Ohio | Governor's Office of Health Transformation

Better Care Coordination: Ohio's Path to Better Health and Lower Costs

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Governor's Office of Health Transformation

Ohio Association of Health Plans
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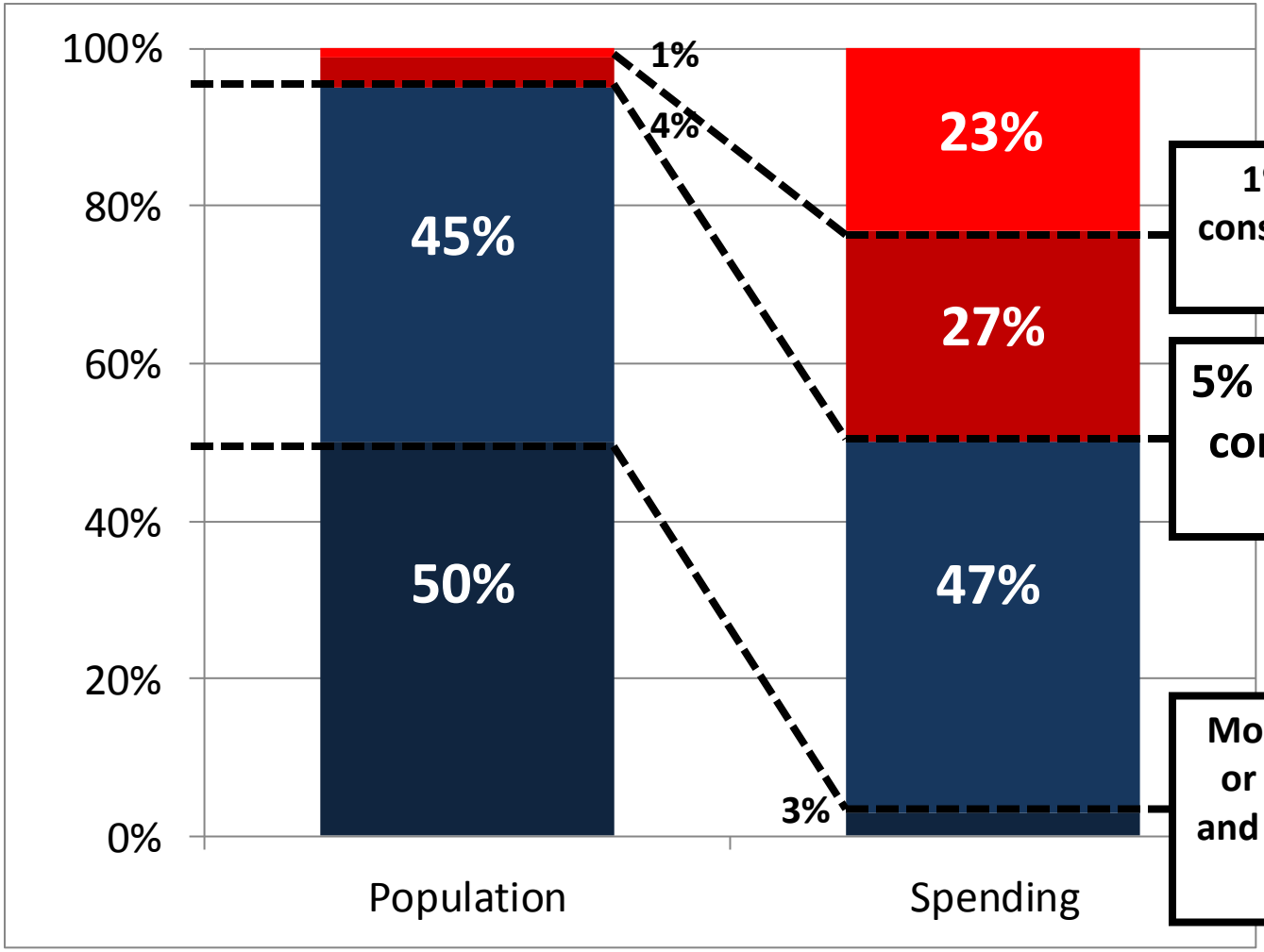
www.HealthTransformation.Ohio.gov

2011 Ohio Crisis

- $7.7 billion fiscal imbalance
- 89-cents in the rainy day fund
- Nearly dead last in job creation
- Medicaid spending increased 33% over the 3 prior years
- Medicaid overspending required multiple budget corrections
- Ohio Medicaid stuck in the past and in need of reform
- More than 1.5 million uninsured Ohioans (75% of them working)

A few high-cost cases account for most health spending



1% of the US population consumes 23% of total health spending

5% of the US population consumes 50% of total health spending

Most people (50%) have few or no health care expenses and consume only 3% of total health spending

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Source: Kaiser Family Foundation calculations using data from AHRQ Medical Expenditure Panel Survey (MEPS), 2007

Health Care System Choices

Fragmentation	vs.	Coordination
• Multiple separate providers		• Accountable medical home
• Provider-centered care		• Patient-centered care
• Reimbursement rewards volume		• Reimbursement rewards value
• Lack of comparison data		• Price and quality transparency
• Outdated information technology		• Electronic information exchange
• No accountability		• Performance measures
• Institutional bias		• Continuum of care
• Separate government systems		• Medicare/Medicaid/Exchanges
• Complicated categorical eligibility		• Streamlined income eligibility
• Rapid cost growth		• Sustainable growth over time

SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)

The Vision for Better Care Coordination

- The vision is to create a person-centered care management approach – not a provider, program, or payer approach
- Services are integrated for all physical, behavioral, long-term care, and social needs
- Services are provided in the setting of choice
- Easy to navigate for consumers and providers
- Transition seamlessly among settings as needs change
- Link payment to person-centered performance outcomes
- Rely on community partnerships

Improve Managed Care Plan Performance

Competitively rebid managed care contracts

- Went from 7 plans in 8 regions to 5 plans statewide (3 regions)
- Increased choice for enrollees from 2 or 3 plans to 5
- Increased administrative efficiency (cut administrative rates 1% in the last budget and another 1% is proposed)
- Combined Covered Families and Children (CFC) and Aged, Blind and Disabled (ABD) programs to prevent beneficiary "dumping"
- Required managed care plans to locate key personnel and member services call centers in Ohio
- Changed the auto-assignment process to build new membership for incoming plans for a limited time
- Created the authority to terminate a plan for low membership

Improve Managed Care Plan Performance

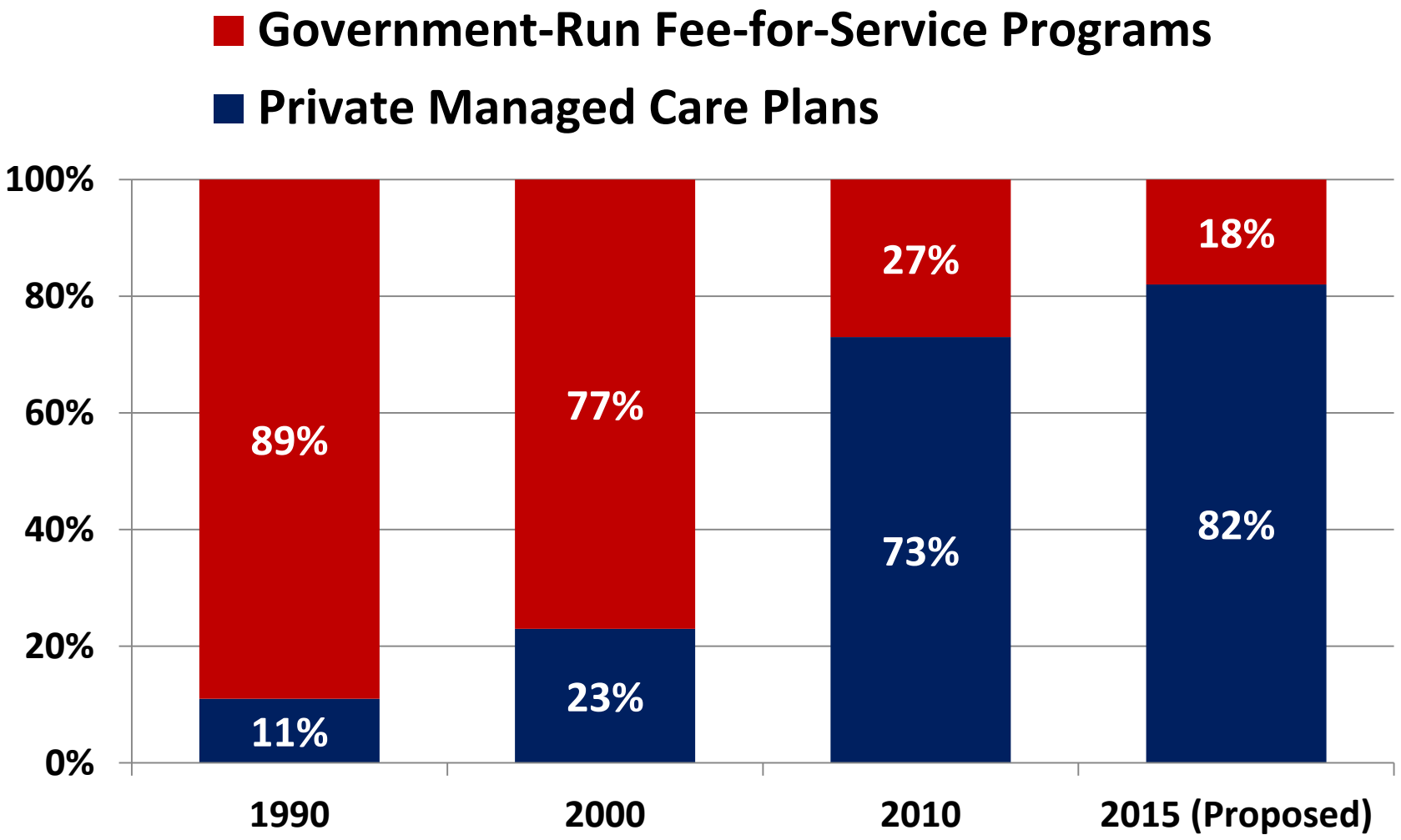
Getting Results

- Saving Ohio taxpayers' money:
  - Budget reforms saved $144 million ($52 million state) 2012-2013
  - Proposed reforms will save $646 million ($239 million state) 2014-2015
- Reforms allowed the following adjustments to 2013 rates:
  - 8% decrease to emergency room
  - 1.5% decrease to inpatient hospital
  - 12% decrease to pharmacy
- Better high-risk care management is cutting costs:
  - One plan achieved a 51% reduction in inpatient hospital costs and a 5% reduction in medical costs, including outpatient and ED visits, in 2012
  - Another plan reported a 20% reduction in inpatient hospital and ED visits for 1,300 members enrolled in high-risk care management

Integrate Medicare-Medicaid Benefits

- 182,000 Ohioans are eligible for Medicare and Medicaid
- They represent 14% of Medicaid enrollment and 34% of costs
- Ohio was the 3rd state in the nation approved to implement a Medicare-Medicaid "integrated care delivery system":
  - 115,000 people (63% of Ohio's Medicare-Medicaid population)
  - 7 regions (29 counties)
  - 5 health plans (Aetna, Buckeye, CareSource, Molina and United)
- Ohio's vision for better care coordination:
  - Person centered (vs. provider, program or payer centered)
  - Integrated across physical, behavioral, long-term care, and social needs
  - Services are provided in the setting of choice
- Ohio Medicaid will share in savings that accrue to the federal Medicare program as a result of improved care coordination

Ohio Medicaid Increasingly Relies on Managed Care



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Source: Ohio Medicaid (2013); 2015 Executive Budget as proposed.

Ohio Health Transformation Plan

Modernize Medicaid	Streamline Health and Human Services	Pay for Value
Initiate in 2011	***Initiate in 2012***	***Initiate in 2013***
Medicaid Cabinet: OHT (sponsor); AGE, ODH, ADA, MH, DD, Medicaid; with connections to JFS	**HHS Cabinet:** DAS, OBM, OHT (sponsors); JFS, RSC, AGE, ADA, MH, DD, ODH, Medicaid; with connections to ODE, DRC, DYS, DVS, ODI, TAX	**Payment Innovation Task Force:** OHT (sponsor); Medicaid, BWC, DAS, DEV, DRC, JobsOhio, OPERS, ODI, TAX
• Eliminate fraud and abuse • Prioritize home and community services • Reform nursing facility payment • Enhance community DD services • Integrate Medicare and Medicaid benefits • Rebuild community behavioral health system capacity • Create health homes for people with mental illness • Restructure behavioral health system financing • Improve Medicaid managed care plan performance • Extend Medicaid coverage to more low-income Ohioans	• Create the Office of Health Transformation (2011) • Implement a new Medicaid claims payment system (2011) • Create a unified Medicaid budget, accounting system • Create a cabinet-level Medicaid Department (July 2013) • Consolidate mental health and addiction services (July 2013) • Simplify and replace Ohio's 34-year-old eligibility system • Coordinate workforce programs • Share services across local jurisdictions • Recommend a permanent HHS structure (coming soon)	• Participate in Catalyst for Payment Reform • Provide access to medical homes for most Ohioans • Use episode-based payments for acute medical events • Coordinate health sector workforce and training programs • Accelerate electronic health information exchange • Report and measure performance • Promote insurance market competition and affordability • Support regional payment innovation

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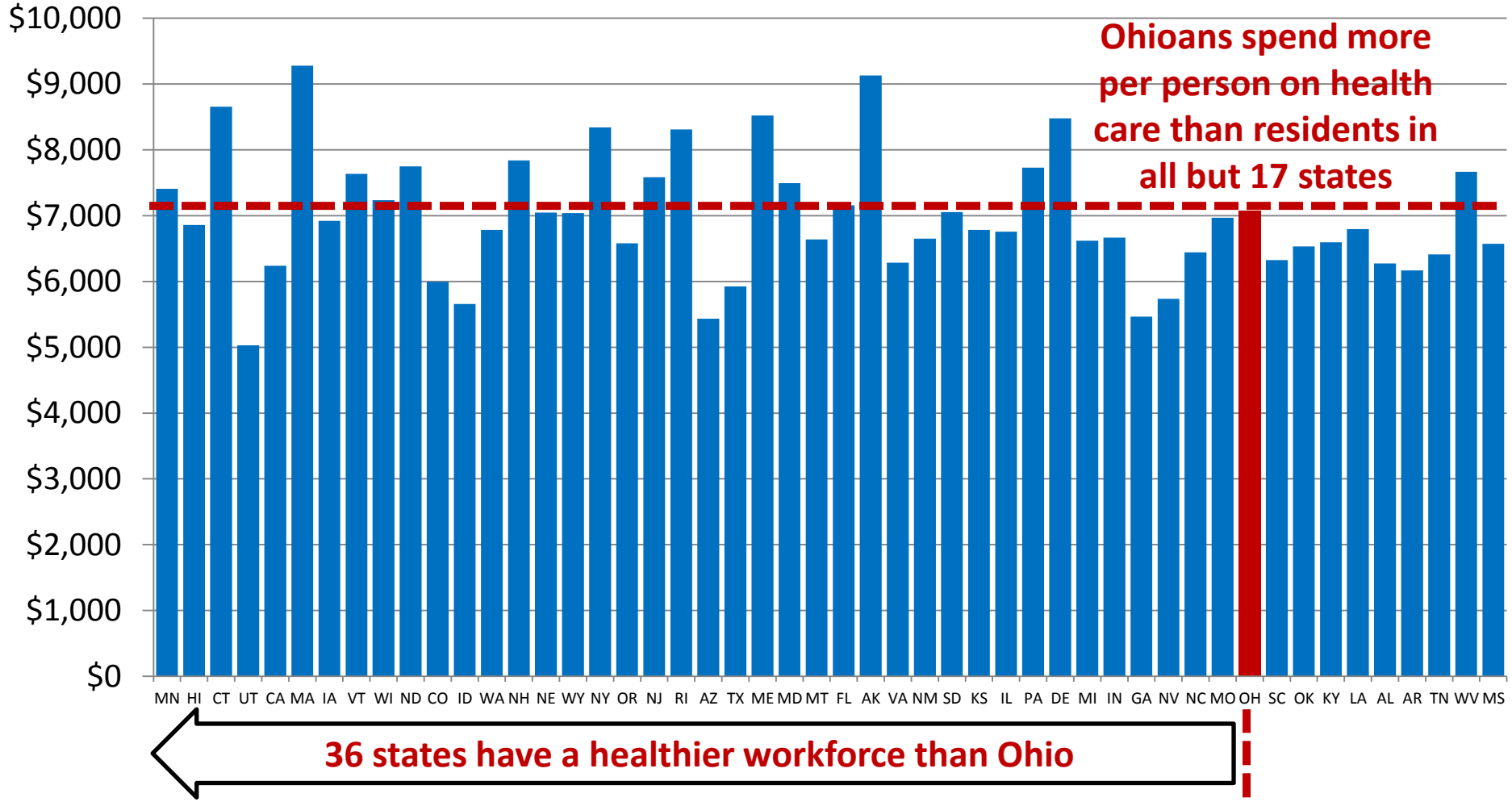
How can the State of Ohio leverage its purchasing power to improve overall health system performance?

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2009)



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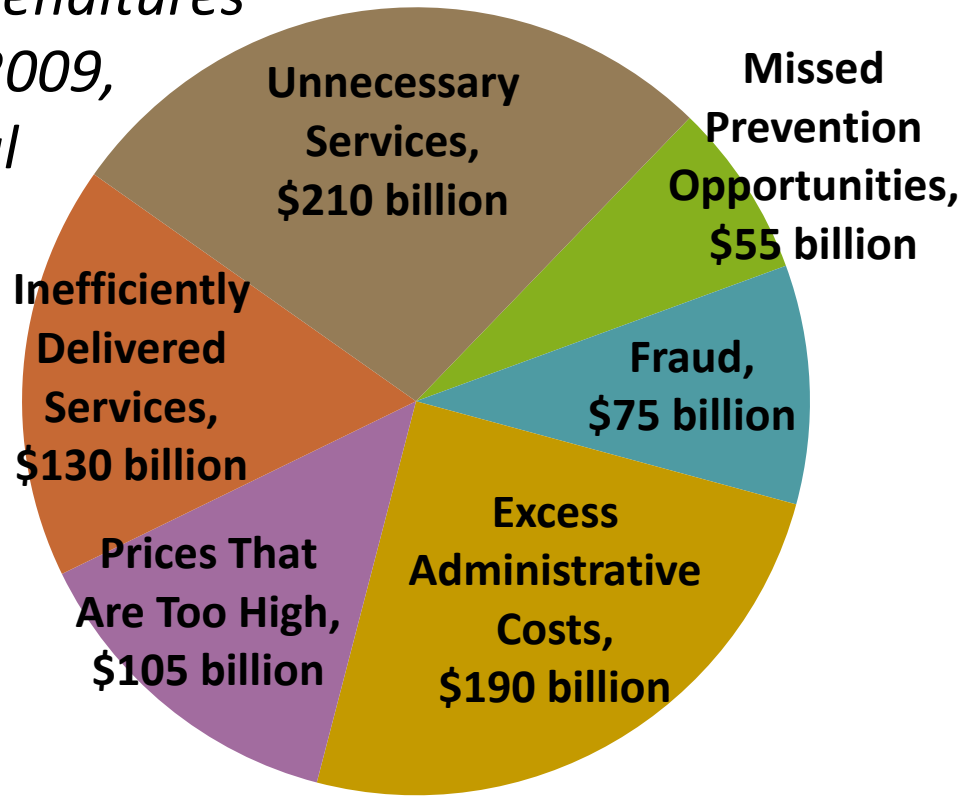
Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Much health spending is wasted

Wasted health care expenditures totaled $750 billion in 2009, 29% of $2.6 trillion total health spending



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Source: Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (September 2012).

In fee-for-service, we get what we pay for

- **More volume** – to the extent fee-for-service payments exceed costs of additional services, they encourage providers to deliver more services and more expensive services
- **More fragmentation** – paying separate fees for each individual service to different providers perpetuates uncoordinated care
- **More variation** – separate fees also accommodate wide variation in treatment patterns for patients with the same condition – variations that are not evidence-based
- **No assurance of quality** – fees are typically the same regardless of the quality of care, and in some cases (e.g., avoidable hospital readmissions) total payments are greater for lower-quality care

Source: UnitedHealth, *Farewell to Fee-for-Service: a real world strategy for health care payment reform* (December 2012)

Ohio Catalyst for Payment Reform (CPR)

- Coordinate existing payment reform among public and private purchasers to align expectations for better care
- Ohio – Medicaid, PERS, Administrative Services, Workers Compensation, Rehabilitation and Corrections, Insurance
- Nationally – 3M, Boeing, CalPERS, Delta, Dow, eBay, Equity, FedEx, GE, Intel, Marriott, Safeway, Verizon, Wal-Mart, Xerox*
- Work on shared agenda to increase the proportion of payments designed to cut waste or reflect performance
- Ohio was the first state Medicaid program to join CPR
- Incorporating CPR's "model contract" for payment innovation into Medicaid managed care plan contracts (January 2013)

* www.catalyzepaymentreform.org

Governor's Council on Payment Innovation

- Convene health care purchasers, providers, plans and consumer advocates to prioritize and coordinate multi-payer health care payment innovation activities statewide
- Prioritize state activities that enable payment innovation and pull waste out of the system
- Received a federal State Innovation Model (SIM) grant to design and test payment models across multiple payers
- Expand the capacity and availability of patient-centered medical homes to most Ohioans within 5 years
- Define and administer episode based payments for most acute medical events within 5 years
- Aetna, Anthem, CareSource, Medical Mutual, and United are on Ohio's PCMH and episode-based "core team"

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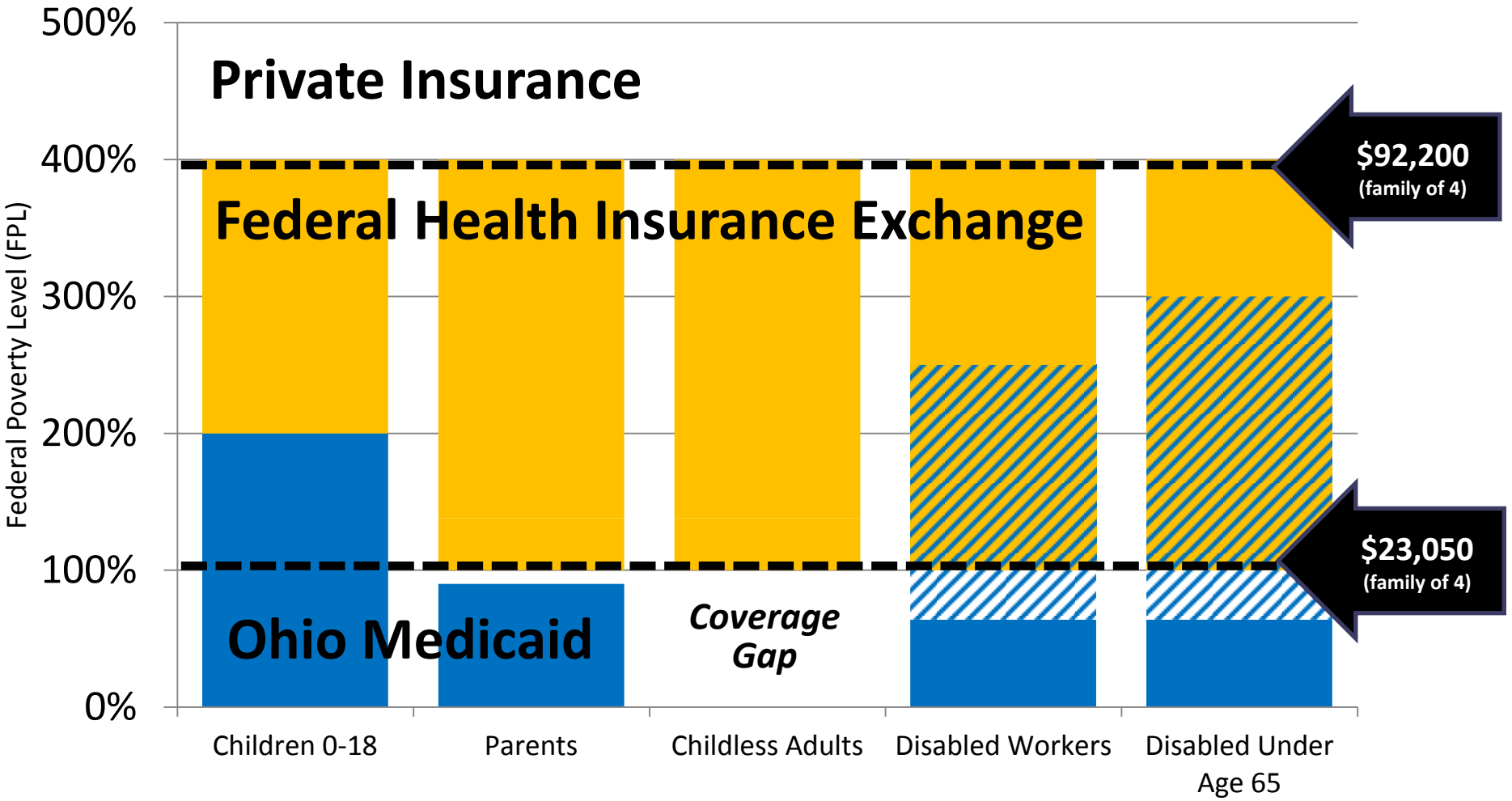
- Ohio Medicaid stuck in the past and in need of reform
- More than 1.5 million uninsured Ohioans (75% of them working)

2011 Ohio Crisis	vs.	Results Today
• $7.7 billion fiscal imbalance		• Balanced budget
• 89-cents in the rainy day fund		• $1.4 billion in the rainy day fund
• Nearly dead last in job creation		• Ranked number 1 in the Midwest
• Medicaid spending increased 33% over the 3 prior years		• Medicaid spending was held to below 3% in 2012
• Medicaid overspending required multiple budget corrections		• Medicaid spending came in $590 million under budget in 2012
• Ohio Medicaid stuck in the past and in need of reform		• Ohio has emerged as a leader in reforms to modernize Medicaid
• More than 1.5 million uninsured Ohioans (75% of them working)		• There are still 1.5 million Ohioans who are uninsured

Ohio Medicaid and Insurance Exchange Eligibility in 2014



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SOURCE: Ohio Medicaid; Medicaid eligibility as of February 2013; Federal Health Insurance Exchange eligibility as of January 2014; 2012 poverty level is $11,170 for an individual and $23,050 for a family of 4; over age 65 coverage is through Medicare, not the exchange.

Who is Stranded in the Coverage Gap?

- Ohioans with income less than 100% of poverty ($11,170 for an individual or $23,050 for a family of four)
- Many work but their employer does not offer or they cannot afford health insurance
- Many work as health care providers for others but don't themselves have coverage
- Many are over age 55 looking for work but finding it difficult
- At least 26,000 are veterans
- Some are unable to work because of mental illness or addiction but have no regular source of care to recover
- ***When these uninsured individuals seek care, often in the emergency room, other Ohioans pay the cost through higher premiums and other indigent care programs***

Consequences of Not Extending Coverage

Over the next two years, not extending coverage will cost Ohio taxpayers $404 million in state general revenue funds to:

- NOT extend coverage to 275,000 more low-income Ohioans
- NOT keep $2.4 billion in Ohioans' federal tax dollars in Ohio ($13 billion over seven years)
- NOT provide coverage for 26,000 uninsured veterans
- NOT protect local hospitals
- NOT provide relief for Ohio businesses from $88 million in Obamacare penalties annually
- NOT provide $811 million in mental health and addiction services (the House budget restores $100 million)

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www.healthtransformation.ohio.gov

CURRENT INITIATIVES | BUDGETS | NEWSROOM | CONTACT | VIDEO

Current Initiatives

Modernize Medicaid

Extend Medicaid coverage to more low-income Ohioans
Reform nursing facility reimbursement
Integrate Medicare and Medicaid benefits
Prioritize home and community based services
Create health homes for people with mental illness
Rebuild community behavioral health system capacity
Enhance community developmental disabilities services
Improve Medicaid managed care plan performance

Streamline Health and Human Services

Consolidate mental health and addiction services
Create a cabinet-level Medicaid department
Modernize eligibility determination systems
Coordinate health sector workforce programs
Coordinate programs for children
Share services across local jurisdictions

Improve Overall Health System Performance

Pay for health care based on value instead of volume
Encourage Patient-Centered Medical Homes
Accelerate electronic Health Information Exchange
Federal Health Insurance Exchange