Chairman and members of the Health and Human Services Subcommittee, thank you for allowing me to testify today. My name is Miranda Motter and I am the President and CEO of the Ohio Association of Health Plans. OAHP is the statewide trade association representing 16 health insurance companies that provide coverage to more than nine million Ohioans. Many of our members participate in the Medicaid managed care program and work diligently to provide coordinated, quality and cost-effective care to Ohioans receiving Medicaid benefits.

Today, the program provides high quality, well-coordinated health care benefits to over 2.6 Million Ohioans. The managed care approach to coverage has resulted in a proven track record of success and positive impact that is not achievable in the traditional fee-for-service (FFS) system of coverage.

Managed care plans (MCPs) leverage best practices and innovations to help Ohio Medicaid improve care quality and reduce overall cost. With almost 40 years of Ohio experience, plans have provided Ohio's Medicaid program the ability to modernize care delivery and improve health outcomes through care coordination, value-added services, and partnerships with quality providers and community organizations.

Managed Care is Reshaping Ohio Medicaid

Managed care plans are the State's primary partners in driving Ohio Medicaid's quality strategy. The quality strategy is a performance and value agenda for specific populations, and Ohio's managed care partners have consistently stepped forward to implement new and innovative initiatives that drive overall quality improvement. This partnership is not only strategic, but also intentional, as it recognizes that managed care can do what the state's single payer FFS system cannot do. Here are a couple of examples:

Care Coordination. Medicaid managed care plans use care coordination to execute the state's quality strategy. Care coordination is key to managing the healthcare needs and costs of patients with complex and chronic conditions. This results in a better quality of life for the patient, fewer unmet needs, fewer avoidable health care episodes, and improved patient satisfaction. Care coordination is also a critical tool in addressing social determinants of health, including economic, environmental and social factors that impact the health and well-being of individuals.

Improving Quality and Providing Accountability. Managed care plans are held to quality and accountability standards that are foreign to the fee-for-service system. The State's contract with the plans includes a series of quality metrics that measure plans' success in improving the quality of care and health outcomes of members, as well as reducing costs. ODM has also established a pay for performance system – commonly referred to as 'P4P' - that incentivizes managed care plans for meeting specific performance standards. The P4P program is composed of national performance measures and specific measures that align with ODM's Quality Strategy and hold Medicaid plans accountable for evidence-based prevention and treatment practices. Ohio's Medicaid plans have demonstrated high quality on a national scale. ***All Ohio Medicaid plans are required to complete a rigorous and detailed NCQA accreditation process and Ohio's Medicaid plans scored higher than both the national and the large state group averages on NCQA metrics for 2016-2017.***

Paying for Value. Health plans are partnering with providers to improve quality and access to care, raise health awareness, promote early detection and reduce costs. These value-based payment relationships are critical to ensuring long-term sustainability for the state's Medicaid program. Through these initiatives, providers are eligible to receive additional payments when they achieve the quality goals outlined in their agreements. The General Assembly is leveraging managed care's ability to drive value in Ohio's health care delivery system by requiring Medicaid plans to implement value-based purchasing agreements with providers (ORC 5167.33). By 2020, at least 50 percent of Medicaid plan provider contracts must be value-based and the plans are well on their way to achieving this goal. Today, more than 25 percent of Medicaid plan provider agreements are value based. No such value-based purchasing requirement exists in the current fee-for-service program.

Cost Savings. The managed care model provides the state with greater predictability in budgeting, while also relieving taxpayers of financial risk. Today, 86 percent of Medicaid consumers receive care through this model where by health plans are paid monthly fixed capitation rates for all covered health services that the individual may need.

A recent report by Wakely Consulting Services found that Medicaid plans operate efficiently and produce significant savings when compared to fee-for-service. It is estimated that capitation rates paid to health plans were 9 to 11 percent lower in calendar year 2013 through 2015 than the cost of serving Ohioans through traditional fee-for-service – an estimated $2.5 to $3.2 billion dollars in savings.

From cost-savings to improved health outcomes, the State has been well-served by the innovation, state and national expertise, and community and provider partnerships provided by the managed care plans. In addition to the data provided today, we also want to talk about lives that have been impacted by managed care.

- In January, children in custody and adopted children were included in managed care and today more than 25,000 children receive the benefit of care coordination and increased access to services. You will hear from a plan regarding managed care's approach to new populations, specifically children in custody.

- Ohio was just the third state to garner federal approval for a demonstration program to coordinate benefits for individuals covered by both Medicare and Medicaid. Today, approximately 70 percent of those enrolled in MyCare Ohio receive coordinated benefits through this coordinated model. It is worth noting that the MyCare Ohio plans have scored - on average - above the 90th percentile on almost half of the 2016 HEDIS measures and above the 50th percentile on more than 75 percent of measures and on average. Additionally, when asked to assess the care coordination they received, the collective response of MyCare Ohio beneficiaries registered a 3.57 on a 4-point scale - which is above the national average. Two of the MyCare Ohio plans will provide you with testimony regarding the demonstration's benefits, as well as the innovative partnerships with local organizations.

- On January 1, 2018, individuals enrolled in managed care will receive the full benefit of having their physical and behavioral health needs coordinated. You will hear how plans have spent two years preparing for the redesign's implementation on July 1, 2017 and for overall integration on January 1, 2018.

- The Executive Budget aims to provide approximately 150,000 Ohioans with quality, coordinated care through the implementation of managed long-term services and supports. Today, you will hear one plan's experience administering MLTSS in other states and why Ohio is well positioned to move forward with this program.

The OAHP Medicaid and MyCare Ohio plans will now provide you further testimony on the value managed care brings to Ohio's Medicaid program. Before I turn it over to the plan leadership, I would like the committee to hear firsthand how Ohioans have been impacted by managed care.