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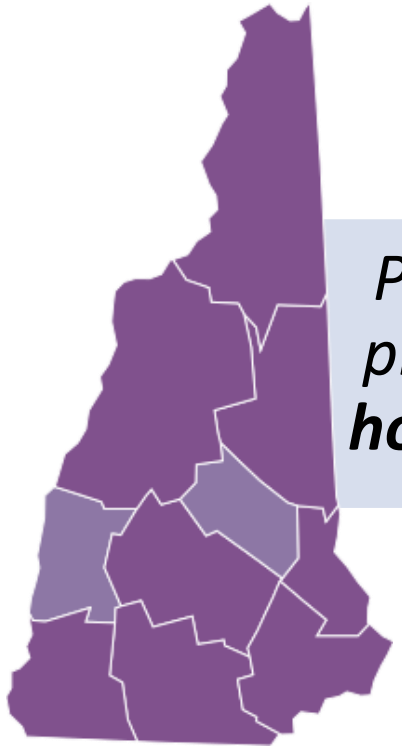
DHHS
DEPARTMENT OF
HEALTH & HUMAN SERVICES

Medicaid Care Management Re-Procurement

Public Information Sessions

July-August 2023

Aim of this Procurement



*Promote **optimal health** and **equitable access** by better integrating physical and behavioral healthcare through a **more meaningful and holistic role of providers** in the delivery of care in the MCM Program.*

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Key Objectives

Center **patient-provider relationships** in care delivery and preventive services

Increase focus on **priority populations** such as DCYF-involved children and infants with Neonatal Abstinence Syndrome

Ensure **safe and effective use of medications**, while providing **access to new therapies**

Strengthen the **alignment of CMHC funding** with existing state behavioral health investments

Improve the **reliability and safety** of Non-Emergency Medical Transportation

Capture the **full potential of program integrity** functions

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New Program Features - 1

Primary Care and Preventive Services Model of Care: Built on authentic patient/provider relationships and provider-delivered Care Coordination. MCOs to provide analytic support to medical providers for Care Coordination

Integrated Pharmacy Benefit Management: High-Cost Pharmacy Risk Pool for High-Cost Therapies. MCOs share in the utilization management and risk of new high-cost drugs and gene therapies. DHHS may exercise an **option for a single PBM** (Pharmacy Benefit Manager) after year three to streamline prescribing and enhance state rebates

Focused MCO-delivered Care Management services on priority populations: including previously incarcerated members, DCYF-involved children, infants with low-birthweight and/or neonatal abstinence syndrome, and members in the community who have had a behavioral health inpatient facility admission within past 12 months.

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New Program Features - Continued

Restructure the CMHC Capitation Model: Further aligning funding with state behavioral health investments and program goals.

Strengthened Reliability, Quality, Safety, and Access in the performance of the NEMT program: Elevated standards and remedies applied to MCOs' performance of oversight of their NEMT brokers and transportation providers.

Amplification of Program Integrity Objectives: Expanded use of incentives and remedies for MCO performance for key quality and performance metrics.

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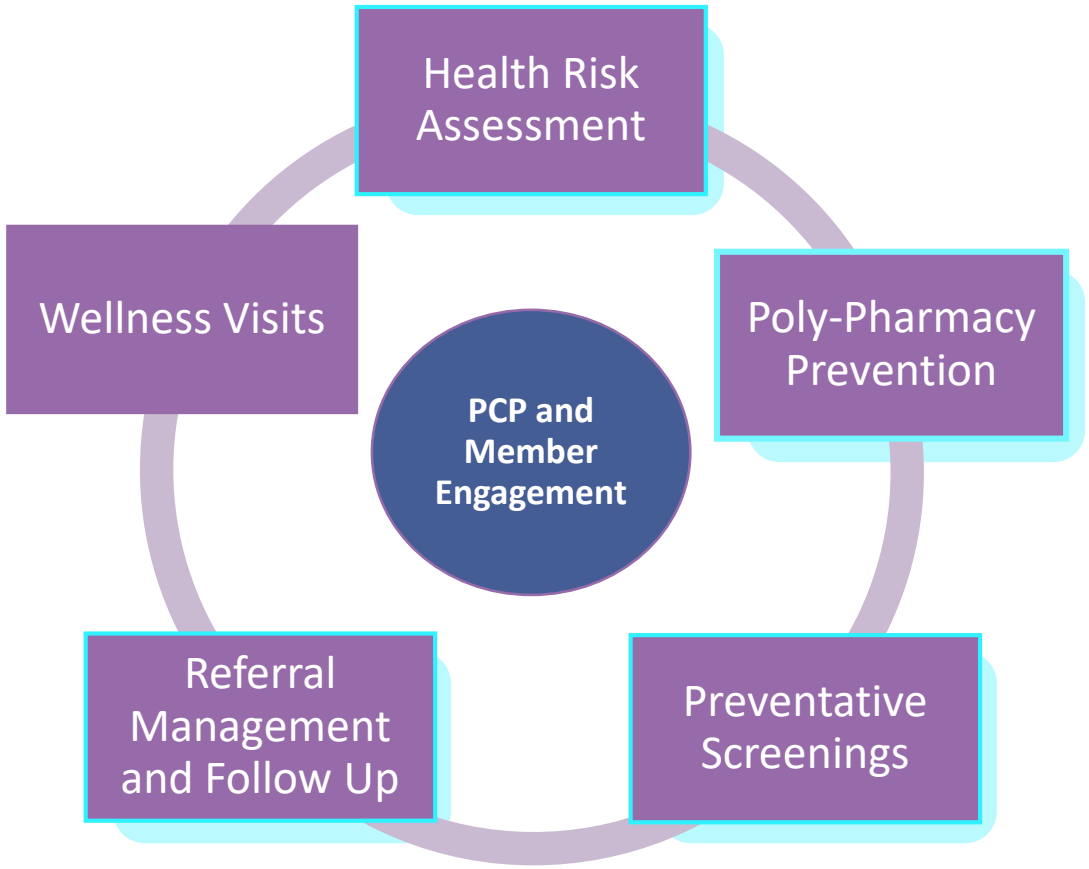
1. Primary Care and Preventive Services Model of Care

Model Amplifies Role of Primary Care Providers, Strengthens Relationships Between Providers and Member, and Emphasizes Prevention to Effectively Reduce Future Illness Burden



Changes Include:

- Primary Care and Preventive Services Model of Care reflects DHHS' (the State's) longitudinal interest in members' long-term health and delivering coordinated, whole-person care.
- Providing payment and incentives for primary care to develop meaningful relationships with members to foster longitudinally beneficial medical and behavioral healthcare.
- Offering financial incentives and payment for medical providers to complete annual health risk assessments, wellness visits, preventive screenings and care coordination.
- Enabling payment to primary care providers and community pharmacists to conduct comprehensive medication reviews to support appropriate pharmaceutical use among adults and children.

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2. Integrated Pharmacy Benefit Management

Streamlines existing systems and improves cost-savings

Integrated Medication Management

- Increase provider capabilities for reimbursable Rx review activities
- Contract criteria for polypharmacy review and DHHS authority on PA review criteria
- Member incentives for engagement in medication review
- Extend Rx efficiency analyses

High-Cost Pharmacy Risk Pool

- Strategy for financial management of largest and least predictable cost area for MCM program
- Allocates funding to MCOs based on outlier cost pharmacy claims
- Expected effect: Sharing Risk with MCOs and promoting MCO engagement in the course of care and treatment

Option for Single PBM

- Reduce provider and member abrasion
- Fully uniform Preferred Drug List
- More expansive pharmacy network
- Maximize supplemental rebates to DHHS
- MCOs retain certain contracting responsibilities

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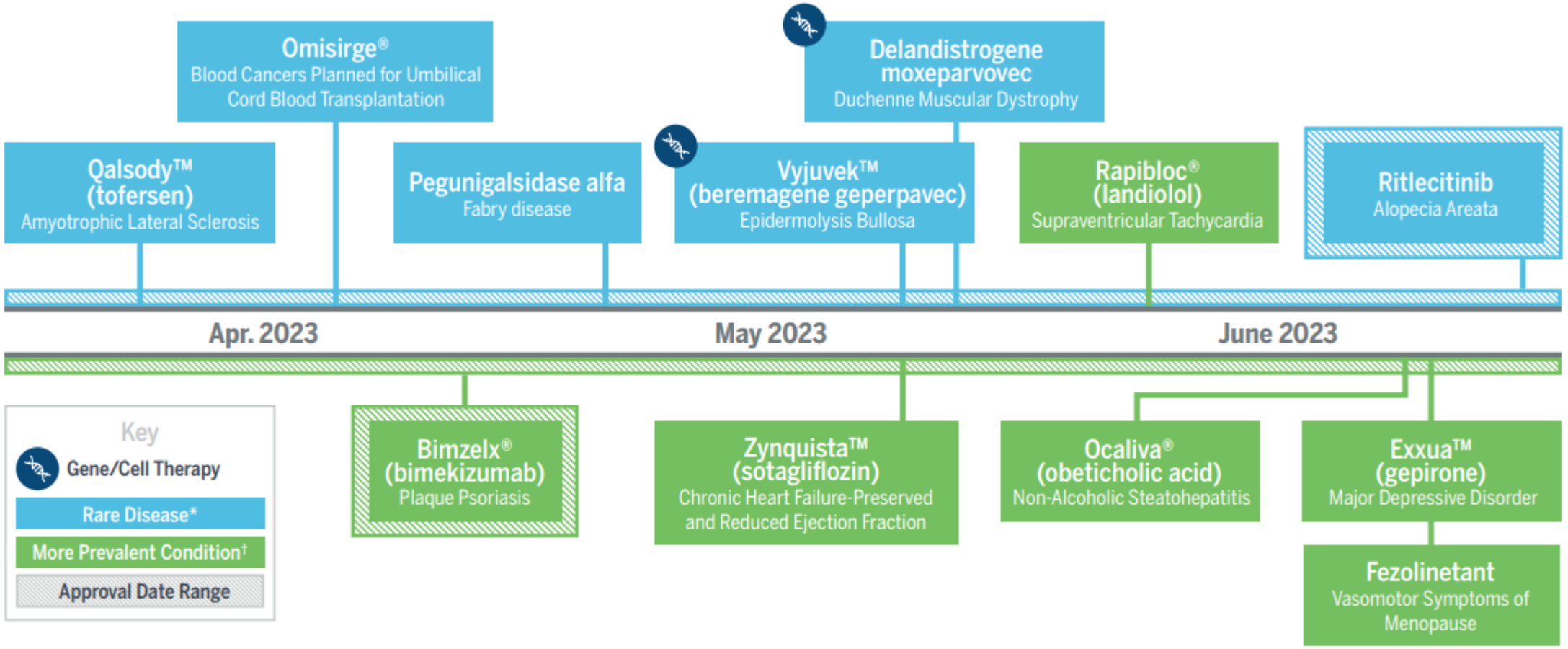
Medicaid Relevant Drug Pipeline: Q2 2023



***Rare Disease:** Condition affects fewer than 200,000 individuals in the U.S.
†**More Prevalent Condition:** Condition affecting at least 200,000 individuals in the U.S.

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High-Cost Drug Projection: Zynteglo Case Study

Projections can be replicated for other gene therapies as well as high-cost, high-impact drugs

Approved August 17, 2022

Zynteglo is a gene therapy that received Food and Drug Administration (FDA) approval on August 17, 2022, for the treatment of adult and pediatric patients with beta-thalassemia who require regular red blood cell transfusions.

Estimated Cost of >$2.8 million

Zynteglo is a one-time treatment that costs $2.8 million, plus additional cost for required hospitalizations and ancillary services to administer the drug.

Claims Analysis

We analyze claims data for members with a diagnosis of beta-thalassemia using an ICD-10 diagnosis code of D56.1 and identify members who have regular blood transfusions. Blood transfusions are identified using HCPCS and CPT codes. We also identify members with contraindications who are unlikely to be candidates for Zynteglo.

Utilization & Financial Impact Estimation

From the claims analysis we capture members potentially eligible for Zynteglo, which MCO those members are enrolled in, the current healthcare costs associated with each member, and project Zynteglo financial impact (e.g., PMPM cost).

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Single PBM Examples

Kentucky Single PBM

- A study found that in 2018, PBMs were retaining $123M in spread pricing
- Kentucky passed Senate Bill 50 mandating that Medicaid Managed Care entities implement a single PDL, remove spread pricing, and contract with a Single PBM.
- On 1/1/2021 Kentucky transitioned to a single PDL
- Providers were subsequently notified that MedImpact would serve as the State's single PBM starting 7/1/2021
- The State requires providers to be reimbursed using FFS pricing logic
- MCOs remain at risk for pharmacy expenditures with capitated rates

Ohio Single PBM as a PAHP

- A study found that PBMs were retaining spread of around $150M-$186M per year
- In 2019, Ohio Medicaid (ODM) directed managed care plans to implement pass-through pricing
- In 2020, ODM sought to further refine their pharmacy program by proposing a Single PBM model and began the process to procure a CMS waiver
- ODM named Gainwell as their Single PBM effective 10/1/2022
- MCOs are not under a capitated arrangement
- ODM no longer retains revenue from the premium tax

https://www.chfs.ky.gov/agencies/ohda/Documents1/CHFSMedicaidPharmacyPricing.pdf
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7251257/

3. Focus MCO-Delivered Care Management on Priority Populations

MCOs retain responsibility for delivering care management services to targeted priority populations: DCYF-involved children, infants with low-birthweight and Neonatal Abstinence Syndrome, previously incarcerated population, and members in the community who have had a behavioral health inpatient admission

<u>MCOs Retain Direct Responsibility for Delivering Care Management Services, Including:</u>

- Providing traditional, episodic care management as needed for members of all populations the MCOs identify as needing services
- Providing care management for priority populations (expected to be less than 3% of total membership)
- Developing a care management team and care management plan for each priority population member receiving MCO-delivered care management services.
- Providing Care Manager to priority population members who who need them.

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Select Primary Care-Delivered Care Coordination Services and MCO-Delivered Care Management Services

Focused Service	Primary Care Provider	Managed Care Organization
Wellness visit	Delivers Annually To Attributed Patients	Enables claims-based payment; enables service to be billed within an appointment for another service or as a stand-alone service.
Health Risk Assessment	Delivers Annually To Attributed Patients	Enables claims-based payment; enables service to be billed within an appointment for another service or as a stand-alone service.
Comprehensive Medication Review	Delivers Annually To Patients Determined At-Risk for Polypharmacy	Provides Rx data about attributed members with polypharmacy risks to primary care providers; enables service to be billed within an appointment for another service or as a stand-alone service; enables claims-based payment to medical providers and community pharmacists.
Care Coordination	Medical clinicians and office team such as community health workers, social workers, medical assistants all deliver care coordination.	Enables claims-based payment for care coordination; enables service to be billed within an appointment for another service or as a stand-alone service; provides data about attributed members to Primary Care Providers.

Select Primary Care-Delivered Care Coordination Services and MCO-Delivered Care Management Services

Focused Service	Primary Care Provider	Managed Care Organization
Care Management Identification and Assessment	Support MCO-Delivered Care Management Services as Needed for Priority Population Members	Creates and Implements Assessment for Priority Population members who require MCO-Delivered Care Management services.
MCO Provided Care Manager	N/A	Responsible for designating Care Manager for Priority Population members who require MCO-Delivered Care Management services.
MCO-Designated Care Teams	Participates As Requested As Member of Team	Responsible for convening and leading Care Team for Priority Population members who require MCO-Delivered Care Management services.

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4. Restructure Capitation to Improve Alignment with State Behavioral Health Investments and Program Goals

- **Capitation Redesign**
- **Reintegration of Substance Misuse Funding**
- **Introduction of Certified Community Behavioral Health Clinics**
- **Directed Payment Expansion (e.g., SUD, co-occurring)**
- **1115 Waiver Extension**
- **Sustainability of Governor's Commission Funding**

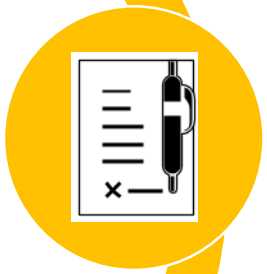
→ **Financial Alignment** → **Greater Integration of Behavioral Health and Physical Health Services** → **Comprehensively Serve the Needs of Individuals with Co-occurring Illnesses**

Changes Include:

- Restructured Capitation Design for CMHCs. Ensures Funding Intended for Investment in Behavioral Health Reaches the Front Line of Behavioral Health Care System.

GOAL STATEMENT:

Strengthen community mental health delivery system through financial and operational alignment within the MCM Program. MCO/CMHC contracts will support the State 10-Year Mental Health Plan, and initiatives like Mission Zero.



PROCUREMENT NEXT STEPS:

Alignment of CMHC/ MCO/DHHS partners' responsibilities. To be structured through a State-defined, standardized MCO/CMHC contract. Funding to CMHCs that includes PMPM capitation, directed payment funding and incentives to achieve system-wide improvement.

END RESULT:

Increases resources to achieve service delivery goals. Minimum MCO abrasion to achieve the State's strategic initiatives. Results in improved access to care and a higher level of performance within the behavioral health system for patients.

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5. Strengthened Reliability, Quality, Safety, and Access in the Performance of Non-Emergency Medical Transportation

Ensuring Transportation Is Not A Barrier To Accessing Needed Medical Care

MCO Oversight NEMT

- Increased oversight of MCO transportation broker subcontracts
- Requiring NEMT drivers to use GPS
- Elevated standards and remedies applies to MCO oversight of NEMT Brokers and Transportation Providers

Improved Coordination Broker/MCO

- Requiring a new MCO Key Personnel transportation broker management position

Clear, Efficient Processes

- Heightened MCO financial incentives and penalties to increase reliability, safety, quality and access.

Right Vehicle, Right Time

Member Transportation Needs Met

Strengthened Reliability, Quality, Safety, and Access in the performance of NEMT

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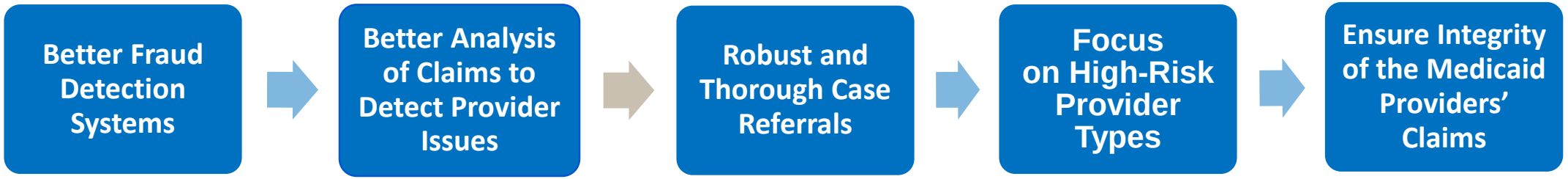
6. Amplify Program Integrity Objectives

Strengthen Fraud, Waste, and Abuse Detection and Investigations



Objectives Will Be Met By:

- Enhanced comprehensive fraud prevention and detection systems including compliance plans, audit plans, data analytics, claims edits, site visits, and service verification
- Thoroughly investigating and providing well-substantiated case referrals to the Medicaid Fraud Control Unit (MFCU) at the Attorney General's Office
- Statistical analysis utilized to determine appropriate investigations and establish methods for reviewing high-risk provider types as categorized by the OIG.

Additional Program Features

- Streamline and standardize **Alternative Payment Model approach.**
- Use **In-Lieu of Services** to address Health Related Social Needs.
- Reserve ability to establish **Dual-Eligible Special Needs Plan (D-SNP).**
- **Performance-based auto-assignment** to increase membership for MCOs who meet program quality metrics.
- Inclusion of new **Maternal Health benefits and Preventive Health benefits** as passed in 2023 budget.

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Thank you

Henry Lipman, Medicaid Director

Dr. Jonathan Ballard, Chief Medical Officer