

Medicaid

Create a Single Point of Care Coordination

Budget Impact

FY 2012	FY 2013	Biennial Total
\$0	\$0	\$0

Background:

Ohio's Medicaid program serves approximately 173,000 individuals with long-term care needs each year. For most of these individuals, long-term care services, behavioral health services, and physical health services are provided through separate delivery systems with little or no coordination. While only seven percent of the Medicaid population uses long-term care services, 41 percent of annual Medicaid expenditures are for services to this population.

Many individuals receiving long-term care services are covered by both Medicare and Medicaid. These "dual eligibles" consume 46 percent of Medicaid long-term care service spending and 16 percent of behavioral health service spending. Because Medicare and Medicaid are designed and managed with little or no connection to each other, the system is unnecessarily complex for individuals and providers to navigate.

In addition to dual eligibles, Ohio serves many "dual-like" individuals who are on Medicaid only but have similar long-term care needs, often as a result of severe mental illness. These individuals receive services through separate physical and behavioral health systems. This fragmented system does not support coordination among providers, results in both unmet needs and over-utilization, and is building toward a financial crisis. Since 2000, public funding for behavioral health services has not kept pace with demand and service costs.

Executive Budget Proposal and Impact:

The Executive Budget builds on a February 2011 [proposal](#) submitted by the Governor's Office of Health Transformation to the federal Center for Medicare and Medicaid Innovation for a planning grant to improve care coordination. The vision is to create a person-centered care management approach – not a provider, program, or payer approach – that reflects the following core values:

- Individuals receive person-centered care through a delivery system designed to address all of the individual's physical health, behavioral health, long-term care, and social needs;
- Individuals have access to the services they need in the setting they choose;
- The delivery system is easy to navigate for both the individuals receiving services and the providers delivering the services;
- Individuals transition seamlessly among settings and programs as needs change; and

- Incentives in the system focus on performance outcomes related to better health, better care, and cost savings through improvement.

To achieve this vision, the planning grant outlines an implementation strategy for a new Individual-Centered Integrated Care Delivery System (ICDS) that will:

- Focus first on Ohio's 113,000 dually eligible individuals who are residents of nursing facilities, enrollees in Ohio's home and community based services waivers who require a nursing facility level of care, and individuals with severe persistent mental illness;
- Explore alternative models for implementation, including managed care plans, accountable care organizations, health homes, and/or other integrated care models;
- Require providers to have ONE point of contact for an individual receiving services;
- Require providers to pursue the triple quality aim of improving the experience of care, enhancing the health of populations, and reducing costs through improvement; and
- Develop innovative rate-setting methods, including outcome-based performance incentives and focused care coordination.

The ICDS program will be implemented in September 2012. One of the first steps toward implementation will be to seek federal waivers to allow Ohio Medicaid to provide a limited room and board option, share in federal Medicare savings that result from state Medicaid reforms, and establish different level of care requirements for nursing facility and home and community based services to reduce the institutional bias. The Executive Budget will allow Medicaid to contract with ICDS providers and enroll dual eligibles in managed care.

ICDS is designed to provide person-centered care addressing all of an individual's physical health, behavioral health, long-term care and social needs. It will be the cornerstone of Ohio's efforts to achieve a balanced delivery system that enables the aged and people with disabilities to live with dignity in the settings they prefer.

Medicaid
Promote Health Homes

Budget Impact

FY 2012	FY 2013	Biennial Total
\$900,000	\$46,350,000	\$47,250,000

Background:

Medicaid consumers with chronic conditions are costly. For Medicaid enrollees living in the community, 34 percent have at least one chronic condition and account for 70 percent of costs, about \$7.2 billion annually (11 percent have two or more chronic conditions and cost Medicaid \$4.0 billion annually). The current uncoordinated, disjointed, provider-centered health system has low value to the state as a health care purchaser. There is growing evidence that primary care is vital to a high performance health system and that care management, care coordination, and transition services at the point of care can reduce other avoidable and costly services.

Creating health homes in Medicaid has the potential to improve the value of health care purchased for individuals with severe and/or multiple chronic conditions. Research demonstrates that a health system built on a solid foundation of primary care delivers more effective, efficient, and equitable care than systems that fail to invest adequately in primary care. States that rely more on primary care have lower resource inputs, lower utilization rates, and better quality of care. Numerous studies demonstrate seeing a regular doctor is associated with fewer preventable emergency room visits and fewer hospital admissions.

Executive Budget Proposal and Impact:

The Executive Budget includes a Health Home initiative to expand on the traditional medical home model by enhancing coordination of medical and behavioral health care consistent with the needs of individuals with severe and/or multiple chronic illnesses. Health Homes are an intense form of care management that includes a comprehensive set of services and meaningful use of health information technology. For each chronically ill person in the Medicaid program, a Health Home will be required to:

- Provide quality-driven, cost-effective, culturally appropriate, person-centered services;
- Coordinate or provide access to high-quality and evidence-based preventive/health promotion services, mental health and substance use/dependence services, comprehensive care management across settings, individual and family supports, and long-term care services;

- Build linkages to other community and social supports to aid the patient in complying with their care treatment plan;
- Develop a person-centered care plan that integrates clinical and non-clinical health care needs and/or services;
- Establish a continuous quality improvement program; and
- Use electronic health records, link services with health information technology, and communicate across teams and with individual and family caregivers.

The Health Home initiative will build on the medical home initiatives already underway throughout Ohio. It will add to these efforts by taking advantage of the federal Affordable Care Act provision that allows states to claim a 90 percent federal match for eight quarters (two years) for a defined set of care coordination services for individuals who are severely chronically ill or have multiple chronic conditions. All qualifying Medicaid patients under the care of a Health Home will receive these additional services, including those who are dually eligible for Medicaid and Medicare. The state will work with CMS to design payment methods that work for Ohio, and phase the program in by condition and/or geography.

The Health Home model is independent of delivery systems. For example, the single point of care coordination proposed in the Executive Budget for dual eligible and “dual-like” individuals will provide a Health Home for this subset of individuals enrolled in Medicaid. A Health Home can operate within fee-for-service, managed care, or other service delivery systems.

Medicaid

Provide Accountable Care for Children

Budget Impact

FY 2012	FY 2013	Biennial Total
\$0	\$87,100,000	\$87,100,000

Background:

Currently, 37,544 disabled children are served through Ohio’s fee-for-service program at a cost of \$313 million per year. These children often have complicated and long-term medical conditions, but receive little assistance in accessing and coordinating care. Without some form of care coordination, these children will continue to experience difficulties in managing complicated medical conditions, and have less than desirable health outcomes at a significant cost to the Medicaid program.

Several of Ohio’s children’s hospitals are working to develop a new model of care – called a Pediatric Accountable Care Organization (ACO) – to provide the additional support required to meet the complex medical and behavioral health needs of disabled children. These efforts are encouraging, but many of the potential ACO sites are not ready to accept the risk and responsibilities of a free-standing ACO.

Executive Budget Proposal and Impact:

The Executive Budget will improve care coordination for disabled children and encourage the development of pediatric ACOs. As shown in the chart below, the process begins by enrolling disabled children who do not reside in an institution or receive home and community based waiver services in Medicaid managed care beginning July 1, 2012 (Phase I). Managed care plans will be encouraged to form new contract relationships with developing ACOs where the ACO assumes responsibility for care coordination and a portion of the risk for children enrolled in the ACO (Phase II). This allows potential ACO sites to develop and eventually decide whether or not to take on the full risk and responsibilities of a free-standing ACO (Phase III).

Responsibility	Current	Phase I	Phase II	Phase III
Medicaid Contract	Fee-for-Service	Health Plan	Health Plan	ACO
Care Coordination	None	Health Plan	ACO	ACO
Financial Risk	Medicaid	Health Plan	Health Plan	ACO
Savings	None	Medicaid	Health Plan/ACO	ACO/Medicaid

Pediatric ACOs will be expected to provide additional attention and care to the unique needs of disabled children. Such attention will assist in delivering the proper care in the proper setting resulting in improved health care outcomes and reduced cost. Until the pediatric ACOs can be fully developed, Ohio's managed care program will provide access to specialized care management services to improve outcomes while decreasing costs in the Medicaid program. Eventually, Medicaid children will have another avenue of specialized care available to them directly through the pediatric ACO.

This change will cost \$87 million over the biennium as a result of \$288 million in savings expected to result from better utilization control, and \$375 million in costs associated with moving from a retrospective to prospective payment system.