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Ohio Health and Human Service Transformation

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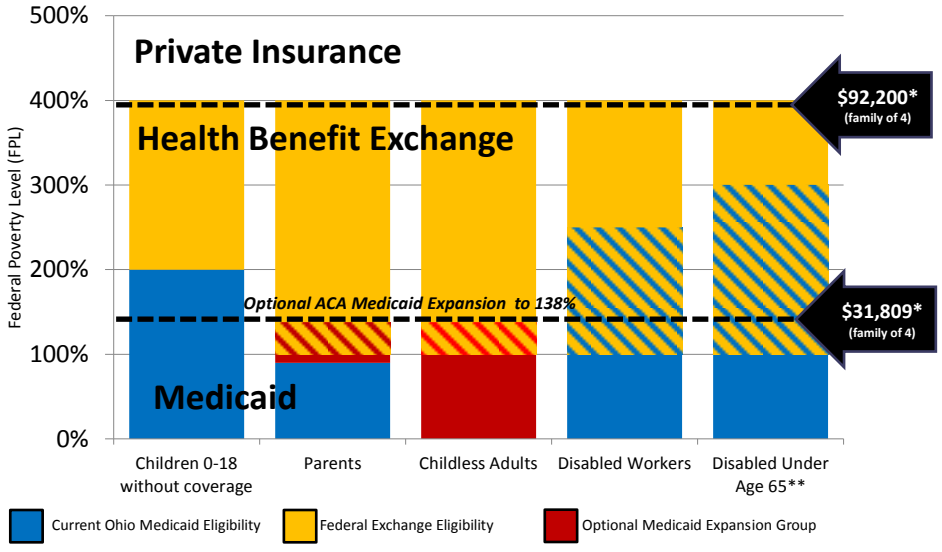
Federal Health Care Reform:
Patient Protection and Affordable Care Act (ACA)

- Individual mandate to purchase health insurance
- Insurance market reforms: limit preexisting conditions, guaranteed issue, community rating
- Health benefit exchange: provide individuals with income between 100% and 400% of poverty a sliding-scale federal subsidy to purchase private insurance
- Expand Medicaid to everyone below 138% of poverty
- The Supreme Court upheld all provisions of the ACA but made the Medicaid expansion *optional* for states

Affordable Care Act:
Federal Income Eligibility Levels in 2014



* The 2012 poverty threshold is $11,170 for an individual and $23,050 for a family of four.
**Over age 65 coverage is provided through Medicare, not the Exchange.

After the Supreme Court Decision: Key Health Policy Questions for Ohio

- Can Ohio further reform its insurance market to promote competition and affordability?
- Should Ohio build a state-run health benefit exchange or coordinate with a federal exchange?
  - *Ohio's exchange "blueprint" is due November 16, 2012*
  - *Leaning toward federal-run but retain plan oversight*
- Should Ohio expand Medicaid eligibility or not?

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Ohioans spend more per person on health care than residents in all but 17 states[1]

Rising health care costs are eroding paychecks and profitability

Higher spending is not resulting in higher quality or better outcomes for Ohio citizens

36 states have a healthier workforce than Ohio[2]

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Sources: (1) Kaiser Family Foundation State Health Facts (December 2011), (2) Commonwealth Fund 2011 State Scorecard on Health System Performance

Medical Hot Spot:
Per Capita Health Spending: Ohio vs. US

Measurement	US	Ohio	Percentage Difference	Affordability Rank (Out of 50 States)
Total Health Spending	**$6,815**	**$7,076**	**+3.8%**	**33**
Hospital Care	$2,475	$2,881	+16.4%	36
Physician/Clinical	$1,650	$1,456	-11.8%	12
Nursing Home Care	$447	$610	+36.5%	43
Home Health Care	$223	$223	--	38

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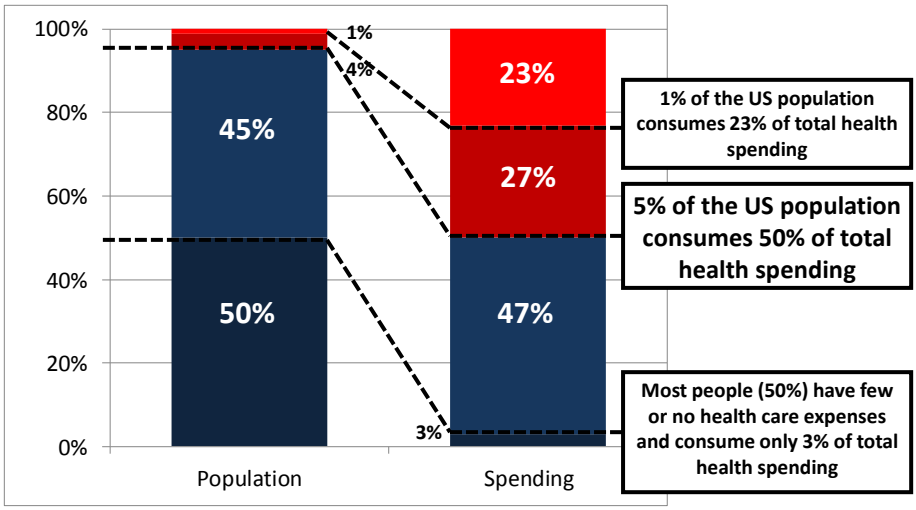
Source: 2009 Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released December 2011; available at http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip

Medical Hot Spot:
A few high-cost cases account for most 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

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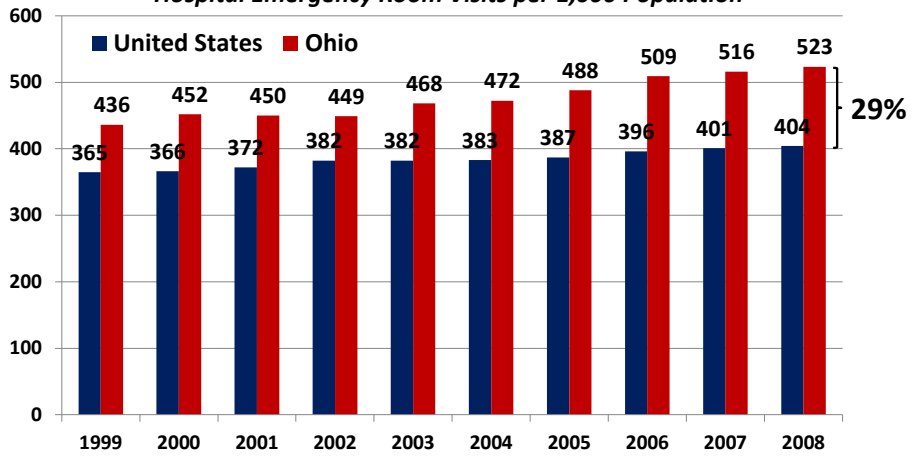
SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)

Medical Hot Spot:
Emergency Department Utilization: Ohio vs. US

Hospital Emergency Room Visits per 1,000 Population



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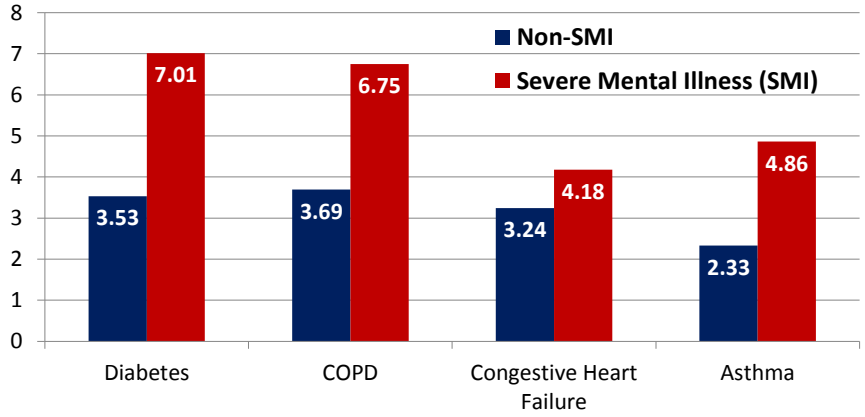
Source: American Hospital Association Annual Survey (March 2010) and population data from Annual Population Estimates, US Census Bureau: http://www.census.gov/popest/states/NST-ann-est.html.

Medicaid Hot Spot:
Hospital Admissions for People with Severe Mental Illness

Avoidable hospitalizations per 1000 persons for ambulatory care sensitive conditions (avoidable with proper treatment)



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Source: Ohio Colleges of Medicine Government Resource Center and Health Management Associates, Ohio Medicaid Claims Analysis (February 2011)

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- Executive Order creates authority to plan and budget across multiple agencies
- Align problems, policies and politics to create a window of opportunity for action
- Belief in individuals, the power of small teams, shared sense of responsibility, long-term view
- Coach counterparts in policy, communications, legislation, stakeholder, operations, technology
- Establish a comprehensive vision but focus on "hot spots" and "high value targets"
- Convene, Innovate, Disband, Convene …

Don't let the fear of failure prevent you from taking the risk necessary to innovate.

— Governor John Kasich

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Our 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

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SOURCE: Ohio's Demonstration Model to Integrate Care for Dual Eligibles, a proposal to the Center for Medicare and Medicaid Innovation (February 1, 2011)

Ohio Health and Human Services Innovation Plan

Modernize Medicaid	Streamline Health and Human Services	Improve Overall Health System Performance
Medicaid Cabinet: Aging, ODADAS, ODMH, DODD, 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 Reform Task Force:** Medicaid, BWC, DAS, DEV, DRC, JobsOhio, OHT, OPERS, ODI, TAX
• Reform nursing facility payment • Update provider regulations to be more person-centered • Integrate Medicare and Medicaid benefits • Create health homes for people with mental illness • Restructure behavioral health system financing • Improve Medicaid managed care plan performance • Transfer ICF program to DD • Coordinate Medicaid with other state programs	• Create a unified Medicaid budget, accounting system • Create a cabinet-level Medicaid department • Consolidate ODMH/ODADAS • Integrate HHS information capabilities, incl. eligibility • Coordinate housing and workforce programs • Coordinate programs for children • 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 • Pioneer accountable care organizations • Accelerate electronic health information exchange • Decide Ohio's role in creating a Health Insurance Exchange • Promote insurance market competition and affordability • Support local payment reform initiatives

Payment Innovation Framework

MODEL:	Fee for Service		Bundled Payments			Global Payment	
GOAL:	Discrete service and related incentives, including "pay for performance"		Achieving a specific patient objective and including all associated upstream and downstream care and cost			Total health, quality of care, and total cost of a population of patients over time	
EXAMPLES:	Charges	Fee Schedule	Per Diem	DRG	Episode Case Rate	Partial Capitation	Full Capitation

Increasing Accountability, Risk, Provider Collaboration, Resistance, and Complexity

Performance Based Payment
(potential financial upside and/or downside for performance on quality, efficiency, cost, etc.)

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SOURCE: Catalyst for Payment Reform (August 2012)