Ohio’s Integrated Care Delivery System: Comprehensive Care through Greater Coordination

John McCarthy
Ohio Medicaid Director
Integrated Care Delivery System for Individuals Enrolled in both Medicare and Medicaid
A few high-cost cases account for most Medicaid spending

- 4% of the Medicaid population consumes 51% of total Medicaid spending.
- 1% of the Medicaid population consumes 23% of total Medicaid spending.

Source: Ohio Department of Job and Family Services; SFY 2010 for all Medicaid populations and all medical (not administrative) costs.
Medicaid Hot Spot:
Enrollment and Spending for Dual Eligibles

Enrollment

Medicare-Medicaid
“Dual” Eligibles

14%

86%

All Other

66%

Spending

Source: Ohio Department of Job and Family Services; based on SFY 2010 average monthly enrollment and total cost of coverage.
Why must we act?

- The current system is confusing and difficult to navigate
- Presently, there is no entity accountable for the whole person
- Despite years of substantial investments, Ohio’s LTSS system remains in the third quartile of states. (35th in AARP 2011 Scorecard)
- The aging of Ohio’s population has arrived – and is accelerating rapidly
- Current trends in spending are unsustainable
<table>
<thead>
<tr>
<th>Fragmentation</th>
<th>vs.</th>
<th>Coordination</th>
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<tr>
<td>Multiple separate providers</td>
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<td>Accountable medical home</td>
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<td>Provider-centered care</td>
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<td>Reimbursement rewards volume</td>
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<td>Reimbursement rewards value</td>
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<td>Lack of comparison data</td>
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<td>Price and quality transparency</td>
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<td>Outdated information technology</td>
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<td>No accountability</td>
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<td>Institutional bias</td>
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<td>Separate government systems</td>
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<td>Complicated categorical eligibility</td>
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<td>Rapid cost growth</td>
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<td>Sustainable growth over time</td>
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SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)
The Vision for Better Care Coordination

• 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
Geographic Area

Ohio’s Integrated Care Delivery System will be composed of:

- Seven regions
- Covering 29 counties
- Approximately 114,000 beneficiaries
Ohio ICDS Regions

ICDS Regions and Demo Counties

- **Central**
- **EC - East Central**
- **NE - Northeast**
- **NW - Northwest**
- **SW - Southwest**
- **WC - West Central**

- **NEC - Northeast Central**
# Selected Plans

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Eligible Groups

- Those beneficiaries receiving both Medicare and full Medicaid benefits
- Adults with disabilities and persons over the age of 65
- Persons with serious mental illness will also be included in the program
Exempt Groups

The following groups will not be eligible for enrollment into the ICDS demo:

- Individuals with an ICF/ID level of care served either in an ICF/ID facility or on a waiver are exempt from enrollment
- Individuals who are eligible for Medicaid thru a delayed spend-down
- Individuals who have third party insurance
Enrollee Protections

- Choice of at least two plans per region
  (three in Northeast region)
- Ability to opt out of Medicare portion of ICDS
- ICDS Plan Member Advisory Groups
- A unified grievance and appeal process
- Strong quality management oversight
Timeline

Now:
- Provider association and advocate meetings have begun

November 2012:
- Approval of Medicare-Medicaid MOU
- Capitation rates to be set
- Readiness review of plans begin

April 2013:
- Enrollment -- 3 regions in April / 1 region in May / 3 regions in June

2016:
- Demonstration ends
Questions
Evaluating the Quality of Care for People with Dual Eligibility

Peggy O’Kane, President
The National Association of Medicaid Directors
October 30, 2012
Overview

- Person-centered approach
- Structure and process measures provide the foundation
- New performance measures
- Challenges and opportunities
Quality for vulnerable populations

• Measuring quality for disabled, frail, mentally ill and other groups is very difficult
  – Limited evidence base
  – Multi-dimensional problems
  – Small numbers
  – Lack of policy focus
  – Needs go beyond medical care

• Care models are often unsatisfactory
Case profile:
Reducing hospital readmissions
Case profile: Support individuals’ life goals
Special Populations:
Person-centered care for dual eligibles
Special Populations: Person-centered care for dual eligibles

- Consumer/family perspective
- Coordination of care team across settings
- Issues common across subgroups of dual-eligible population
- Aspirational
Model for Evaluating Quality

Screening and Assessment

Individualized Shared Care Plan

Coordinated Service Delivery

Beneficiary Engagement and Rights
Population Management and Health Information Technology
Quality Improvement Systems

Healthy People
Healthy Communities
Better Care
Affordable Care
The intensity of care needs varies

• **Risk Stratification**
  – Use past utilization and screening data to identify “high risk” beneficiaries
  – “High Risk” could be defined as needing long term services and support, history of hospitalization or emergency department use, unstable care-giving situation

• Continual monitoring for “trigger events” which could change a beneficiary’s risk category
Dual Eligibles:
Structure & Process Measures
Screening & Assessment: Structure & Process Measures

- Short person-reported screening questionnaire
- Plan for re-screening/identifying triggers
- Comprehensive individualized assessment
- Plan for assessment
## Screening & Assessment: Performance Measures

| Existing Performance Measures | • Depression screening  
|                              | • Pain & functional status assessment  
|                              | • Advanced care planning |
| Potential New Performance Measures | • % of beneficiaries with risk assessment within 90 days of enrollment; % who have re-assessment after trigger event  
| | • % of beneficiaries who are making progress on their goals  
| | • Longitudinal assessment of quality of life |
Challenges in measurement
Challenges in measurement

• How to use person-reported outcomes
• Incenting care for people with challenging conditions and complex needs
• Honoring preferences that conflict with evidence or increase risk
Challenges in measurement

- Small numbers
- Risk adjustment
- Proxy respondents
- Comparable data sources
- Data exchange (especially for behavioral health)
Opportunities

- Give input on Structure and Process measures today
- Pilot test Structure and Process Measures in entities responsible for integrated care
- Adapt existing measures for the dual-eligible population
- Collaborate in iterative development of new performance measures
Key Points

• Person-centered approach

• Structure and process measures provide the foundation

• New performance measures

• Challenges and opportunities
Acknowledgements

- The SCAN Foundation
- Participants in our stakeholder panels