Improving Workers’ Compensation Medical Care in Ohio

Discussing the impacts and opportunities for Ohio’s workers’ compensation system
Steve Buehrer

Administrator/CEO

The Ohio Bureau of Workers’ Compensation
Of the 97,000 claims allowed in FY 2013:

- **TARGET MARKET**: There were nearly 17,000 injured workers (or 17%) who missed more than seven days of work.
Current state - Ohio’s workers’ comp system

- Of all lost-time claims:
  - Nearly 50 percent missed more than 45 days.
  - Nearly 32 percent missed more than 100 days.
Current state - Ohio’s workers’ comp system

- Outcomes:
  - LT claims account for 79 percent of paid losses and MIRA reserves.
  - Total lost productivity on LT claims to date is more than 1.8 million days.
Current state - Ohio’s workers’ comp system

- Impact of opiates and narcotics
  - BWC monitors injured workers’ morphine-equivalent dosage (MEDs).
  - MEDs – commonly used metric to evaluate utilization of opioids and narcotics.

- According to ODMHAS:
  - A person exceeding 80 mgs MED per day (or fourteen 5-mg Vicodin) for more than 60 days will develop a physical dependence.
Current state - Ohio’s workers’ comp system

- Of the FY 2013 lost time injured-worker population:
  - Approximately 22 percent (or 3,600) received opiates.
  - The average daily MED level for those injured workers is 42mg MED/day (8 Vicodin a day) as of December 31, 2013.
  - Nearly 14 percent of those receiving opiates had an MED level greater than 80mg MED/day.
  - More broadly, nearly 20 percent of all injured workers receiving opiates at the end of FY 2013 are physically dependent.
Current state - Ohio’s workers’ comp system

- National health statistics – overall population
  - According to data from the National Health and Nutrition Survey, nearly 29 percent of responders have hypertension.
  - Eleven percent of people over age 20 have diabetes, according to the National Institutes of Health (NIH).
  - NIH studies also show that more than 26 percent of people have a diagnosable mental disorder.
Current state - Ohio’s workers’ comp system

- Ohio health statistics
  - More than 32 percent of Ohioans suffer from hypertension.
  - Nearly 12 percent of Ohioans suffer from diabetes.
Guiding principles for care

- Provide quality care as soon as possible.
- Help the injured worker navigate the system.
- Pay for positive outcomes.
- Coordinate care for the worker holistically.
- Manage costs appropriately on behalf of employers.
Improving Workers’ Compensation Medical Care in Ohio

Discussing the impacts and opportunities for Ohio’s workers’ compensation system
What are the Key Issues Facing Workers’ Compensation Medical Care in Ohio?

Allard E. Dembe, Sc.D.,
Professor and Director

The Ohio State University, College of Public Health
Center for Health Outcomes, Policy & Evaluation Studies

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## Workers’ Compensation Medical Care Performance Measures

<table>
<thead>
<tr>
<th>Measurement Domains</th>
<th>Examples of Performance Indicators</th>
</tr>
</thead>
</table>
| Access to Care                       | • Getting needed care  
• Wait time to get care                                                                                 |
| Appropriateness of Care              | • Work history taken  
• Job capabilities assessed                                                                                     |
| Work-Related Outcomes                | • Time needed to return to work  
• Ability to perform job after return                                                                        |
| Utilization of Services              | • Utilization of medical services  
• Appropriate services provided for specific conditions                                                       |
| Medical Costs                        | • Medical costs compared to benchmarks  
• Disability costs compared to benchmarks                                                                         |
| Patient Satisfaction/Experience      | • Satisfaction with overall care  
• Satisfaction with choice of provider                                                                              |
| Coordination of Services             | • Timely referral  
• Advice given on return to work                                                                                   |
| Communication                        | • Provider communicates well  
• Provider treats worker with respect                                                                                   |
| Prevention                           | • Injury prevention counseling                                                                                   |

*Source: URAC (American Accreditation HealthCare Commission, Washington, D.C.)*
### 2013 MCO Report Card

<table>
<thead>
<tr>
<th>MCO Name</th>
<th>Number of policies</th>
<th>Number of claims</th>
<th>FROI timing</th>
<th>FROI turnaround</th>
<th>Days absent</th>
<th>Recent medical</th>
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<tbody>
<tr>
<td>1-888-OHIOCOMP</td>
<td>17,317</td>
<td>24,222</td>
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<tr>
<td>3-hab</td>
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<td>AdvoCare MCO</td>
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<tr>
<td>CareWorks</td>
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<td>Comp One</td>
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<td>CompManagement Health Systems</td>
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<td>Frank Gates Managed Care Services</td>
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<td>GENEX Care for Ohio</td>
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<td>Health Management Solutions</td>
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<td>Medical Administrators</td>
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<td>Occupational Health Link</td>
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<td>The Health Plan</td>
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<td>University Hospitals CompCare</td>
<td>4,236</td>
<td>5,997</td>
<td>6.11</td>
<td>1.30</td>
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<tr>
<td>WorkStar Health Services</td>
<td>1,467</td>
<td>3,173</td>
<td>6.07</td>
<td>1.00</td>
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<tr>
<td><strong>Statewide Average</strong></td>
<td></td>
<td></td>
<td><strong>6.20</strong></td>
<td><strong>0.85</strong></td>
<td>51.31</td>
<td>50.21</td>
</tr>
</tbody>
</table>

*The dashed lines above represent the statewide average.*
What are the most important issues facing medical care delivery in the BWC system?

Scoring: 1 = Not an important issue, 2 = A slightly important issue, 3 = A moderately important issue, 4 = A very important issue, 5 = A critical issue

Quality of Care:
1. By what means can the quality and consistency of care to injured workers best be assured? [1 2 3 4 5]
2. How can the BWC make sure that participating clinicians provide appropriate and high-quality care in a cost-effective way? [1 2 3 4 5]
3. Should the care provided to injured workers in Ohio be governed by evidence-based treatment guidelines? [1 2 3 4 5]
4. Are the systems in place for assessing patient satisfaction with care sufficient? [1 2 3 4 5]
5. What measures are needed to ensure adequate access to prescription medications in the OBWC system, while preventing inappropriate long-term use of opioids? [1 2 3 4 5]

Care Delivery and Outcomes
6. What criteria, if any, ought to be used to determine whether a particular provider ought to be allowed to provide care to injured workers within the OBWC system? [1 2 3 4 5]
7. How can utilization management activities by BWC and participating MCOs best be structured to achieve optimal results for all parties? [1 2 3 4 5]
8. Will the provision of economic or other non-economic incentives to providers or MCOs result in significantly better outcomes? [1 2 3 4 5]
9. How can the (short and long-term) outcomes of workers’ compensation care best be assessed and measured? [1 2 3 4 5]
10. What standards, if any, ought to be established to determine the level of performance provided by participating MCOs? [1 2 3 4 5]

Care Coordination
11. Is care coordination and case management being used as effectively as possible in the OBWC system? (for various kinds of circumstances, including catastrophic and non-catastrophic cases) [1 2 3 4 5]
12. Are the current systems for communication and coordination between providers, BWC, and MCOs effective, or is improvement needed? [1 2 3 4 5]
13. Is the expanded use of electronic data exchange systems a feasible and effective strategy for improving BWC system performance? [1 2 3 4 5]
14. How important is it to develop approaches for treating the “whole patient,” by coordinating care for work-related conditions with care for general non-occupational conditions (e.g., chronic conditions like diabetes or asthma)? [1 2 3 4 5]

Other Issues, (write-in):
Glossary of Terms

Care Coordination
Care coordination involves the organization and facilitation of patient care activities across multiple providers and healthcare settings, to facilitate the appropriate delivery of health care services. Care coordination provides information, communication, and other resources to achieve optimal outcomes by systematic planning and structuring of interactions among the patient, providers, insurers, and other key participants in the care experience.

Case Management
Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy to meet an individual's health care needs through communication and acquisition of services to promote high-quality and cost-effective outcomes. With respect to workers' compensation, case management focuses on a process in which the recovery and rehabilitation of an injured worker is overseen by a case manager. The goal of the case manager is to focus on the rehabilitation of the individual so that the return to work is quickened while aiding the worker in achieving preinjury physical condition and function.

Electronic Data Exchange Systems
The transferring of information and data between care units or facilities to provide useful and reliable information to aid the healthcare process. The kind of data typically transferred includes electronic health records, imaging results, claims files, and enrollment and eligibility information.

Evidence-Based Treatment Guidelines
Recognized guidelines established by health systems and government agencies designed to improve patient outcomes, reduce physician bias and help standardize care of patients. The guidelines are based on the best available evidence and research results to help practitioners make well-informed decisions about health care treatment.

Opioids
Opioids, also called opiates, are a class of drug. This class includes drugs derived from the opium poppy, such as morphine and codeine. It also includes synthetic or partially synthetic forms, such as Vicodin, Percocet, oxycodone, and heroin. Many opioids are used to treat acute and persistent pain. Opioid dependence is a medical diagnosis characterized by an individual's inability to stop using opioids.

Utilization Management
Utilization management involves evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan. Typically, an insurer or purchaser will retain an utilization management vendor to help review the appropriateness of care and determine eligibility for benefits and coverage amounts. The review can include determination of allowable benefits through precertification, concurrent certification, or retrospective certification of eligibility for benefits.
What are the most important issues facing medical care delivery in the BWC system?

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What other issues are important to consider for promoting optimal medical care delivery within the BWC system?

Write-in other thoughts and ideas you have about the important issues facing medical care at BWC!
Some of my own thoughts about what’s most important in creating a high-performing workers’ compensation medical care system?

1. Provide care promptly; identify and remove barriers to fast effective care
2. Hold medical providers accountable for providing high-quality care
3. Measure the quality and outcomes of care, including complete and safe recovery of work functionality following injury.
4. Ensure effective care management and care coordination by MCOs
5. Adopt evidence-based standards of care and assess compliance
6. Develop approaches for better coordinating/integrating care for occupational and non-work related conditions.
7. Perform additional research to identify underlying cost drivers and the true determinants of care outcomes.
What are the Key Issues Facing Workers’ Compensation Medical Care in Ohio?

Allard E. Dembe, Sc.D.,
Professor and Director

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Improving Workers’ Compensation Medical Care in Ohio

Discussing the impacts and opportunities for Ohio’s workers’ compensation system
Improving Workers’ Compensation Health Care: A Case Study from Washington State

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Background

- Washington State’s workers’ compensation (WC) program is administered by the Dep’t of Labor & Industries (DLI)
- The DLI and Ohio BWC are both organized as State Funds and thus share many characteristics
- Prior to coming to OSU in 2009, I was on the faculty at the University of Washington School of Public Health and evaluated DLI-sponsored quality improvement pilots
• In the next 15 minutes I highlight some of the important work that improved WC outcomes

• Take home message from my experience is:
  – Collaboration among stakeholders is critical!

• Without genuine collaboration, WC initiatives designed to improve quality and outcomes at a system level for injured workers is likely to fail
DLI Managed Care Pilot

• In 1994 the DLI sponsored a major pilot to assess effects of delivering WC health care through managed care (MC) arrangements.

• MC pilot included:
  – Use of guidelines
  – Board certified occ medicine MD as clinic director
  – On site case manager to improve care coordination
  – Strong emphasis on clinic-employer communication

• MC plans capitated for medical care; disability payments made by DLI in usual fashion.
Surprising results! Plans were not at financial risk for disability payments.

MC Pilot & Subsequent Quality Improvement Initiative

• Why did MC pilot reduce work disability?

• Occupational medicine model used by MC plans:
  – Evidence-based guidelines
  – Ongoing case management to improve care coordination
  – Well trained clinical directors familiar with occ health
  – Emphasis on improved employer communication

• MC pilot prompted DLI to initiate follow-up quality improvement project that did not restrict worker choice
Occupational Health Services (OHS) Quality Improvement Initiative

• In 2000, the DLI, in collaboration with the DLI business and labor council, initiated a second major pilot to improve quality and outcomes:
  – Physician financial incentives to adopt occupational health best practices
    • Complete accident report and submit within 2 business days
    • Telephone contact with employers
    • Complete Activity Prescription Forms
    • 4-week assessment of barriers for RTW
  – Centers of Occupational Health and Education (COHE) developed at 2 sites: Seattle and Spokane)
Activities of Centers of Occupational Health and Education (COHEs) *

- Recruit physicians
- Provide care coordination
- Provide mentoring and CME for physicians
- Disseminate treatment guidelines and best practices information
- Offer consultation for high-risk cases
- Provide direct care

Intervention & Comparison Group Claims for COHE Evaluation

- **Renton**
  - Intervention Group: 26,702
  - Comparison Group: 46,107

- **Spokane**
  - Intervention Group: 16,009
  - Comparison Group: 6,419

Comparison-group: all cases treated by MDs in COHE target area not participating in pilot
### Primary Evaluation Findings (All Cases)*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Adjusted Differences in Outcomes **</th>
<th>95% Confidence Interval</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability days per claim</td>
<td>- 4.1</td>
<td>-6.9 to -1.3</td>
<td>.004</td>
</tr>
<tr>
<td>Disability costs per claim</td>
<td>- $347</td>
<td>-$543 to -$160</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Medical costs per claim</td>
<td>- $245</td>
<td>-$426 to -$61</td>
<td>&lt; .001</td>
</tr>
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</table>

* Wickizer, Franklin, et al. (Medical Care, December 2011).
Other COHE Effects Were Larger

• Back sprain cases involving more complexity leading to average reductions of:
  – 8 days of disability
  – $540 disability costs per claim
  – $202 medical costs per claim (but includes MD incentive)

• Patients treated by physicians who adopted best practices more often (as compared to less often) had average reductions of:
  – 7 days of disability
  – $380 disability costs per claim
  – $390 medical costs per claim
2011 Workers’ Compensation Reform

• SSB 5801 does 3 main things:

1. It creates of a broad statewide provider network administered by DLI
   • Consists of typical health insurance minimum standards.
   • Ensures uniformity in implementation of one network for both self insured and state fund employers.
   • Providers MUST follow DLI coverage polices and treatment guidelines

2. It expands the Centers for Occupational Health and Education (COHEs)
   • Successful RFP-now 6 COHEs-expect over 90% access by 2014

3. For the first time in any jurisdiction, defines clinical harm
Lessons and Conclusions

• Washington State WC collaborative pilots demonstrate it is possible to improve quality and outcomes for injured workers (and save costs!)

• Rigorous evaluation documenting the effect of interventions can have a critical role in getting legislation passed to further strengthen, and make permanent, quality improvement efforts

• Key factor for success is having sustained, committed collaboration among key stakeholder groups!
Improving Workers’ Compensation Medical Care in Ohio

Discussing the impacts and opportunities for Ohio’s workers’ compensation system
Health Transformation in Ohio

Greg Moody, Director
Governor’s Office of Health Transformation

BWC Health Care Workshop
January 29, 2014

The Bureau of Workers’ Compensation is one program among many within the health care system. Many of the challenges BWC faces exist in the health care system overall, not just BWC. It is important to understand the overall challenges and trends to identify opportunities. BWC can leverage its purchasing power to improve overall health system performance.
Agenda

1. Health System Challenges
2. Pay for Value
3. Coordinate Care
A few high-cost cases account for most health spending

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

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

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

Source: Kaiser Family Foundation calculations using data from AHRQ Medical Expenditure Panel Survey (MEPS), 2007.
## Health Care System Choices

<table>
<thead>
<tr>
<th>Fragmentation</th>
<th>vs.</th>
<th>Coordination</th>
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<tbody>
<tr>
<td>Multiple separate providers</td>
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<td>Accountable medical home</td>
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<tr>
<td>Provider-centered care</td>
<td></td>
<td>Patient-centered care</td>
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<tr>
<td>Reimbursement rewards volume</td>
<td></td>
<td>Reimbursement rewards value</td>
</tr>
<tr>
<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>Electronic information exchange</td>
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<tr>
<td>No accountability</td>
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<td>Performance measures</td>
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<td>Institutional bias</td>
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<td>Continuum of care</td>
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<td>Separate government systems</td>
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<td>Medicare/Medicaid/Exchanges</td>
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<tr>
<td>Complicated categorical eligibility</td>
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<td>Streamlined income eligibility</td>
</tr>
<tr>
<td>Rapid cost growth</td>
<td></td>
<td>Sustainable growth over time</td>
</tr>
</tbody>
</table>

SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)
Ohioans spend more per person on healthcare than residents in all but 17 states.

36 states have a healthier workforce than Ohio.

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).
## Per Capita Health Spending: Ohio vs. US

<table>
<thead>
<tr>
<th>Measurement</th>
<th>US</th>
<th>Ohio</th>
<th>Percentage Difference</th>
<th>Affordability Rank (Out of 50 States)</th>
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<td>$6,815</td>
<td>$7,076</td>
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<td>Hospital Care</td>
<td>$2,475</td>
<td>$2,881</td>
<td>+16.4%</td>
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<td>Nursing Home Care</td>
<td>$447</td>
<td>$610</td>
<td>+36.5%</td>
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<td>Home Health Care</td>
<td>$223</td>
<td>$223</td>
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</table>

Agenda

1. Health System Challenges

2. Pay for Value

3. Coordinate Care
Shift from fee-for-service to value-based payment

Payment approach

Population-based
(Patient-Centered Medical Home, capitation)

Episode-based

Fee-for-service
(including pay for performance)

Most applicable

- Primary prevention for healthy population
- Care for chronically ill (e.g., managing obesity, CHF)
- Acute procedures (e.g., CABG, hips, stent)
- Most inpatient stays including post-acute care, readmissions
- Acute outpatient care (e.g., broken arm)
- Discrete services correlated with favorable outcomes or lower cost
### 5-Year Goal for Payment Innovation

**Goal**

80-90 percent of Ohio’s population in some value-based payment model (combination of episodes- and population-based payment) within five years

**State’s Role**

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

### Patient-centered medical homes

**Year 1**

- In 2014 focus on Comprehensive Primary Care Initiative (CPCi)
- Payers agree to participate in design for elements where standardization and/or alignment is critical
- Multi-payer group begins enrollment strategy for one additional market

### Episode-based payments

**Year 1**

- State leads design of five episodes: asthma (acute exacerbation), perinatal, COPD exacerbation, PCI, and joint replacement
- Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year

**Year 3**

- Model rolled out to all major markets
- 50% of patients are enrolled

**Year 5**

- Scale achieved state-wide
- 80% of patients are enrolled

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1. Perinatal
2. Asthma acute exacerbation
3. COPD exacerbation
4. Joint replacement
5. Percutaneous coronary intervention (PCI)
Ohio’s Payment Innovation Partners:
Agenda

1. Health System Challenges
2. Pay for Value
3. Coordinate Care
Ohio Medicaid Increasingly Relies on Managed Care

- **Government-Run Fee-for-Service Programs**
- **Private Managed Care Plans**

Source: Ohio Medicaid (2013); 2015 Executive Budget as proposed.
Improve Managed Care Plan Performance

Competitively rebid managed care contracts in 2012

- Went from 7 plans in 8 regions to 5 plans statewide; increased choice for enrollees from 2 or 3 plans per region to 5
- Increased administrative efficiency; cut administrative rates 1% in 2011 and another 1% in 2013
- Redesigned the overall care management model to place greater emphasis on helping the most high need individuals
- Created a pharmacy lock-in option for plans to limit high-risk members to one physician and one pharmacy
- Use low-acuity non-emergent (LANE) methodology to identify preventable emergency room use
- Required managed care plans to locate key personnel and member services call centers in Ohio
Improve Managed Care Plan Performance

Getting Results

• Saving Ohio taxpayers’ money:
  – 2011 reforms saved $144 million ($52 million state) 2012-2013
  – 2013 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
# Comparing Ohio’s Care Management Systems

<table>
<thead>
<tr>
<th></th>
<th>Ohio Medicaid</th>
<th>Ohio Bureau of Workers’ Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of plans</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Annual medical spending (SFY 2013)</td>
<td>$19.8 billion</td>
<td>$706 million</td>
</tr>
<tr>
<td>Risk model</td>
<td>Capitated, full risk managed care organization</td>
<td>Administrative service organization</td>
</tr>
<tr>
<td>Consumer choice</td>
<td>Choice of plan guaranteed</td>
<td>Choice of provider guaranteed</td>
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</tbody>
</table>
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
Improving Workers’ Compensation Medical Care in Ohio

Discussing the impacts and opportunities for Ohio’s workers’ compensation system

Panel Discussion

Stakeholder perspectives on improving health outcomes in workers’ compensation
Improving Workers’ Compensation Medical Care in Ohio

Discussing the impacts and opportunities for Ohio’s workers’ compensation system

Question and Answer Session
Improving Workers’ Compensation Medical Care in Ohio

Discussing the impacts and opportunities for Ohio’s workers’ compensation system