

**Ohio Department Of Job and Family Services  
Office of Ohio Health Plans**



Application to participate in the Center For Health Care Strategies, Inc.  
Pay-For-Performance Purchasing Institute Initiative

August 14, 2006

Ohio Health Plans (Medicaid) is planning for coordinating provider pay for performance (P4P) across a statewide managed care program, among numerous plans and covered populations, along with services delivered and care for the populations remaining outside of managed care. Since Ohio covers the eligible under the State Children's Health Insurance Program (SCHIP) under its regular Medicaid program for children and families, P4P will cover working aged families and children along with the Aged, Blind, Disabled (ABD) population. Because virtually all of the public sector beneficiaries are included – nearly 20% of the Ohio population – the P4P project will give Medicaid a leadership role in performance improvement in Ohio.

**1. Past Experience with pay for performance:** Please detail your state's previous or current experience with pay-for-performance in Medicaid.

Ohio has attempted three major efforts to incorporate P4P incentive arrangements into Medicaid. Two of the programs, the Catalyst Long Term Care Pharmacy management program, and the Enhanced Care Management (ECM) program for chronically ill Medicaid beneficiaries, had promising results but came to an end because of changes in federal and state legislation. The third, performance payments for at-risk managed care plans, has grown in importance because of statewide expansion of Medicaid managed care.

The Catalyst program created a management incentive payment to LTC pharmacies, based on a per member per month (PMPM) payment for Medicaid nursing home resident who has at least one pharmacy expenditure monthly. The PMPM for pharmacy expenditures was inflated using the producer price index for pharmacy (PPI) to determine a performance target. Consultant pharmacists made recommendations to better manage residents through appropriate utilization of medications, and returning unused medications to stock. In the first year of implementation, pharmacy providers achieved substantial savings and received a savings share payment equivalent to one-half of the difference between actual spending and predicted spending at the PPI rate of growth. The following year, the initial reduction in inappropriate pharmacy utilization was difficult to replicate and no savings were shared. Passage of Medicare Part D moved most pharmacy payments for nursing home residents outside Medicaid.

The ECM program targeted aged, blind, and disabled Medicaid eligibles identified as having specific chronic conditions. Care Management organizations were paid a PMPM care management fee, and formed provider networks in specific geographic regions. Patients were assigned a medical provider as a care coordinator, who also received a PMPM fee for managing their panel of patients. A risk corridor produced incentive or penalty payments, comparing the actual rate of growth in medical costs for the ECM eligible population after program implementation to a target growth rate for ECM eligibles based on actual participation. Incentives were required to be passed on to the primary care providers based upon their performance among selected quality of care indicators. After the ECM program had been running a few months, the Ohio legislature opted to mandate ABD community dwelling population enroll in full risk managed care plans.

Currently, under full risk managed care contracts for each of the Covered Families and Children and Aged, Blind, and Disabled populations, plans are held accountable to meet specific performance targets (see Appendix A). One percent of the plans' PMPM payments are at-risk if the plan fails to meet minimum performance measures, based, for the most part, on HEDIS measures. Furthermore, a bonus payment is available for plans exceeding performance levels defined as superior. However, currently there is no requirement in our contracts with managed care plans to provide incentives to providers for their performance.

**2. State's top short-term (18 months) and long-term (three to five years) goals for implementing a provider-level P4P program.** Please include clinical areas of interest and a timeline of major milestones.

**Scope of the P4P effort.** The overall objective of this project is to implement a provider-level P4P system enhancing quality and reducing program costs. Although we expect to identify specific performance indicators as part of the planning process, we anticipate using measures for both preventive care and for the most costly and prevalent chronic diseases (e.g., congestive heart failure, coronary artery disease, hypertension, chronic obstructive pulmonary disease, asthma, diabetes, mental health conditions). As part of an overall information systems upgrade, Ohio has put into place a state of the art Decision Support System for analyzing Medicaid administrative data on the basis of costs and clinical conditions. Ohio had already used the DSS system to identify targeted populations for the ECM program, and to generate specific measures in areas of clinical focus mentioned above.

The OHP budget to be submitted to the legislature in February 2007 will request funding for supplemental provider payments to be allocated through this initiative; meetings with the legislature indicate a high level of support. In addition, Ohio Medicaid has contracted with experts at the University of Cincinnati to assist in designing and implementing a performance monitoring and reporting system at the provider level, and in the preparatory work leading to P4P.

We recognize that claims data are only part of the foundation for a P4P strategy and are also looking to obtain funding to build, in stages, an electronic health record system for all Medicaid patients, compatible with private sector EMR initiatives. This will eliminate the gaps in patient information caused by a fragmented system of health care financing and delivery in the public sector which is wrought with patient safety concerns. In addition this strategy provides the opportunity to incorporate clinical data which may be used to improve the clinical outcomes of our population.

### **Short-term (18 month) goals**

By the end of 18 month, we expect to have completed: 1) a pilot project monitoring and reporting on selected indicators, 2) have a plan for roll-out state-wide, and 3) have a plan for phasing in P4P. Achieving these goals depends on the completion of the following milestones:

1. Complete an environmental scan to determine what quality monitoring/quality improvement efforts are underway at health plans, ODJFS, and individual physician collaboratives in the state. (completion expected October 2006)

We are currently conducting an environmental scan to determine what is being done nationally and in Ohio, both in the commercial sector and, in other state Medicaid programs. Understanding trends and current applications in Ohio will be important information for stakeholder meetings, described next.

2. Establish an Advisory Committee for the P4P project and convene regional meetings and consensus conferences of key stakeholders throughout the state to secure reaction and buy-in to the system. (Beginning Oct 2006 but ongoing through the project)

We recognize that buy-in from clinical providers will be crucially important and expect consensus conferences to be working with state and community opinion leaders. At the same time we seek to secure buy-in for the endeavor from other stakeholders such as health plan management, other large purchasers, medical society leadership, other branches of state government and the employer community. Regional consensus conferences, described in more detail below under section 3, will be used to accomplish this goal.

3. Finalize selection of performance and develop technical specifications for measurement for selected performance indicators (Nov 2006 to July 2007)

Performance indicators will be selected in concert with the provider community. We expect that they will be related to preventive and chronic care indicators currently used to measure performance at the health plan level. These indicators relate to most prevalent and costly diagnoses in Medicaid, were developed with appropriate input, and are reasonably well accepted. We expect that we will add infrastructure indicators, particularly related to use of an office-based electronic medical record that links to the state summary electronic health record under development.

As part of this task, technical specifications will be developed to use the selected indicators at the provider level. As part of this task, we will need to define "provider" and ascertain how this variable is to be obtained, while comparing results with various denominators (e.g., those beneficiaries meeting continuous enrollment requirements, member months, etc). This task will also entail determining data bases to use to relate beneficiary to a provider, both for all beneficiaries and for beneficiaries with chronic illnesses. Claims data, eligibility files and health plan databases will be used in this task.

4. Design and implement a pilot test for monitoring and feeding back results of performance (August 2007 to October 2007)

Preparation time needed in order to begin a pilot test in November 2007. Pilot site will be selected based on stakeholder recommendations and ability to generate information needed for statewide roll-out. It is likely that pilot sites will be two urban and one rural county.

5. Develop plan for roll-out statewide of performance monitoring and feedback at the provider level (Nov 2007 to June 2008)
6. Develop pilot to allow for provider payments to be adjusted for performance (Nov 2007 to June 2008)

By the end of the 18 month period we will have completed the pilot test and will be ready to launch the statewide roll-out of performance monitoring and reporting at the provider level as of July 2008. Further, by the end of the 18 month period, a plan for adjusting provider payments according to performance will have been developed, and available funds to implement an enhanced payment system should be available in the state fiscal year beginning July 2008.

### **Long-term (3 to 5 year) goals**

During the time from 18 months to 3 years, Ohio will have implemented its P4P system state-wide. Our long-term vision is to collaborate with existing P4P efforts on an all-payor basis and use provider-based electronic health records instead of claims to determine services and outcomes. This will allow us to monitor any disparities in care among different population groups. Pilot projects using these advances will be launched in the 3 to 5 year time frame. We also envision making information available to consumers and envision having a system to strengthen performance of poorly performing providers. Specific goals are:

- A. Develop provider-oriented report cards for consumers.
- B. Develop state-wide quality improvement collaboratives and state-wide technical assistance for quality improvement.

- C. Establish pilots for P4P on an all-payor basis in select communities. Groups in the Cleveland and Cincinnati regions are developing an all-payor data warehouse in order to obtain an all-payor view of community health.
- D. Begin use of electronic health record to determine performance (to enable an eventual phase out of use of claims).

### **3. Ohio's plan to engage the provider community**

Before implementing a measurement and reporting system, it is essential to have buy-in from the affected providers, managed care plans and other stakeholders. It is even more important to secure this buy-in if financial incentives flow from performance on these measures. We plan to secure buy-in several ways. First, an Advisory Committee of opinion leader providers, health plans, other state purchasers, other large commercial purchasers, other branches of government and other stakeholders will be formed to guide the planning and implementation effort. Preliminary discussions about participation on the advisory committee have already occurred with representatives of Ohio's Medicaid Managed Care Plans, the leadership of Ohio's efforts to implement the EHR (Health Policy Institute of Ohio, and Cincinnati HealthBridge) as well as Ohio's leading strategy to implement an all-payer ambulatory care performance measurement system through an EHR (Cleveland MetroHealth Center for Health Care Research & Policy). The Advisory Committee will be chaired by the Medicaid Medical Director, Dr. Mary Applegate, who is a practicing physician in Ohio and well-known and respected in the provider community. The provider members on this proposed P4P team will also be member of the Advisory Committee and will serve as liaison between the P4P endeavor and the larger provider and stakeholder community. Advisory Committee meetings will be attended by state officials involved in this effort, including the Chief of Managed Health Care and the Assistant Medicaid Director, Benefits, and by the technical contractors at University of Cincinnati.

Second, we will hold regional meetings in the eight managed care regions throughout the state and at least one meeting in each major metropolitan center in Ohio. These state-wide regional meetings will be followed by "consensus conferences" to allow the provider and larger stakeholder community to shape the final decisions about measurement, reporting and P4P.

### **4. Significant barriers that could impede implementation of the P4P program**

There are two significant barriers – one political/organizational and the other operational – that need to be solved for a successful implementation. The political/organizational barrier is that we will need to overcome resistance as we move from a system where health plans receive the incentive and have discretion whether to pass payments to the provider to a system where providers are receiving clearly defined payment according to their performance. The operational barrier is that state-level administrative databases need to be improved if they are to be the basis for a provider incentive system.

Because managed care is now mandatory for most Medicaid beneficiaries, much of the P4P will be delivered in a managed care context. Currently, health plans receive incentives for meeting performance targets and have full discretion for how the payments are used. Managed care plans may continue to be the entities receiving payments and distributing incentives to for providers under the P4P system. However, for the P4P to make a difference to providers, incentives will need to be a meaningful amount and have some degree of consistency across health plans. (It would be counterproductive, for example, for providers to have different payments for different performance indicators from the different managed care plans with which they contract.) If we are not able to work out with health plans a strategy that ensures a consistent payment for specified performance, effective implementation could be impeded.

With respect to operations, although Ohio's state of the art Decision Support System incorporates measurement at the provider level, consistent identification of primary care providers across plans at a level of aggregation that is meaningful may be difficult. The new National Provider Identifier system may assist in this area, although the use of Employer Identification Numbers may be a more effective strategy..

Medicaid recognizes that reaction from providers would not be positive if P4P incentive payments were carved from current reimbursement. We have not characterized this as a impediment because we believe that enhanced funding will be forthcoming. A compelling business case for P4P is being made as part of the March 2007 budget request, and reaction from the legislature is positive.

**5. In the attached letter, we list four areas that will be addressed as a part of the P4P Purchasing Institute:**

- \_2\_Developing an Incentive Structure;
- \_4\_Selecting Measures;
- \_1\_Engaging Providers; and
- \_3\_Data Transparency and Dissemination of Outcomes.

Please rank the areas that are the highest priority for your state given your current stage of program development (with 1 signifying the most relevant). Where possible, please list specific technical assistance needs for each area.

**Engaging Providers**

Access to external experts or leaders representing successful implementation of P4P initiatives, from payers and providers.

Identifying most effective methods for engaging disinterested providers

Identifying and supporting physician champions in the current provider population.

Identifying the benchmarks for success in engaging providers.

**Developing an Incentive Structure;**

Paying for participation in improvement strategies/ paying for reaching goals.

Identifying the best method for rewarding desired physician performance.

Identifying most effective improvement strategies (incremental improvement, near-perfection, or high performing benchmarks).

Considerations for complex case-mix of patients.

**Data Transparency and Dissemination of Outcomes.**

Identifying appropriate methods for comparing providers with their peers.

Identifying methods of incorporating results in communications with consumers concerning selection of plans and providers.

Sharing of performance of providers with other interested providers in the delivery system.

**Selecting Measures;**

How many specific measures are manageable to implement at one time.

Identifying the measures for which there is the most opportunity for improvement in outcomes..

### **Team member #1 (Lead ) Contact Information**

Sandra Solano-Mcguire, M.D.  
Title: Chief of Health Services Research  
Bureau of Health Plan Policy  
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#### **Selection Rationale:**

Dr. Solano McGuire is responsible for the implementation of OHPs clinical performance measurement systems, and sponsors the implementation of the Medicaid Data Warehouse and Decision Support Systems. Her staff is key to the effort required. She has excellent experience in measuring health care performance as the principal investigator in performing HEDIS measurement studies using medical records when she worked for Ohio's Medicaid EQRO contractor. She was responsible for implementing inpatient quality improvement initiatives at the Ohio State University Hospitals. She has been responsible for implementation of health related information technology systems having just completed state-wide automation of vital records at the Ohio Department of Health. Dr. Solano McGuire is known as a facilitator, a leader, and a change agent.

### **Team member #2 Contact Information**

Mary Applegate, M.D., FAAP. FACP  
Title: Medical Director  
Office of Ohio Health Plans  
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#### **Selection Rationale:**

Dr. Applegate is a practicing primary care physician in Marysville Ohio. She is also the part-time Medical Director for Ohio Health Plans, working an average of 10 hours per week. Dr. Applegate is Board Certified in Pediatrics and Internal Medicine. She provides leadership in the provider community as the chairman of the quality improvement committee of the local community hospital. She is passionate about serving the needs of the Medicaid population, and reducing or eliminating health disparities. She is extremely knowledgeable about the implementation of performance improvement strategies from the provider perspective.

### **Team member #3 Contact Information**

Mina Chang, Ph.D.  
Title: Chief of Performance Review and Business Support  
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#### **Selection Rationale:**

Dr. Chang is responsible for the implementation of the performance measurement and incentive payment system for Medicaid managed care plans. The involvement of the leadership of the Bureau of Managed Health Care is essential to this effort. She has previous experience in implementing pay for performance strategies in the public community mental health system

### **Team member #4 Contact Information**

Mr. Dan Hecht, M.A.

Title: Manager of Performance Measurement Systems  
Bureau of Health Plan Policy  
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#### **Selection Rationale:**

Mr. Hecht is responsible for the business user leadership in implementation and management of the technology systems that support health plan and provider performance measurement in Ohio Health Plans. This includes an NCQA certified HEDIS measurement system (QSI, from Catalyst Technologies, Inc.) and the AHRQ Hospital Quality Indicators. Mr. Hecht has been using these tools and the Medicaid Decision Support System to measure performance geographically, at a program, health plan, and provider level over the past 4 years.

## **Team member #5 Contact Information**

Gerry Lynn Fairbrother, Ph.D.

Title: Professor and Principal Investigator of the Medicaid Performance Monitoring/P4P Project

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### **Selection Rationale:**

As Principal Investigator on the grant to assist Ohio Medicaid in designing a Medicaid performance monitoring and P4P system, Dr. Fairbrother has been charged with helping the Ohio design the technical specifications of the performance monitoring, using Ohio databases. She has a long history of using state-level data in her research and is knowledgeable in health plan-level data and the exchanges between health plan and state. She will work closely with Ohio Medicaid staff members in charge of databases in her work on this project.