



Ohio Association of Health Plans

# **Ohio's Care Coordination Program**

**A Proven Opportunity for a new way in Ohio's Medicaid Program**

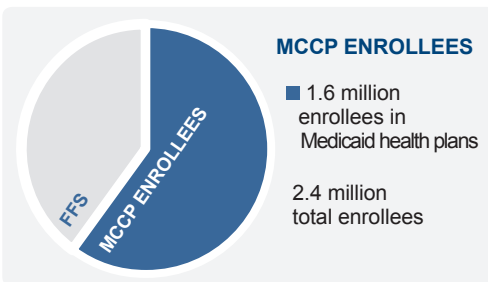
## Ohio's Status Quo:

- The economy and reliance on one time funding has led to an \$8 billion shortfall
- State expenditures for the Medicaid baseline are in jeopardy of increasing by 49%
- Medicaid spending has reached an all time high of over \$15 billion
  - 30% of total state spending
- Medicaid is fragmented, operating in silos with six state agencies involved in operations
- Care is not coordinated for all consumers
- Over 42% of Ohio's total Medicaid budget is spent on long-term care
- Approximately 25% of the Medicaid population account for 70% of the costs
- Ohio incurs some of the highest emergency room costs and utilization in the nation
- Ohio faces a crisis in its behavioral health system – funding and care is fragmented
- Abuse of prescription painkillers has increased to an epidemic level in Ohio
- Medicaid is absorbing the financial costs for the drugs abused or diverted and other health care services associated with drug seeking behavior or the consequences of drug abuse
- Ohio is losing millions of dollars through shortsighted pharmacy policy decisions

## A New Way for Medicaid

Given the realities of our current environment, government operations surrounding Medicaid today cannot continue into tomorrow. Ohio's Medicaid system is not working for many consumers or the state's budget and over two million Ohioans rely on this important safety net for help getting needed medical care.

A new vision for Ohio's Medicaid program must center around meeting all of the needs of Medicaid consumers through an efficient and effective care coordination system.



While the Ohio General Assembly took significant steps to develop systems for improving the efficiencies and effectiveness of the Medicaid program over the years, those successful changes can be taken further to create a fully integrated Medicaid program.

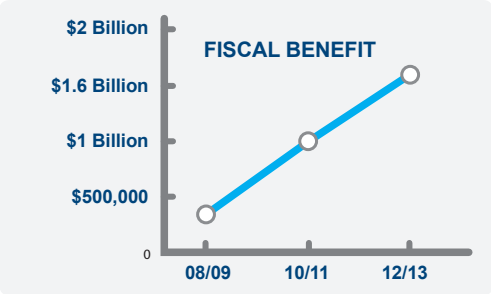
In 2006, policy makers designed and required the use of a care coordination system statewide, which was built on the idea that prevention, coordination, healthy living and responsible use of the health care system can help keep costs in line, to deliver services effectively. Of Ohio's Medicaid enrollees, 1.6 million are currently part of a Medicaid Care Coordination Plan. This model has proven to be cost effective, producing a **\$1 Billion fiscal benefit** in the current budget, has produced better health

outcomes, and provides budget predictability for the State of Ohio all while helping to improve the lives of those Ohioans most in need.

Unfortunately, not all Medicaid recipients are allowed to enroll in the current care coordination program. By law, some categories of Medicaid eligibility are prohibited from this important program such as children with disabilities, those dually eligible for Medicare and those in waiver programs.

Additionally, the layering of bureaucracy, complexity and challenges in creating useful and effective accountability measures has stymied Ohio’s ability to have a fully modernized and forward thinking Medicaid program.

As we look ahead to the challenging fiscal environment the State of Ohio faces in the next biennial budget, we know that we must look at doing things differently, work in new ways and expand the use of the tools we know are proven to deliver value and fiscal prudence to the state. We must get beyond traditional perceptions and be open to new possibilities – it is in this vein that we developed the following vision for Ohio’s Medicaid program.



Through a four step process, Ohio can harness the full power of an integrated program that is effective in improving care for consumers and create efficiencies that provide a **\$1.78 Billion fiscal benefit:**

- Doing Business Differently
- Maximizing Care Coordination
- Integrating Medicaid Benefits
- Modernizing Ohio’s Reimbursement System

**Doing Business Differently**

Legislators, administrators and the public expect value from Ohio’s Care Coordination program. This is due to the nature of the performance-based contract, the inherent flexibility of a care coordination system, and the emphasis on prevention, care coordination and disease management.

**Excluded from Care Coordination:**

- Dual Eligible
- Individuals on Spenddown
- Home and Community Based Waiver Participants
- Institutionalized Individuals
- Children with Disabilities

Today, Ohio is receiving significant value for the dollars expended as evidenced by the cost savings, budget predictability and improved outcomes in the care coordination program over the last several years. Ohio's Medicaid plans strive to improve and realize that in Ohio's current fiscal environment everyone must find additional efficiencies in their business operations. Medicaid plans believe that they are no exception and are ready to help rebalance the long-term care system, fully integrate benefits and enhance care coordination. Ohio's Medicaid plans propose to accomplish this through:

- Common Sense Initiative
- Administrative Efficiencies
- Enhancing Performance Based Contracting
- Support Innovations in the Health Care Delivery System

### Common Sense Initiative

Ohio's Medicaid health plans, as agents of the state, commit to implement the "Common Sense Initiative" in the health care delivery system. Ohio's Medicaid plans will create opportunities for providers to suggest improvements in processes that are common sense and break down barriers for their businesses. We will work with providers and other partners in the health care delivery system to implement the Medicaid program in a more transparent, accountable, performance based system. Processes and requirements should be developed and implemented in a way that reinforces improved health outcomes and accountability but they should not cause such burden that they hinder economic development even in the health care arena. Ohio's Medicaid plans commit to target requirements that hinder economic development and that do not promote better health outcomes as defined by the state. Part of this process will be reducing administrative burden in the overall health system by looking at simplifications for the provider community such as centralized credentialing, provider portal for prior authorizations and formulary information, and opportunities for payment reform.

### Administrative Efficiencies

Medicaid health plans believe that reducing administrative burdens could result in a reduction of administrative costs. Over the last several years OAHF has submitted numerous suggestions on achieving administrative efficiencies in Ohio's Medicaid care coordination program that if implemented could result in reduced administrative costs. More specifically, changing overly burdensome case management requirements, eliminating the utilization management database, and monthly file submissions and changing the grievances and appeals reporting process would result in both greater efficiencies and see the greatest reduction in administrative costs that could be reflected in health plan capitation rates. Together, The state and the Medicaid Plans can identify ways to streamline and consolidate state bureaucracy, eliminate regulatory redundancy, and focus on creating a high performance contracting process that meets the goals of the Medicaid program.

### Performance Based Contracting

A new way for Medicaid also means a focus on improving health outcomes. Each year Medicaid plans sign a performance-based contract with the State of Ohio. They have historically been accountable not only for administrative functions, like call center times, but also for improved health outcomes. As an incentive, these contracts have included a pay-for-performance system for Medicaid plans in which 1% of the plans payments are at-risk if they don't meet the targets for clinical performance measures set by the state. We believe that as we look at improved transparency, value, and personal responsibility we need to enhance the performance-based contract. Ohio's Medicaid plans welcome the opportunity to be held accountable for their part in the health care delivery system. We encourage the state to re-prioritize the pay-for-performance structure – prioritizing health outcomes the state wants improved, using standardized HEDIS measures for on-going monitoring and moving away from the awkward tiered approach used today. In return, Ohio's health plans are willing to explore increasing their financial incentive to meet agreed upon outcomes.

### Restructuring the Delivery System

Medicaid plans understand the need for innovations in the health care delivery system and support reorganizing the overall healthcare delivery structure to create “medical homes,” “health homes,” and accountable care organizations (ACOs) within the Medicaid Care Coordination program. These models are not alternatives to the Medicaid Care Coordination program but rather can function within the program. Ohio's plans have already been working in pilot programs to support medical homes and in some instances have worked to develop the model. Ohio's plans understand that a team approach to care coordination works best for consumers, the state and our overall health delivery system. Ohio's Medicaid health plans commit to supporting one of these models through their plans in each region of the Medicaid care coordination program.



**Medical Homes, Health Homes, and ACOs can operate within the care coordination program. They are not alternatives to the care coordination program.**



As we continue to explore new ways for Ohioans to access medical care, we need state regulators to understand the partnership Medicaid health plans have with providers in the development of these models in a capitated payment structure. For the best efficiencies, medical homes and ACOs should operate within an integrated capitated care coordination system. However, to accomplish this we must change reimbursement structures, and those changes must be acknowledged in the Medicaid program by the State of Ohio. We support the potential these new delivery models can provide in the

future to better reorganize our health care delivery system, and we understand as an efficient administrator of the Medicaid program we play an important role in their development both from a reimbursement perspective as well as a support encompassing them as part of the overall system so they can optimally function with the tools and resources of our health plans. Ohio's Medicaid Plans are committed to making these necessary changes so that these new models of care delivery can focus on high utilizers that make up a majority of costs in the Medicaid program.

Finally, getting someone healthy is more than just providing medical care. Our health plans know that it is a holistic approach to care management programs that does the most good. Stable housing arrangements, employment, and adequate nutrition can have a major impact on a person's health status. To address such circumstances, health plans work with community organizations for outreach and providing assistance to their members such as housing agencies, and food programs such as Food Stamps and the Women, Infant and Children (WIC) nutrition program.

A national survey of Medicaid health plans found that 95 percent interacted with city/county social services agencies and 82 percent offered their enrollees aid in applying for public assistance programs.

Similarly, Medicaid health plans recognize the important role that community-based organizations can play in a beneficiary's health and well being. The survey found that 97 percent of Medicaid health plans interact with schools, 89 percent with volunteer organizations such as local members of the American Cancer Society or the American Diabetes Association, and 87 percent with faith-based organizations.

Ohio's seven Medicaid Care Coordination Plans serve as the Health Care Home for their members, giving Medicaid consumers access to needed primary care as well as helping consumers with a variety of other needed services so that members can get well and stay well.

Being part of a Health Care Home through a Medicaid Care Coordination Plan connects these Ohioans to benefits and programs that can also help them with health-related problems, like food and shelter, home health assistance, or support services for special challenges.



## Maximizing Care Coordination

Today, Ohio excludes some 500,000 Medicaid consumers from Medicaid Care Coordination. These consumers are left in Ohio's Fee-For-Service payment model. As a result, they lack the additional benefits and services coordination that have benefited other Medicaid enrollees and the state. The services used by these individuals account for over 70% of the costs in Ohio's Medicaid program. This fragmented approach of two separate programs has resulted in a complex web of funding streams, bureaucracy and disjointed programs that are preventing an integrated streamlined care program that can be easily navigated. Individuals excluded from Medicaid Care Coordination today include:

- Dual Eligible (those individuals on Medicaid and Medicare)
- Individuals on Spenddown
- Home and Community Based Waiver Participants
- Institutionalized Individuals (Nursing Facility and ICF/MR)
- Children with disabilities

As Ohio looks to the short term of balancing the budget and being more efficient with tax dollars, care and service coordination should be expanded to all individuals in Ohio's Medicaid program.

While there is a spectrum of options in expanding care coordination such as certain individuals, services, and venues, the most effective approach is a fully integrated, capitated care coordination model for all Medicaid consumers. To accomplish this goal, Ohio must first eliminate the language in the Ohio Revised Code 5111.16 that prevents dual eligible, institutionalized individuals (nursing facilities), home and community based waiver participants and children with disabilities to be enrolled in a fully integrated, capitated Medicaid Care Coordination Plan.

Additionally, a new integrated program for all Medicaid consumers should include coordination of all Medicaid covered services from acute care needs to long-term

**Give 500,000 Medicaid enrollees access to fully integrated, capitated Care Coordination Program**

**Delete Ohio Revised Code language**

**Apply for 1915 (b/c) Waiver  
Include all services (acute and long-term care)**

**Implement January 1, 2012**

**\$400 million fiscal benefit  
in SFYs 2012-2013**

services. As a result, we can rebalance the long-term care system and simplify Ohio's home and community based waivers by allowing for more leverage in the system. Effectively it would allow for the services in PASSPORT and the Ohio Home Care Waiver to be expanded to all Aged, Blind and Disabled Medicaid enrollees under a single integrated program.

The next step towards accomplishing a fully integrated system will be for Ohio to apply for a 1915 (b)/(c) combination waiver from the federal government and begin enrolling individuals in the Medicaid Care Coordination Program beginning January 1, 2012.

Creating an integrated approach allows for opportunity to support restructuring within our healthcare system, such as long-term care and behavioral health. New relationships will need to be formed such as agreements between Area Agencies on Aging, local behavioral health boards and Medicaid health plans and there will be a need for further development of health plan's networks to provide the full array of behavioral health and long-term care services and supports.

Finally, for individuals in ICF/MRs and on Developmental Disability waivers, Ohio should immediately, under the direction of the Office of Health Transformation, initiate a study on including acute care,



**The Social Security Act provides for federal waivers to allow states flexibility in operating Medicaid programs.**

**1915(b) waivers allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.**

**1915(c) waivers allow long-term care services to be delivered in home and community settings.**



ICF/MR, and waiver services in the Medicaid Care Coordination Program. While this is a long-term goal, Ohio should begin to study the specific structural needs that will be required for future integration.

Maximizing care and service coordination in the near term will not only be a **\$400 Million fiscal benefit to Ohio** in the SFYs 2012-2013 budget but will set the stage for even greater efficiencies and improved health for Medicaid consumers in the future.

## Integrating Medicaid Benefits

Today, while Ohio's care coordination program is robust and is delivering results, it has become fragmented because policy makers in the past have carved out behavioral health and pharmacy benefits from the care coordination program. This fragmentation has proven to be inefficient and tax dollars are being wasted. Part of the effectiveness of the Medicaid Care Coordination Program is that Medicaid health plans have a complete picture of the consumer's health care needs. The plans know when someone is not adhering to medications, has been to an emergency room or is visiting multiple doctors. This type of information allows them to better coordinate care and use limited resources more effectively and efficiently.

### Prescription Drugs

Pharmaceuticals are a driving force in any health care system. While they provide for the complete health of consumers, they are also an opportunity for abuse. Medications must be coordinated, and Ohio should immediately reverse a shortsighted policy decision and include the Medicaid pharmacy benefit in the care coordination program. Additionally, federal law changes (the Drug Rebate Equalization Act) allow the state to access the greatest rebates for drugs even when administered through the care coordination program. Given the change, economically it makes the most sense to include the pharmacy benefit in the Medicaid Care Coordination Program. Such a reversal of policy would save Ohio approximately **\$92 Million per year**.

**Immediately reverse policy decision on pharmacy benefit**

**Include pharmacy benefit in the fully integrated, capitated care coordination program by May 1, 2011.**

**\$184 million savings SFYs 2012-2013**

**Move Behavioral Health Funding to ODJFS Medicaid Line**

**Include all behavioral health services in fully integrated, capitated care coordination program by October 1, 2011.**

**\$52 million savings in SFYs 2012-2013**

Additionally, this change will improve the effective use of these benefits. Internal reviews by Medicaid health plans since the pharmacy benefits have been carved out have shown a drop in effective and continued use of some prescription drugs to manage chronic conditions. Ohio should act on this immediately to ensure that Medicaid health plans have the ability to again work with their enrollees to promote the use of this important benefit and achieve the efficiency potential. If Ohio reversed this policy decision in February 2011, the pharmacy benefit could be "carved in" to the care coordination program by May 1, 2011 providing better care coordination and generating fiscal benefits to the state.

## Behavioral Health

The Behavioral Health system in Ohio is in a fiscal crisis and using resources more efficiently and effectively is not a luxury - it is a must for sustainability of that system. Ohio should move behavioral health funding to the Ohio Department of Job and Family Services Medicaid funding line. Additionally, these services should then be included in a fully integrated, capitated Medicaid Care Coordination Program.

Such an approach would require the behavioral health system in Ohio to work more closely with Medicaid health plans and will remove the silos and fragmentation that exists today.

By including the benefit in the care coordination program Ohio will realize a **\$52 Million fiscal benefit** in the SFYs 2012 -2013 budget.

## Modernize Ohio's Reimbursement System

Today, Ohio sets up a reimbursement market that doesn't allow for fair negotiation and as a result taxpayers are paying for services at a rate they can't afford. Ohio requires Medicaid health plans to contract with certain providers but doesn't provide any incentive for those providers to contract with the plans. This doesn't allow the market to work and some of those providers demand reimbursement at rates that far exceed what is fair and reasonable. Ohio should remove these artificial barriers to the free market – and create a level playing field for all parties. Such a move would allow for fair negotiation of payment rates and would align reimbursement policy consistent with Medicare. It would also be consistent with the way Ohio pays for hospital services through the Department of Rehabilitation and Corrections. Making this change would allow Ohio to save approximately **\$145 Million over SFYs 2012-2013**.

**\$145 million savings over the biennium**

**Align with Medicare Standards, other Medicaid programs and Ohio's current practice for Rehabilitation and Corrections.**

**Incentivize fair negotiation and reasonable rates**

**Change and update fee schedule to be consistent with national standards**

**Align with other states and Medicare hospital reimbursement for capital, outliers and emergency services**

Additionally, further changes in the Medicaid fee schedule would result in additional savings. Areas Ohio should focus on include:

- Consistent with Medicare – move to the current DRG version for hospital charges
- Move to a cost to charge ratio for unlisted codes
- Change the methodology for hospital outlier payments
- Implement changes in the way emergency department services are paid
- Include care coordination data when the state calculates its fee for service capital reconciliation with hospitals.

Ohio would be following suit with Medicare and other states and be more aligned with national standards. Such a move would result in even greater savings for the state and would allow for appropriate care in the appropriate setting - using tax dollars more efficiently and effectively.

### **A New Way – The Time is Now**

Ohio is at a crossroads with our publicly funded health care system, and now is the time to think about doing things differently. We must move beyond old turf issues and look at new ways to interact in the system. Now is a time to build new partnerships, expand on what is working and pave the way for future enhancements and efficiencies in the system. While we understand this new way may present challenges, we believe that it is the most effective way for Ohio's Medicaid program. This new way will allow the state to focus on coordination of an integrated benefit (physical, mental health, substance abuse, and pharmacy), requiring medical and health home support, established performance standards and improved health outcomes supported by audited data --all while supported by actuarially sound rates.

Now is the time to:

- Do Business Differently
- Maximize Care Coordination
- Integrate Medicaid Benefits
- Modernize the Medicaid Reimbursement System

Extraordinary times call for bold decisions and new ways of doing business. Ohio's Medicaid plans stand ready to address the challenges facing Ohio and the Medicaid program. We are steadfast in our commitment to finding solutions that work for Ohioans, policy makers, and our partners in the health care delivery system.



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