health policy institute of ohio

Emerging trends in law and state health policy

Dec. 8, 2014 • Renaissance Columbus Downtown Hotel • Columbus, Ohio

Agenda

11:30 a.m.	**Registration** Pick up lunches
12 p.m.	**Welcome and overview of the day** **Amy Rohling McGee,** HPIO
12:05 p.m.	**Presenting sponsor remarks** Health Innovations Ohio
12:10 p.m.	**Introduction to HPIO** **Amy Rohling McGee,** HPIO
12:15 p.m.	**Payment: Aligning payment with improved population health and sustainable costs and the SIM** **Greg Moody**, Director, Governor's Office of Health Transformation
12:40 p.m.	**Prevention: Prioritizing health and safety** **Amy Bush Stevens**, HPIO
1 p.m.	**Insurance basics: Provisions of the Affordable Care Act and how Ohioans are covered** **Reem Aly**, HPIO
1:20 p.m.	**2014 Ohio Medicaid Enrollment Trends and Impact Analysis** **Amy Rohling McGee** and **Stephanie Gilligan**, HPIO **William Hayes**, Director, Healthcare Reform Strategy, OSU Wexner Medical Center and adjunct faculty at OSU College of Public Health
1:35 p.m.	**Medicaid waivers: Exploring approaches from other states** **Maia Crawford,** Program Officer, Center for Health Care Strategies
2:05 p.m.	**Break**
2:15 p.m.	**Medicaid ACOs** **Rob Houston**, Program Officer, Center for Health Care Strategies
2:45	**Long-Term Care** **Robert Applebaum**, Director of the Ohio Long-Term Care Research Project, Scripps Gerontology Center, Miami University
3:15	**Spotlight on health-related legislative activity** **Sen. Shannon Jones**, infant mortality **Rep. Robert Sprague**, opiates **Rep. Barbara Sears**, JMOC and Insurance
3:55	**Wrap-up and Adjourn**

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Speaker biography

Robert A. Applebaum

Robert A. Applebaum, PhD, is Director of the Ohio Long-Term Care Research Project, Scripps Gerontology Center; and Professor, Department of Sociology and Gerontology, at Miami University in Oxford, Ohio. Applebaum's research interests include long-term care; quality assurance; program planning and evaluation; health and social welfare policy. He has published extensively on a variety of long-term care issues, including Medicaid waiver programs and long-term services and supports. He earned his doctorate in Social Welfare from the University of Wisconsin.

Maia Crawford

Maia Crawford, MS, is a program officer at the Center for Health Care Strategies (CHCS). She is providing technical assistance to states designing and testing new care delivery and payment models as part of the Center for Medicare & Medicaid Innovation's State Innovation Models (SIM) initiative. She is also engaged in projects focused on the integration of health and social services and the Medicaid primary care rate increase. Additionally, Ms. Crawford manages the Affinity Group for U.S. Charity Care Programs and supports CHCS' technical assistance activities for the Robert Wood Johnson Foundation's State Health Reform Assistance Network, which helps state agencies maximize opportunities to improve care and coverage under the Affordable Care Act.

Prior to joining CHCS, Ms. Crawford worked at Community Catalyst, a national non-profit consumer advocacy organization working to make affordable, quality health care accessible to all Americans. Previously, she served as a member of AmeriCorps' Community HealthCorps program, providing case management services to homeless individuals with Boston Health Care for the Homeless Program.

Ms. Crawford holds a master's degree in health policy and management from the Harvard School of Public Health. She received a bachelor's degree in government from Dartmouth College.

William Hayes

William D. Hayes, Ph.D., has over 24 years of health policy and health services research experience. Dr. Hayes is currently Director, Healthcare Reform Strategy for The Ohio State University Wexner Medical Center and adjunct faculty in the OSU College of Public Health. His duties include working on how health care reform affects the OSU Health System and all of OSU's health-related Colleges and Schools. He also teaches one or two courses a year on health policy and health care organization.

Prior to joining OSU, Dr. Hayes was the founding President of the Health Policy Institute of Ohio (HPIO), a non-partisan health policy center. He served as HPIO's President from 2004 to 2010. Before leading HPIO, Dr. Hayes was Assistant Deputy of Policy for Ohio Medicaid from 1999 to 2004, Deputy Director for Policy, Planning and the Ohio Health Care Center at the Ohio Department of Health from 1997 to 1999, Chief of Health Policy at ODH from 1994 to 1997, and Management Analyst at the Bureau of Children with Medical Handicaps from 1990 to 1994.

Rob Houston

Rob Houston, MBA, MPP is a program officer at the Center for Health Care Strategies (CHCS). He works on projects involving payment and delivery system reform, providing technical assistance to state Medicaid agencies and provider organizations to facilitate the development of Medicaid accountable care organizations (ACOs). He is currently partnering with the Rutgers Center for State Health Policy and Camden Coalition of Health Care Providers (CCHP) to spread CCHP's "super-utilizer" model to four cities through a Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovations Award. Mr. Houston also helps to lead the Accountable Care Organization Learning Collaborative (ACO LC), which convenes eight leading-edge states working to develop and implement Medicaid ACO programs through support from The Commonwealth Fund. Mr. Houston has also authored several publications related to ACO development and alignment.

Prior to joining CHCS, Mr. Houston consulted with Robert Wood Johnson Partners (a Medicare Shared Savings Program ACO) and the Rutgers Center for State Health Policy on issues pertaining to ACO development.

Mr. Houston holds a master of public policy with a concentration in health policy from the Edward J. Bloustein School of Planning and Public Policy and a master of business administration in marketing from Rutgers Business School. He graduated with a bachelor of arts in political science from Rutgers University – New Brunswick.

Greg Moody

Governor John R. Kasich appointed Greg Moody in January 2011to lead the Office of Health Transformation. OHT is responsible for advancing Governor Kasich's Medicaid modernization and cost-containment priorities, engaging private sector partners to improve overall health system performance, and recommending a permanent health and human services structure for Ohio.

Moody began his public service career as a budget associate for the U.S. House Budget Committee in Washington D.C. The Budget Chairman at the time, Rep. John Kasich, asked Moody to study the impact of Medicaid on federal spending – an assignment that set the course for his public policy career.

Prior to joining the Kasich Administration, Moody was a senior consultant at Health Management Associates, a national research and consulting firm that specializes in complex health care program and policy issues. He worked with clients to improve Medicaid system performance, and wrote extensively about state health system innovations for the Commonwealth Fund, National Governor's Association, and other foundations. Moody's Ohio experience includes serving as Interim Director of the Ohio Department of Job and Family Services (2001), Executive Assistant for Health and Human Services for Governor Bob Taft (1999-2004), and Chief of Staff to the Dean at the OSU College of Medicine (1997-1999).

Moody has a master's in philosophy from George Washington University and bachelor's in economics from Miami University.

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Transforming Payment for a Healthier Ohio

Greg Moody, Director
Governor's Office of Health Transformation

Health Policy Institute of Ohio
December 8, 2014

www.HealthTransformation.Ohio.gov

- Governor Kasich created the Office of Health Transformation to improve overall health system performance
- Pay for health care value instead of volume across Medicaid, state employee, and commercial populations
  - Launch episode based payments in Q1 2015
  - Take Comprehensive Primary Care to scale in 2015
- Partners include Anthem, Aetna, CareSource, Medical Mutual, and UnitedHealthcare, covering ten million Ohioans
- Build on momentum from extending Medicaid coverage, Medicare-Medicaid Enrollee project, etc.
- Comprehensive, complementary strategies for health sector workforce development and health information technology
- Active stakeholder participation: 150+ stakeholder experts, 50+ organizations, 60+ workshops, 20 months and counting …

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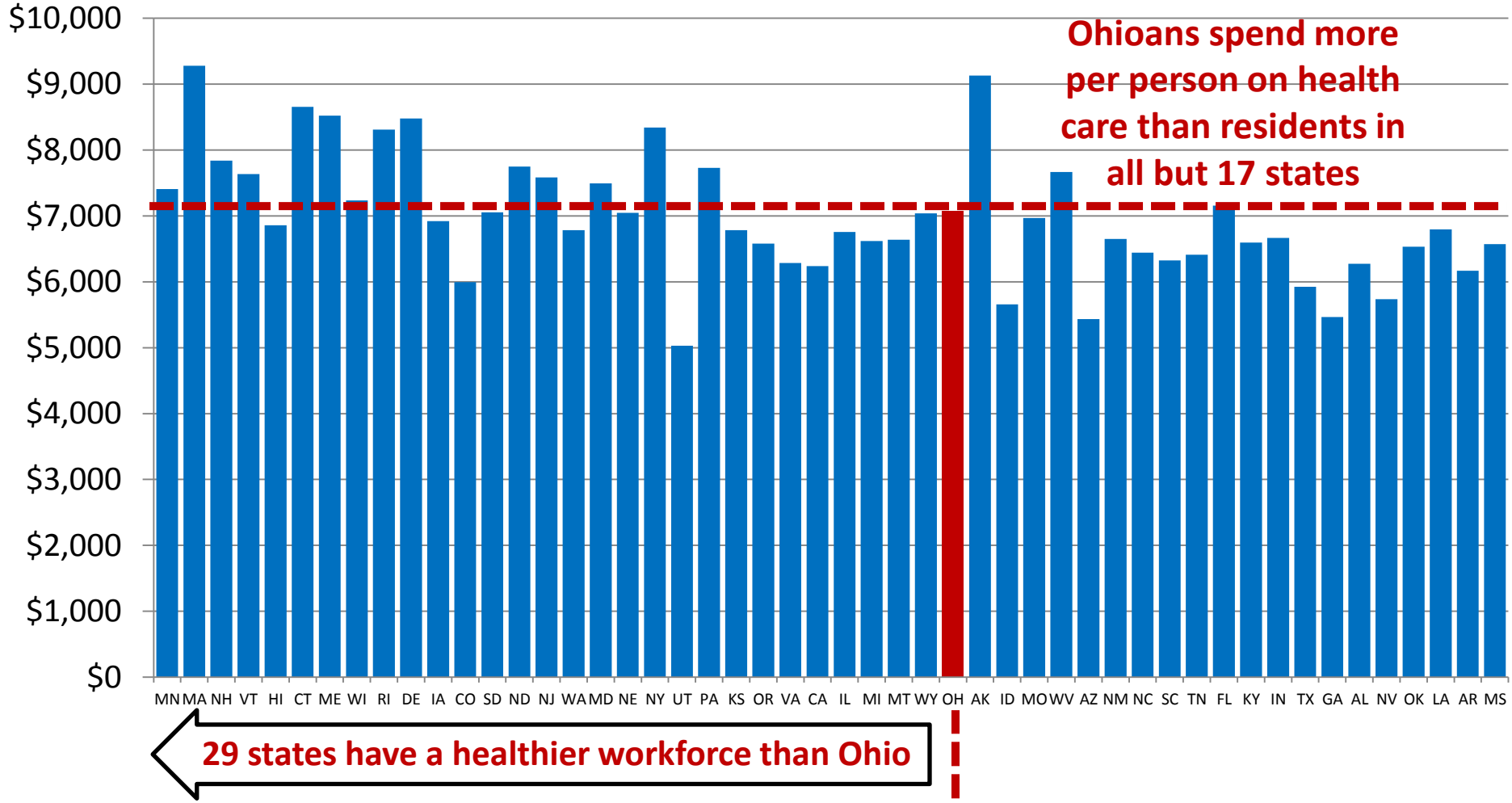
1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Medical Home Model
3. Episode-Based Payment Model
4. Episode Example

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2014)



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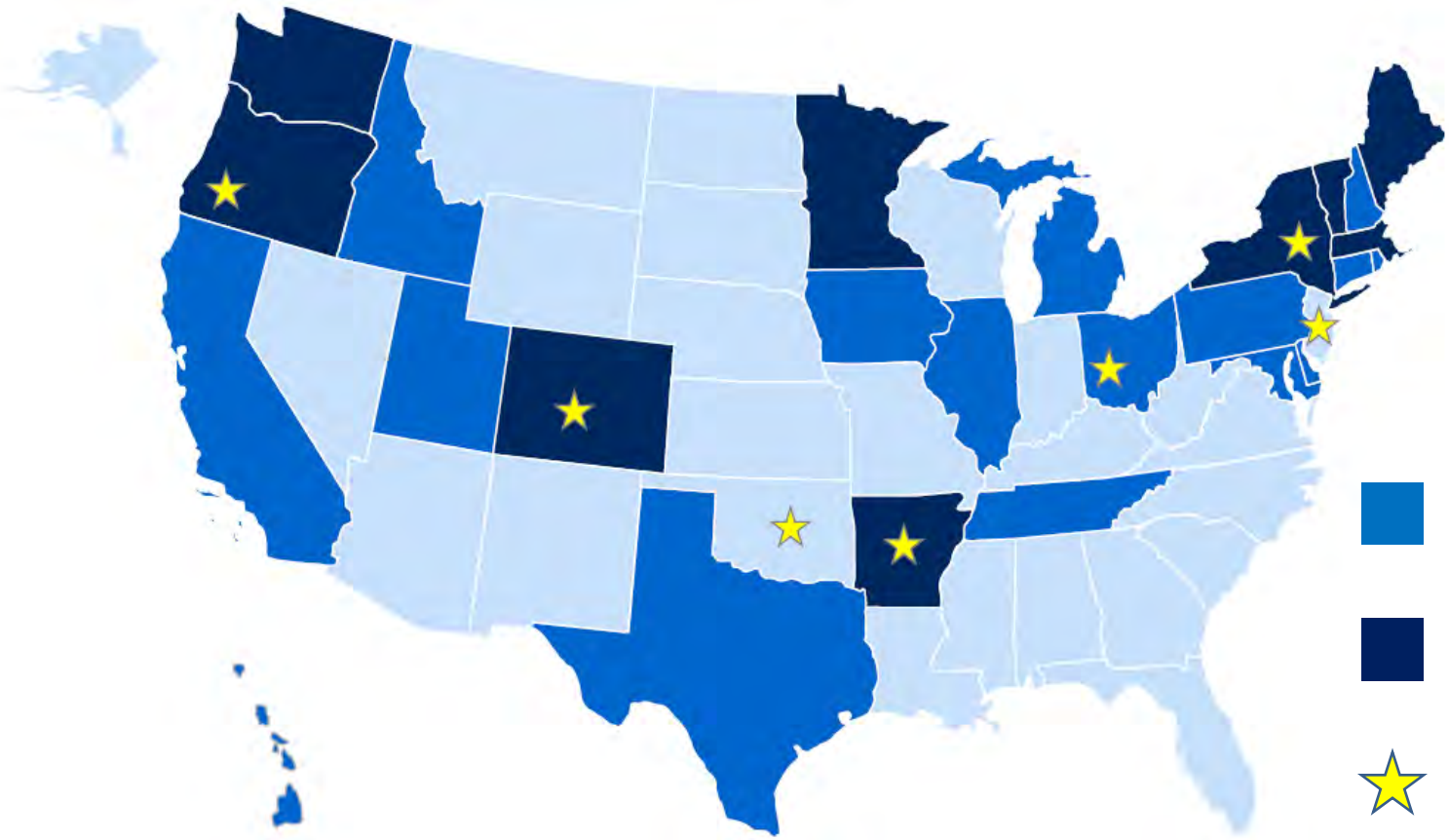
Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (May 2014).

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)

27 states are designing and testing payment innovation programs



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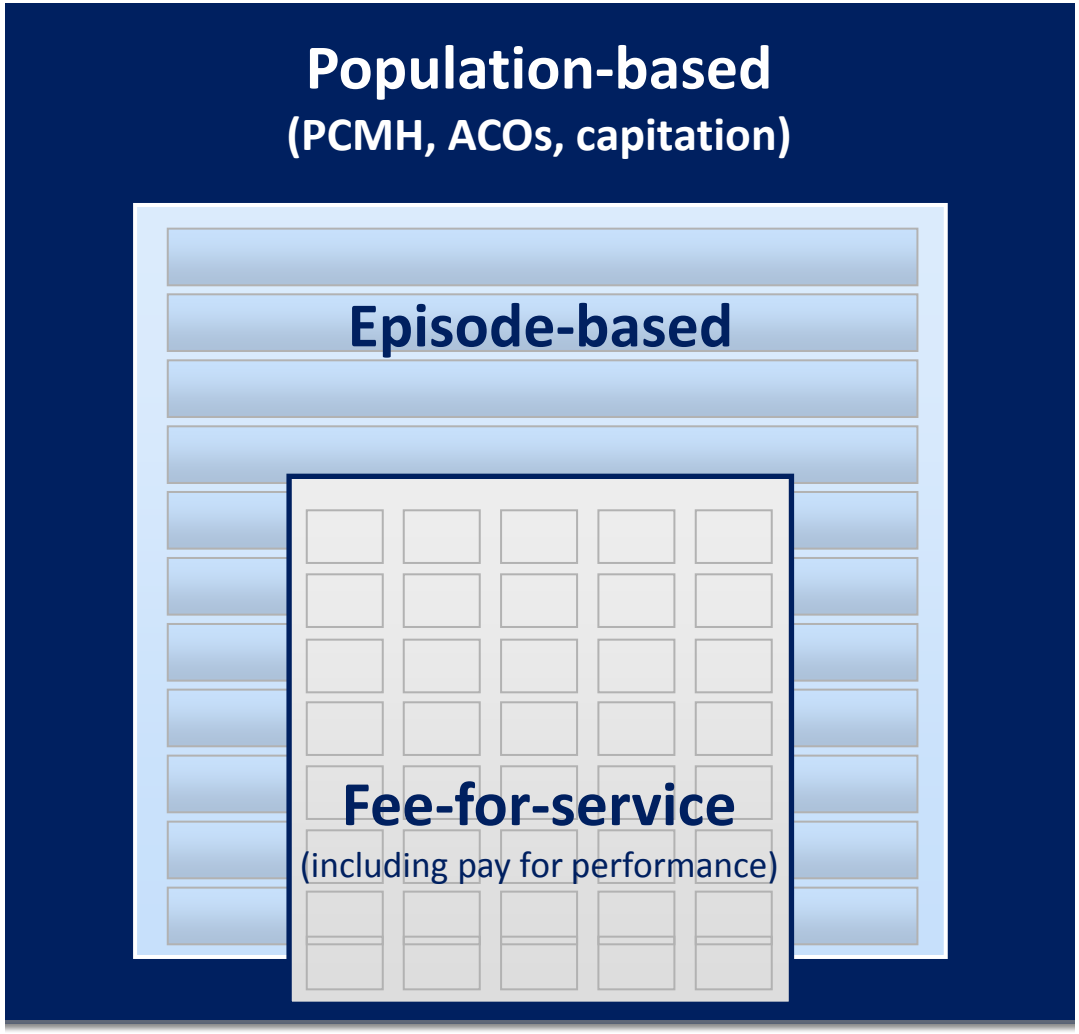
SIM: State Innovation Model; CPCI: Comprehensive Primary Care Initiative
SOURCE: U.S. Centers for Medicare and Medicaid Services (CMS).

Shift to population-based and episode-based payment

Payment approach



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

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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	Episode-based payments
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	▪ 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	▪ 20 episodes defined and launched across payers
Year 5	▪ Scale achieved state-wide ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers

Ohio's Health Care Payment Innovation Partners:

Anthem

MEDICAL MUTUAL

aetna

UnitedHealthcare

CareSource

MOLINA HEALTHCARE

Buckeye Community Health Plan

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1. Ohio Approach to Paying for Value Instead of Volume
2. **Patient-Centered Medical Home Model**
3. Episode-Based Payment Model
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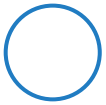
Ohio already has various PCMH projects underway

- Major focus of pilots
- Some focus
- Minimal or no focus

	HB 198 Education Pilot Sites	NCQA, AAAHC, Joint Commission	Cincinnati/Dayton CPCi	Private Payer Pilots
	▪ 42 pilot sites target underserved areas ▪ Potential to add 50 pediatric pilots	▪ 455 NCQA-recognized sites ▪ 51 Joint Commission accredited sites ▪ 7 AAAHC-accredited	▪ 61 sites in OH (14 in KY), incl. Tri-Health, Christ Hospital, PriMed, Providence, St. Elizabeth (KY)	▪ Vary in scope by pilot, but tend to focus on larger independent or system-led practices
Care delivery model				
Payment model				
Infrastructure				
Scale-up and practice performance improvement				

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Source: Ohio Patient-Centered Primary Care Collaborative , ODH; as of August 2014.

Comprehensive Primary Care Initiative

- Dayton/Cincinnati is one of only seven CPC sites nationally
- Bonus payments to primary care doctors who better coordinate care
- Multi-payer: Medicare, Medicaid, nine commercial insurance plans
- 75 primary care practices (261 providers) serving 44,500 Medicare enrollees in 14 Ohio and 4 Kentucky counties

The goal is to learn from CPC in developing an approach to roll out PCMH statewide

- Practices were selected based on their use of HIT, advanced primary care recognition, and participation in practice improvement activities
- Supported by a unique regional collaborative: The Greater Cincinnati Health Council, the Health Collaborative, and HealthBridge

Creating connections. Improving care.

Better information. Better care. Better outcomes.

Regional Health Improvement Collaboratives

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Elements of a Patient-Centered Medical Home Strategy

Care delivery model	Target patients and scope Care delivery improvements e.g., ▪ Improved access ▪ Patient engagement ▪ Population management ▪ Team-based care, care coordination Target sources of value	Vision for a PCMH's role in the healthcare eco system, including who they should target, how care should be delivered (including differences from today), and which sources of value to prioritize over time.
Payment model	Technical requirements for PCMH Attribution / assignment Quality measures Payment streams/ incentives Patient incentives	Holistic approach to use payment (from payers) to encourage the creation of PCMHs, ensure adequate resources to fund transformation from today's model, and reward PCMH's for improving in outcomes and total cost of care over time
Infrastructure	PCMH infrastructure Payer infrastructure Payer / PCMH infrastructure PCMH/ Provider infrastructure System infrastructure	Technology, data, systems, and people required to enable creation of PCMH, administer new payment models, and support PCMHs in making desired changes in care delivery
Scale-up and practice performance improvement	Clinical leadership / support Practice transformation support Workforce / human capital Legal / regulatory environment Network / contracting to increase participation ASO contracting/participation Performance transparency Ongoing PCMH support Evidence, pathways, & research Multi-payer collaboration	Support, resources, or activities to enable practices to adopt the PCMH delivery model, sustain transformation and maximize impact

Elements of a Patient-Centered Medical Home Strategy

Care delivery model	Target patients and scope
	Care delivery improvements e.g., ▪ Improved access ▪ Patient engagement ▪ Population management ▪ Team-based care, care coordination
	Target sources of value
Payment model	Technical requirements for PCMH
	Attribution / assignment
	Quality measures
	Payment streams/ incentives
	Patient incentives
Infrastructure	PCMH infrastructure
	Payer infrastructure
	Payer / PCMH infrastructure
	PCMH/ Provider infrastructure
	System infrastructure
Scale-up and practice performance improvement	Clinical leadership / support
	Practice transformation support
	Workforce / human capital
	Legal / regulatory environment
	Network / contracting to increase participat
	ASO contracting/participation
	Performance transparency
	Ongoing PCMH support
	Evidence, pathways, & research
	Multi-payer collaboration

- Payers agree to provide resources to support business model transformation for a finite period of time, particularly for small, less capitalized practices
- Agree to provide resources to compensate PCMH for activities not fully covered by existing fee schedules (care coordination, non-traditional visits like telemedicine, population health)
- Agree to reward PCMHs for favorably affecting risk-adjusted total cost of care over time by offering bonus payments, shared savings, capitation, or sub-capitation.

Source: Ohio PCMH Multi-Payer Charter (2013)

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1. Ohio Approach to Paying for Value Instead of Volume
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4. Episode Example

Elements of an Episode-Based Payment Strategy

Program-level design decisions

Participation	Provider participation Payer participation } Related to 'scale-up' plan for episodes
Account-ability	Providers at risk – Number Providers at risk – Type of provider(s) Providers at risk – Unique providers Cost normalization approach
Payment model mechanics	Prospective or retrospective model Risk-sharing agreement – types of incentives Approach to small case volume Role of quality metrics Provider stop-loss Absolute vs. relative performance rewards
Performance management	Absolute performance rewards – Gain sharing limit Approach to risk adjustment Exclusions
Payment model timing	Preparatory/"reporting-only" period Length of "performance" period Synchronization of performance periods
Payment model thresholds	Approach to thresholds How thresholds change over time Specific threshold levels Degree of gain / risk sharing Cost outliers

Episode-specific design decisions

Core Episode definition	Quarterback selection Triggers Episode timeframe – Type/length of pre-procedure/ event window Claims in- or excluded: pre-procedure/event window Claims in- or excluded: during procedure/event Claims in- or excluded: post procedure/event (incl. readmission policy)
Episode cost adjustment	Risk adjustors Unit cost normalization - Inpatient Unit cost normalization - Other Adjustments for provider access Approach to cost-based providers Clinical exclusions
Quality metric selection	Approach to non-claims-based quality metrics Quality metric sampling Quality metrics linked to payment Quality metrics for reporting only

Retrospective episode model mechanics

Patients and providers continue to deliver care as they do today

1

Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

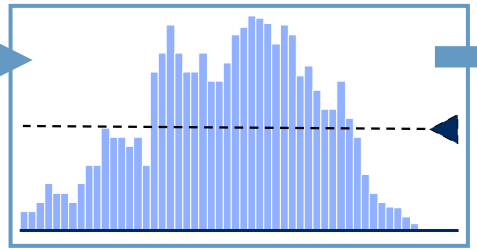
Payers reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period

4

Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5 Payers calculate **average cost per episode** for each PAP



Compare average costs to predetermined "commendable" and "acceptable" levels

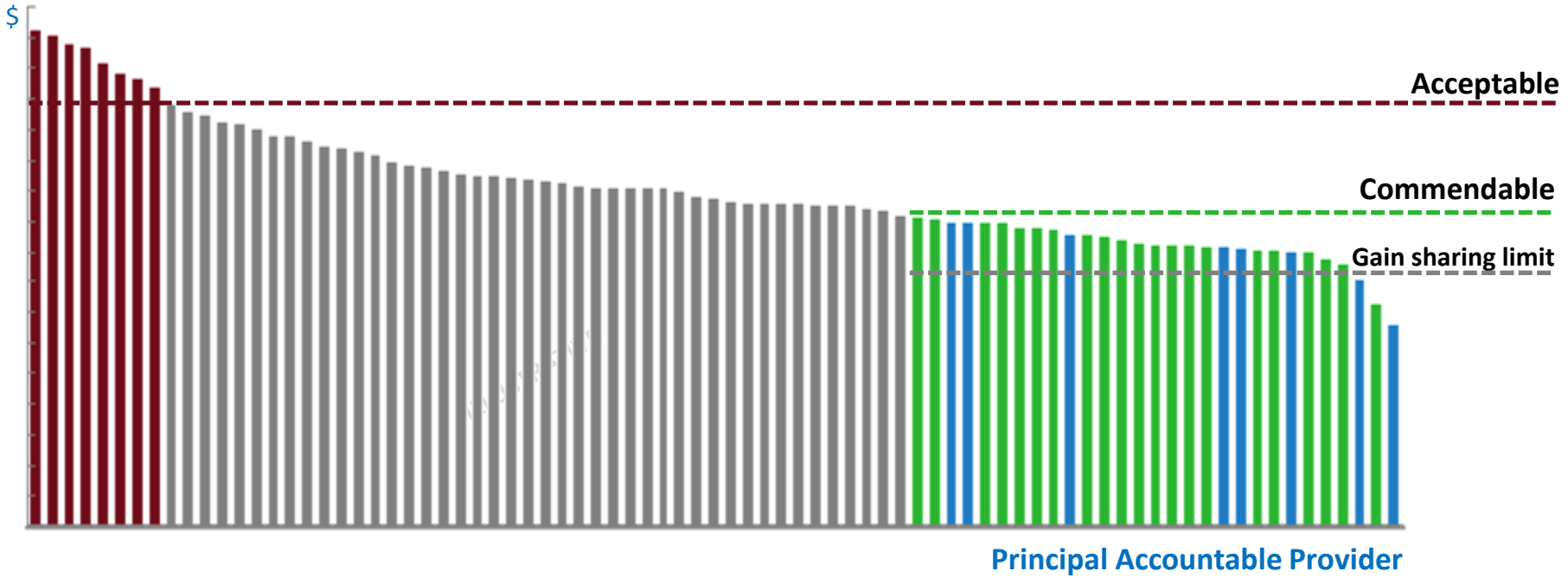
6 **Providers may:**

- **Share savings**: if average costs below commendable levels and quality targets are met
- **Pay part of excess cost:** if average costs are above acceptable level
- **See no change in pay:** if average costs are between commendable and acceptable levels

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average episode cost per provider)

- ***Risk sharing*** Pay portion of excess costs
- ***No change*** Payment unchanged
- ***No Change*** Eligible for gain sharing based on cost, but did not pass quality metrics
- ***Gain sharing*** Eligible for incentive payment



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NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Selection of episodes in the first year

Guiding principles for selection:

- Leverage episodes in use elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with **clear sources of value** (e.g., high variance in care)
- Select episodes that incorporate a **diverse mix** of accountable **providers** (e.g., facility, specialists)
- Cover a **diverse set of "patient journeys"** (e.g., acute inpatient, acute procedural)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

First six episodes selected:

Episode	Principal Accountable Provider (PAP)
Perinatal	Physician/group delivering the baby
Asthma acute exacerbation	Facility where trigger event occurs
COPD exacerbation	Facility where trigger event occurs
Percutaneous coronary intervention (PCI)	Facility where PCI performed (acute) OR physician (non-acute)
Total joint replacement	Orthopedic surgeon performing the total joint replacement procedure

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This is a sample report; actual reports will be released in 2015

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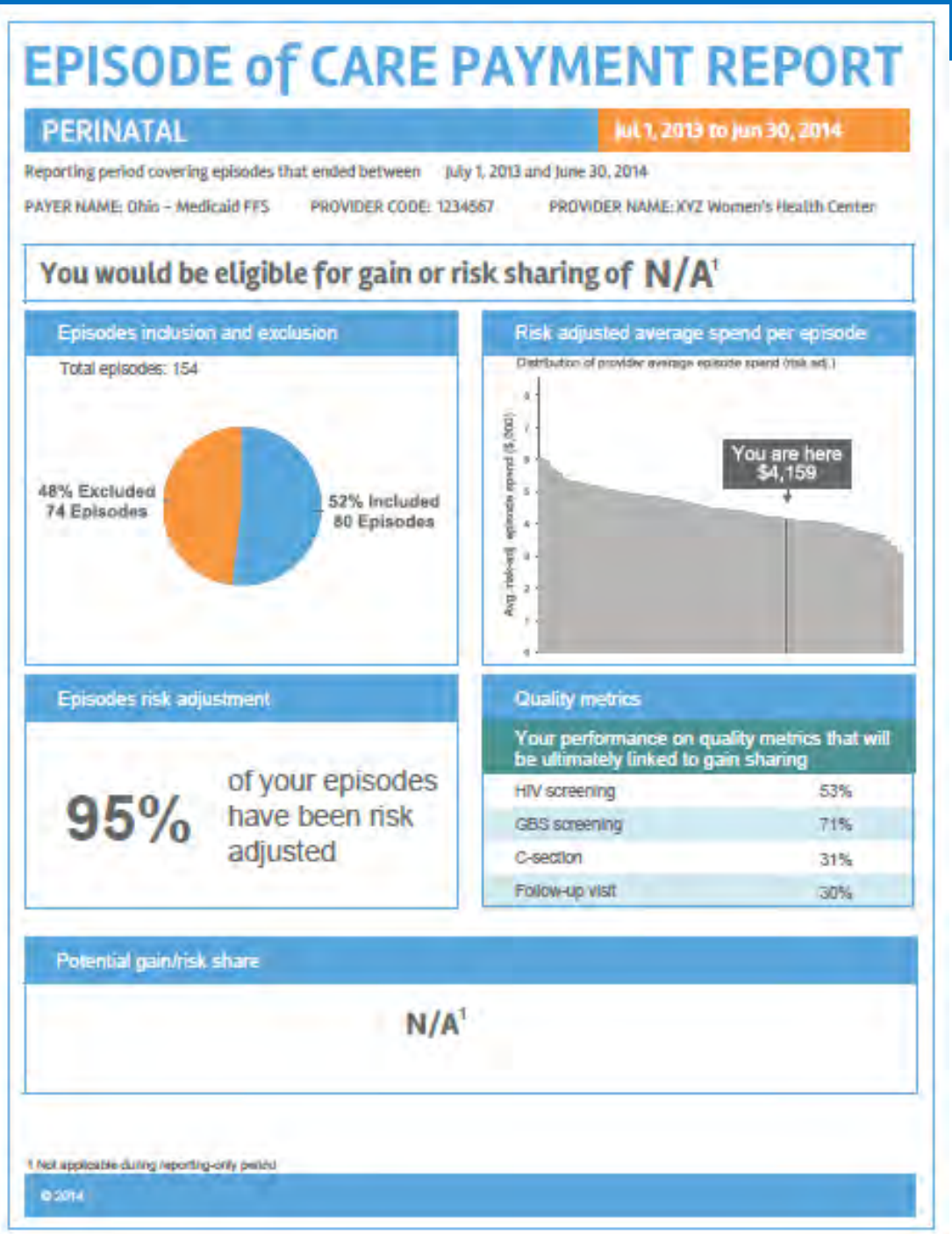

EPISODE of CARE PAYMENT REPORT

PERINATAL

Jul 1, 2013 to Jun 30, 2014

Reporting period covering episodes that ended between July 1, 2013 and June 30, 2014

PAYER NAME: Ohio – Medicaid FFS PROVIDER CODE: 1234567 PROVIDER NAME: XYZ Women's Health Center

You would be eligible for gain or risk sharing of N/A[1]

Episodes inclusion and exclusion

Total episodes: 154

48% Excluded
74 Episodes

52% Included
80 Episodes

Risk adjusted average spend per episode

Distribution of provider average episode spend (risk adj.)

You are here
$4,159

Episodes risk adjustment

95% of your episodes have been risk adjusted

Quality metrics

Your performance on quality metrics that will be ultimately linked to gain sharing

HIV screening	53%
GBS screening	71%
C-section	31%
Follow-up visit	30%

Potential gain/risk share

N/A[1]

1 Not applicable during reporting-only period

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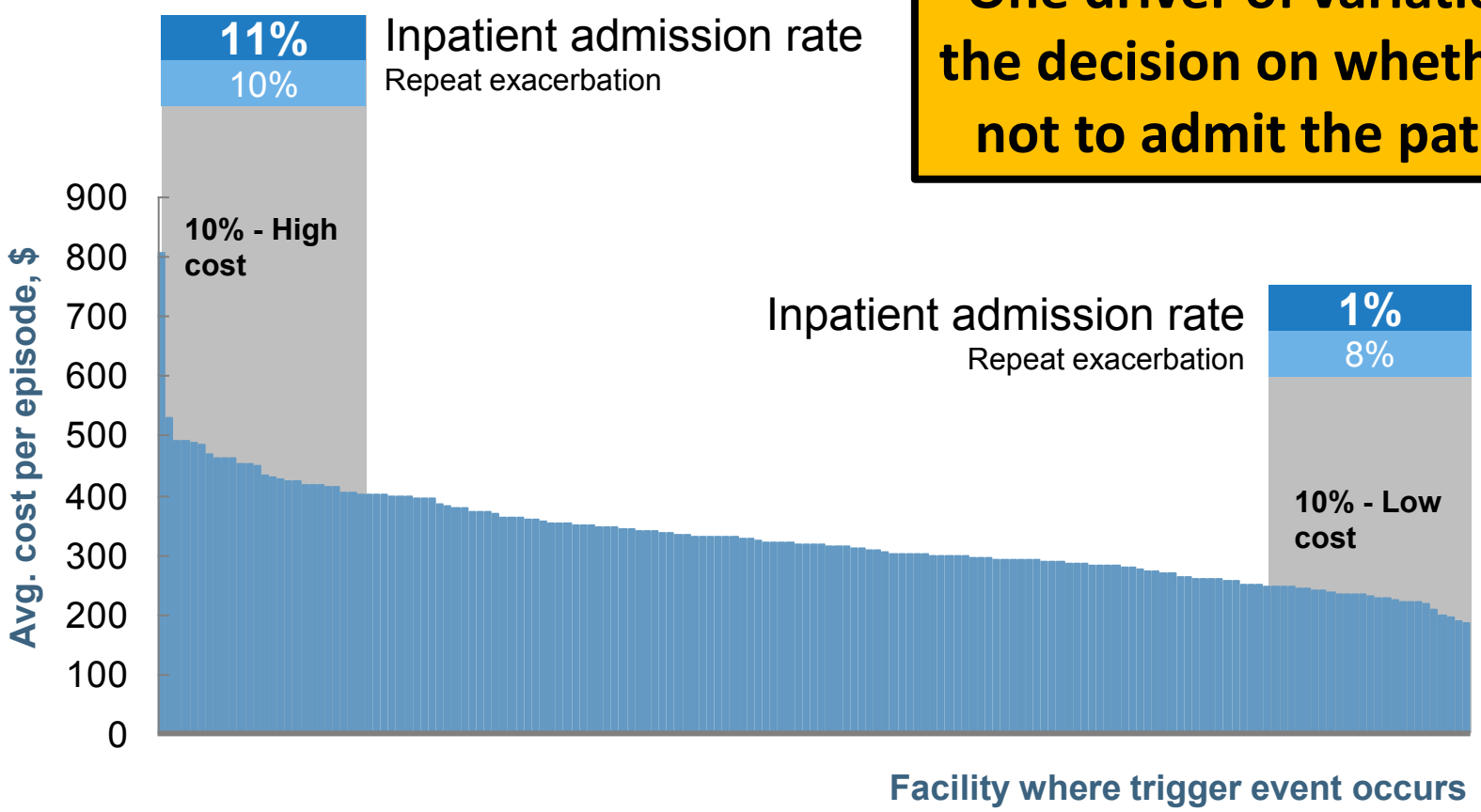
Variation across the Asthma Acute Exacerbation episode

Distribution of provider average episode cost

$



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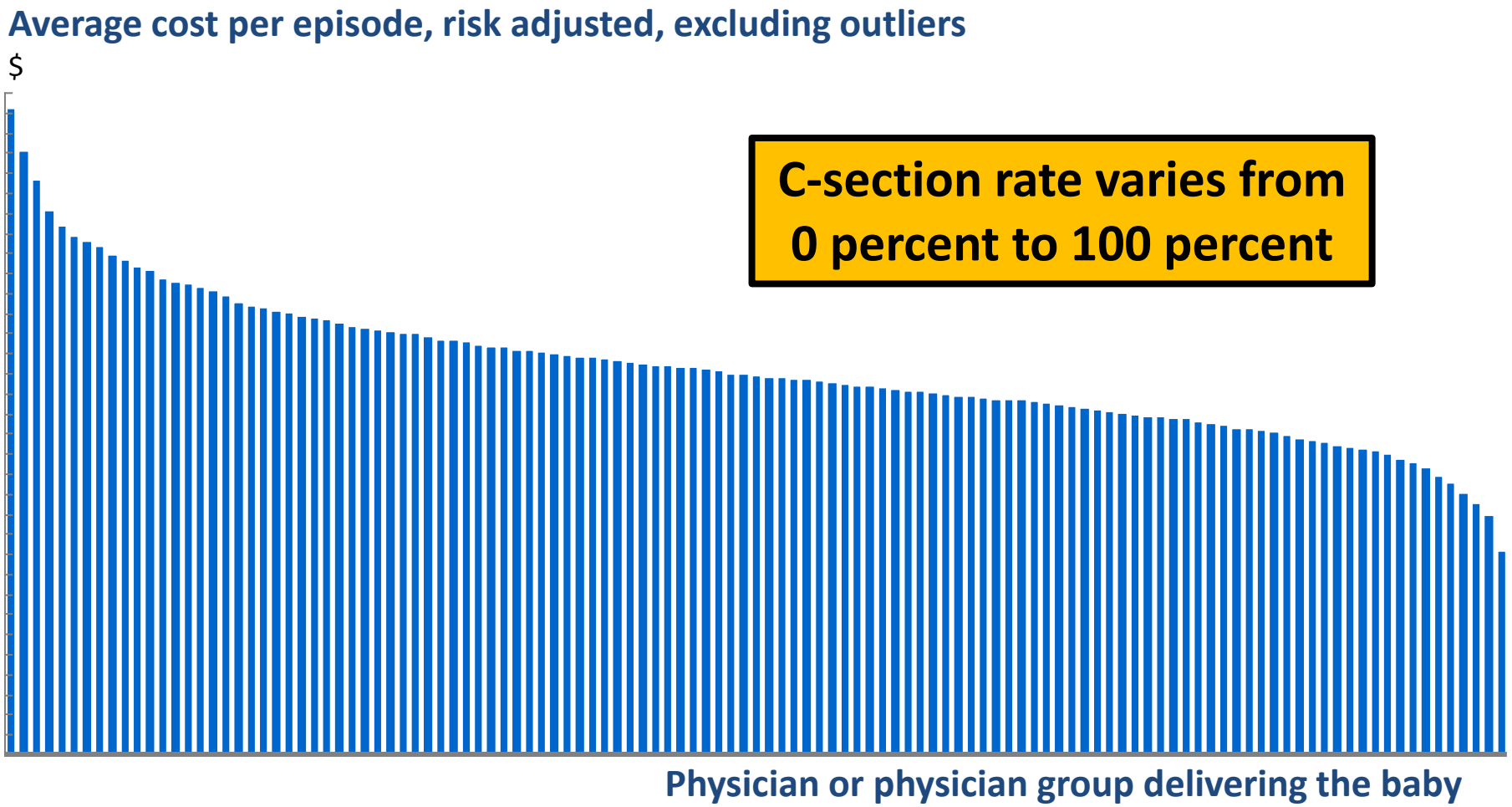
NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-12.

Variation across the perinatal episode



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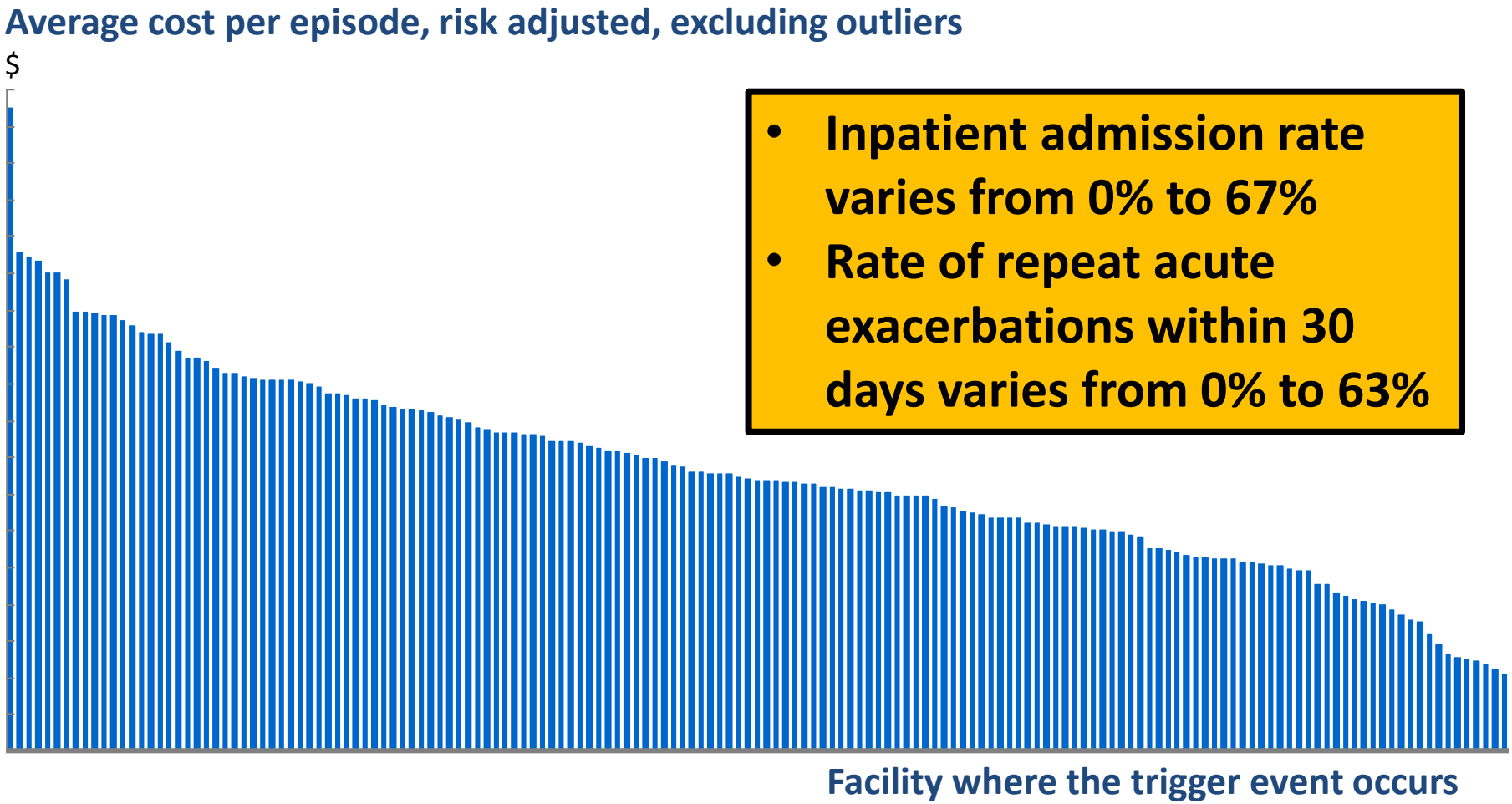
NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-12.

Variation across the COPD Acute Exacerbation episode



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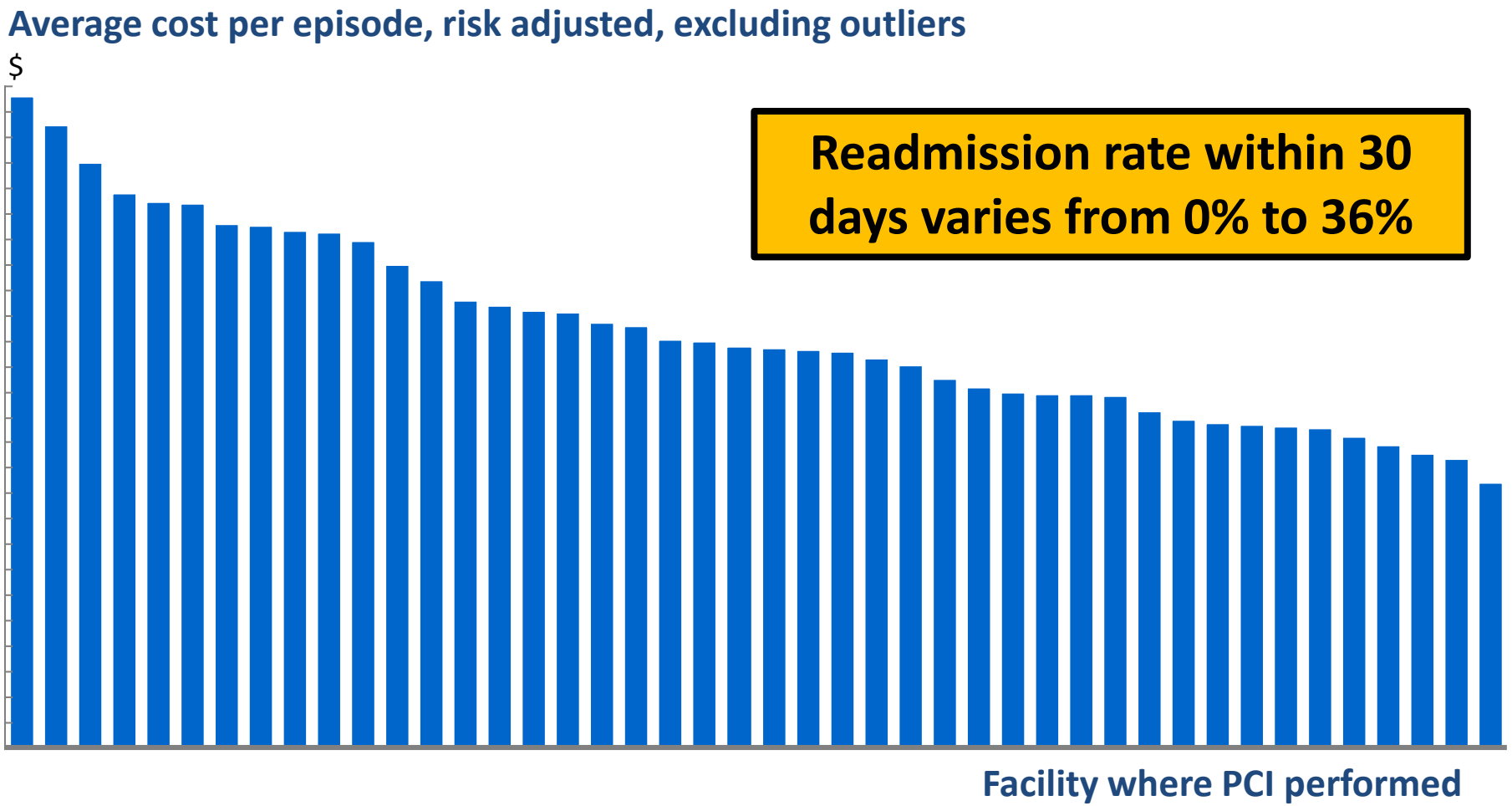
NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-12.

Variation across the Acute PCI episode



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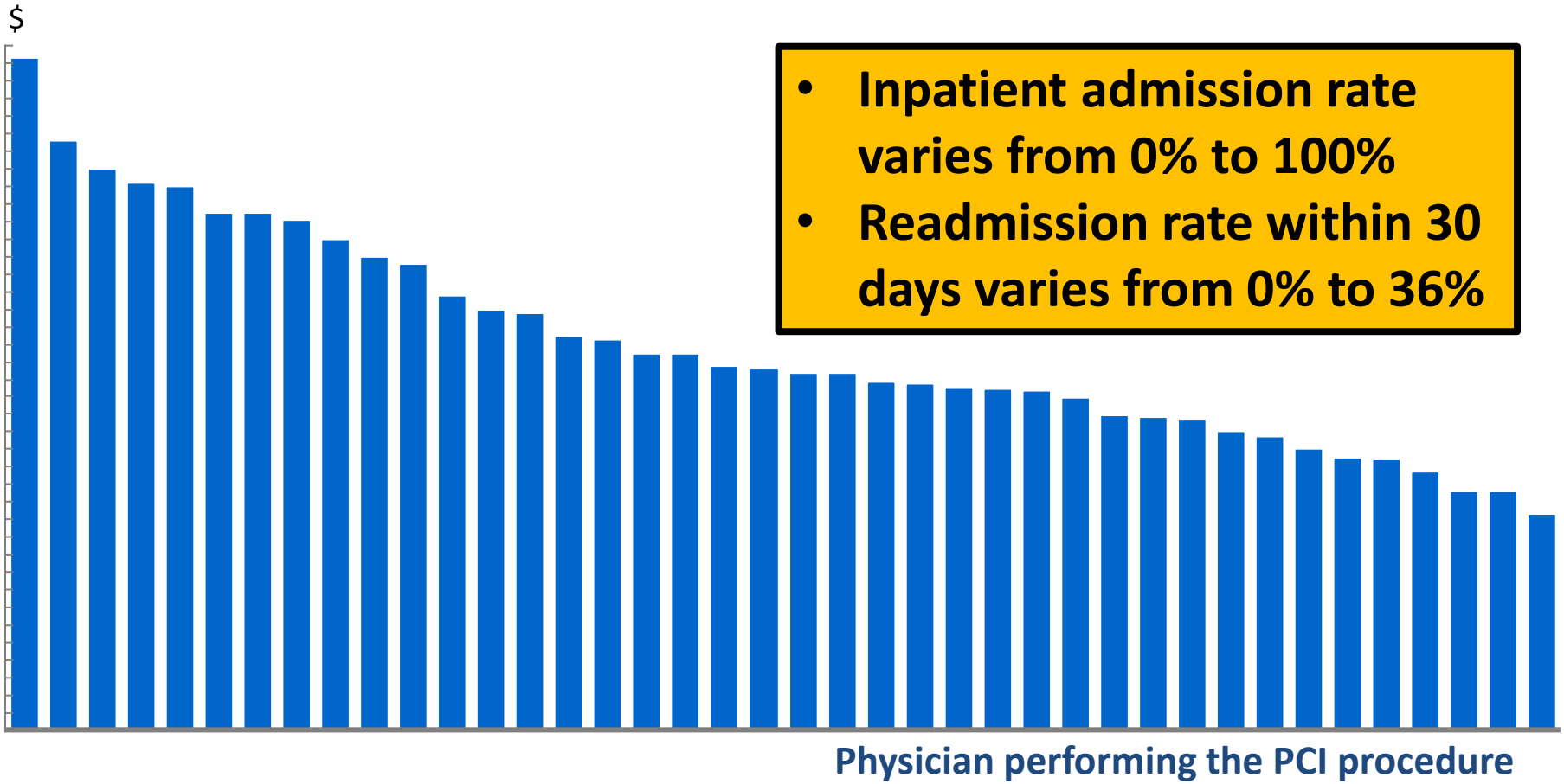
NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-12.

Variation across the Non-Acute PCI episode

Average cost per episode, risk adjusted, excluding outliers



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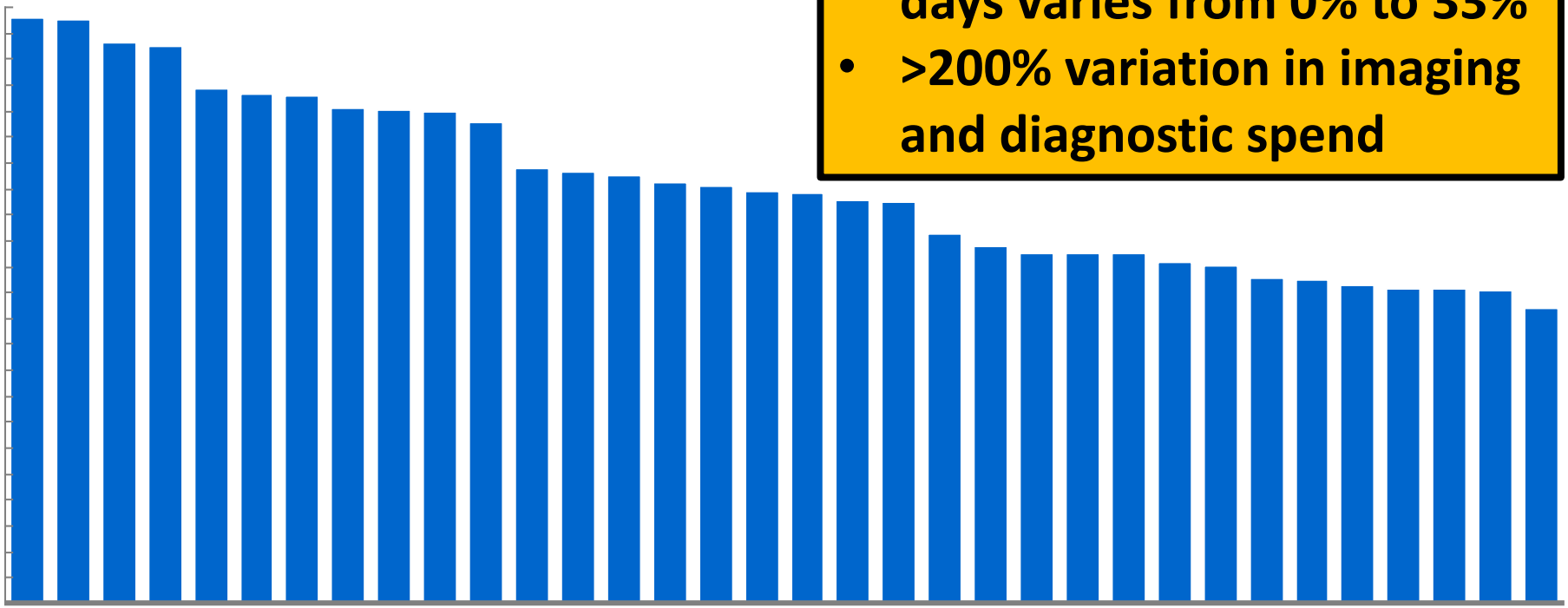
NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-12.

Variation across the Total Joint Replacement episode

Average cost per episode, risk adjusted, excluding outliers

$



- **Readmission rate within 30 days varies from 0% to 33%**
- **>200% variation in imaging and diagnostic spend**

Orthopedic surgeon performing the TJR procedure

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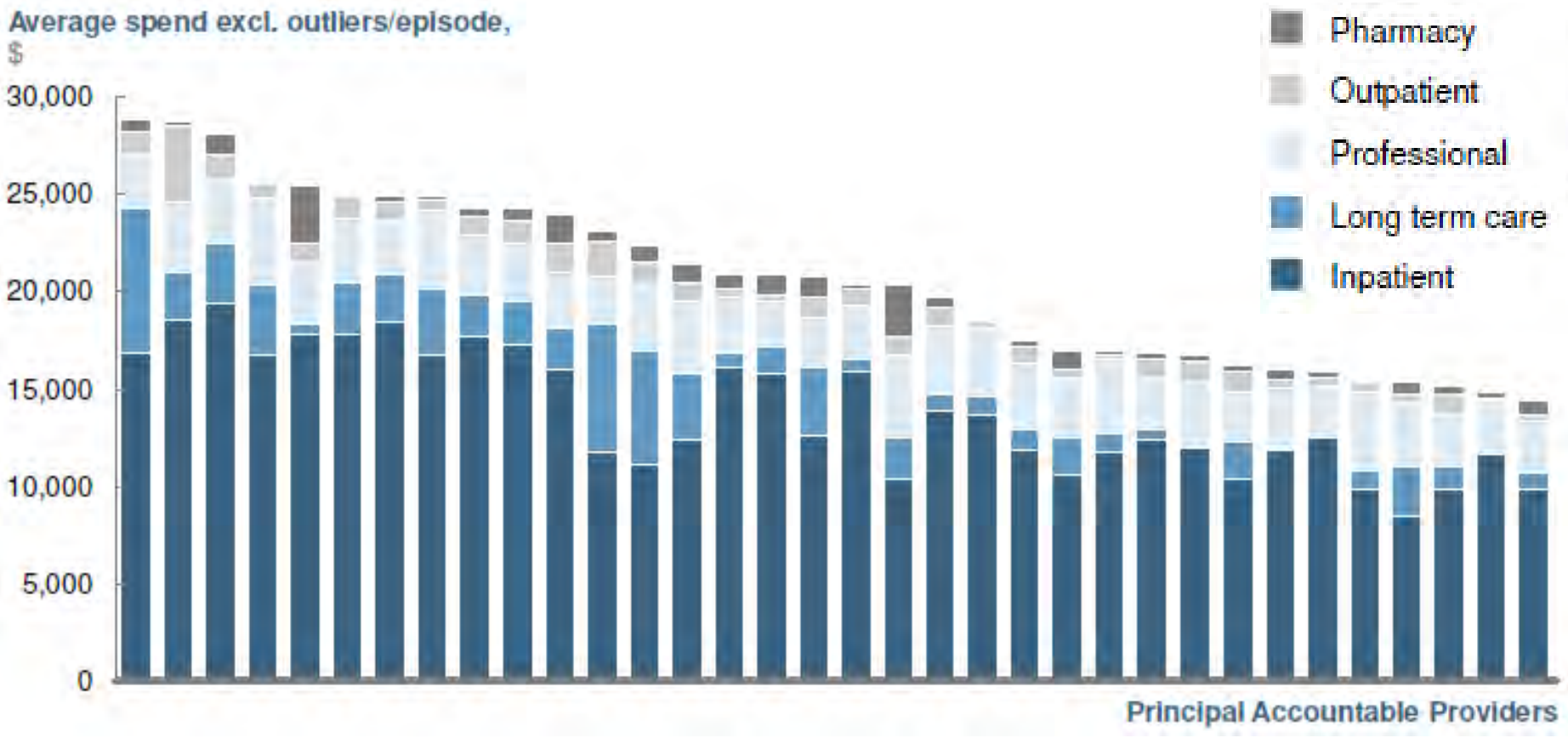
NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-12.

Total Joint Replacement Episode Distribution by Claim Type



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NOTES: Average episode spend distribution by claim type for PAPs with five or more episodes; each vertical bar represents the average spend for a PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-2012.

Health Transformation Next Steps

- Communicate next steps on payment innovation to health care provider associations and all stakeholders (Dec 5)
- Expect Ohio to receive federal SIM Test Award (Nov/Dec)
- Announce the official release date for episode reports
- Coordinate Ohio's Provider Transformation Network federal grant application (Jan 6)
- SIM Test Award activities (Jan 2015 – Dec 2018)
- Launch reporting for first six episodes (Q1 2015)

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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
Implement a new Medicaid claims payment system
Create a cabinet-level Medicaid department
Consolidate mental health and addiction services
Simplify and integrate eligibility determination
Coordinate programs for children
Share services across local jurisdictions

Pay for Value
Engage partners to align payment innovation
Provide access to patient-centered medical h
Implement episode-based payments
Coordinate health information technology infrastructu
Coordinate health sector workforce programs
Support regional payment reform initiatives
Federal Health Insurance Exchange

Ohio's State Innovation Model (SIM) Test Grant Application:

- Population Health Plan
- Delivery System Plan
- Payment Models
- Regulatory Plan
- HIT Plan
- Stakeholder Engagement
- Quality Measurement

Payment Models:

- PCMH Charter
- Episode Charter
- Overview Presentation

www.medicaid.ohio.gov/providers/paymentinnovation.aspx

Ohio Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

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PROVIDERS > Payment Innovation

Payment Innovation

The Ohio Department of Medicaid has joined the Governor's Office of Health Transformation to engage public and private sector partners in designing a new health care delivery payment system that rewards the value of services – not the volume.

In early 2013, the Governor's Advisory Council for Payment Reform was convened to seek input and set clear expectations for better health, better care, and cost savings through improved payment. As part of the effort, Ohio applied and received a State Innovation Model (SIM) design grant from the Center for Medicare and Medicaid Innovation (CMMI). The State of Ohio's proposal centers around design payment models that increase access to patient-centered medical homes and support retrospective episode-based payments for acute medical events.

Transforming Payment for a Healthier Ohio

Information for Providers

Episode Definitions:
Detailed definitions for perinatal, asthma, chronic obstructive pulmonary disease, total j
episodes.

Detailed Business Requirements - Detailed definitions of and associated coding algorithms

- Perinatal
- Asthma and Chronic Obstructive Pulmonary Disease
- Total Joint Replacement
- Percutaneous coronary intervention (acute and non-acute) episodes

Code Tables - Excel spreadsheets of code detail for:

- Perinatal
- Asthma
- Chronic Obstructive Pulmonary Disease
- Total Joint Replacement
- Percutaneous Coronary Intervention (acute and non-acute) episodes

Risk Adjustment Document:
Detailed description of principles and process of risk adjustment for episode-based payment model.

Episode Frequently Asked Questions

Details for Providers:

- **Episode Definitions**
- **Business Requirements**
- **Code Tables**
- **Risk Adjustment**

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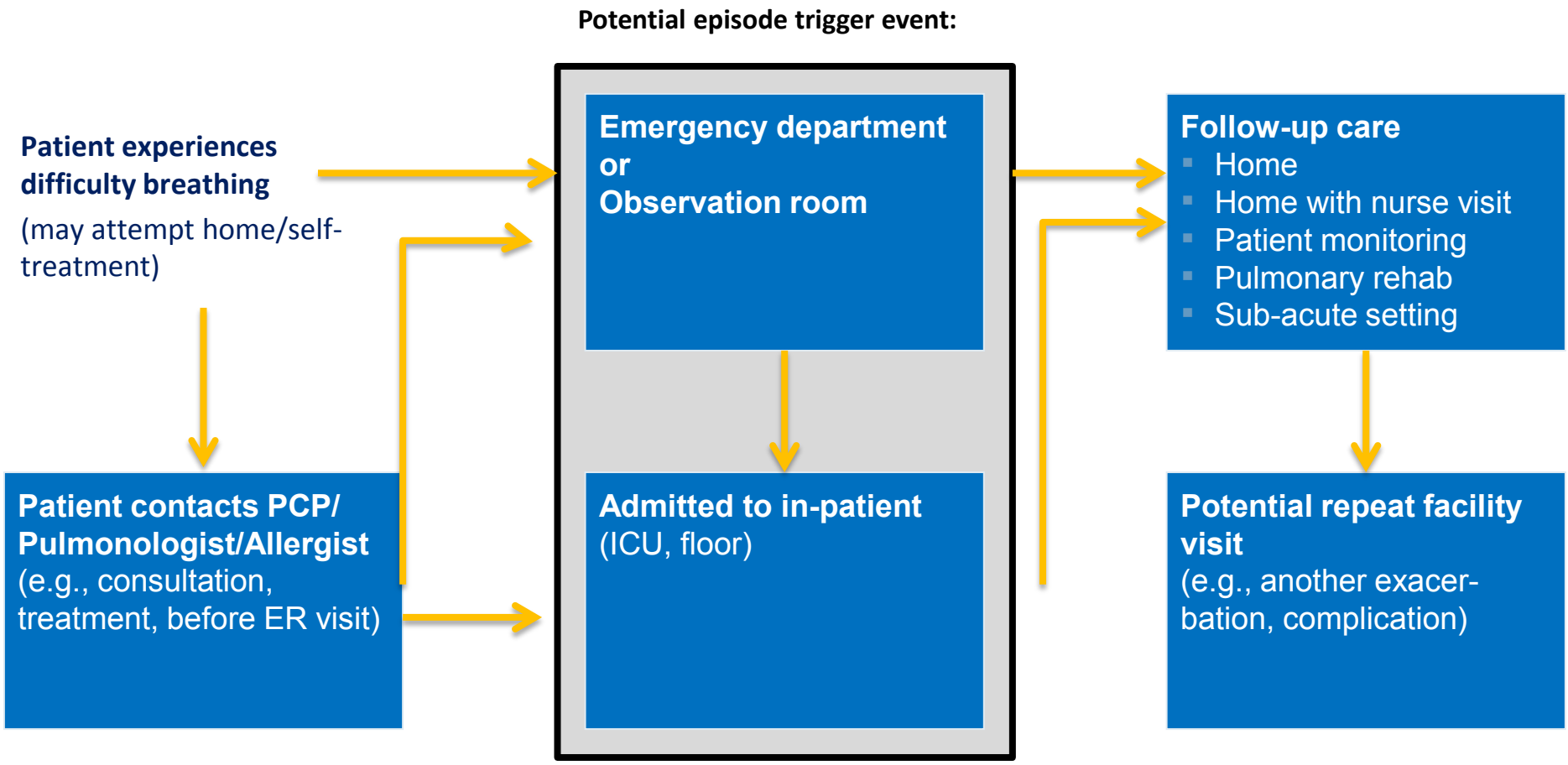
1. Ohio Approach to Paying for Value Instead of Volume
2. Patient-Centered Medical Home Model
3. Episode-Based Payment Model
4. **Episode Detail: Asthma Acute Exacerbation**

Asthma Acute Exacerbation: Patient Journey



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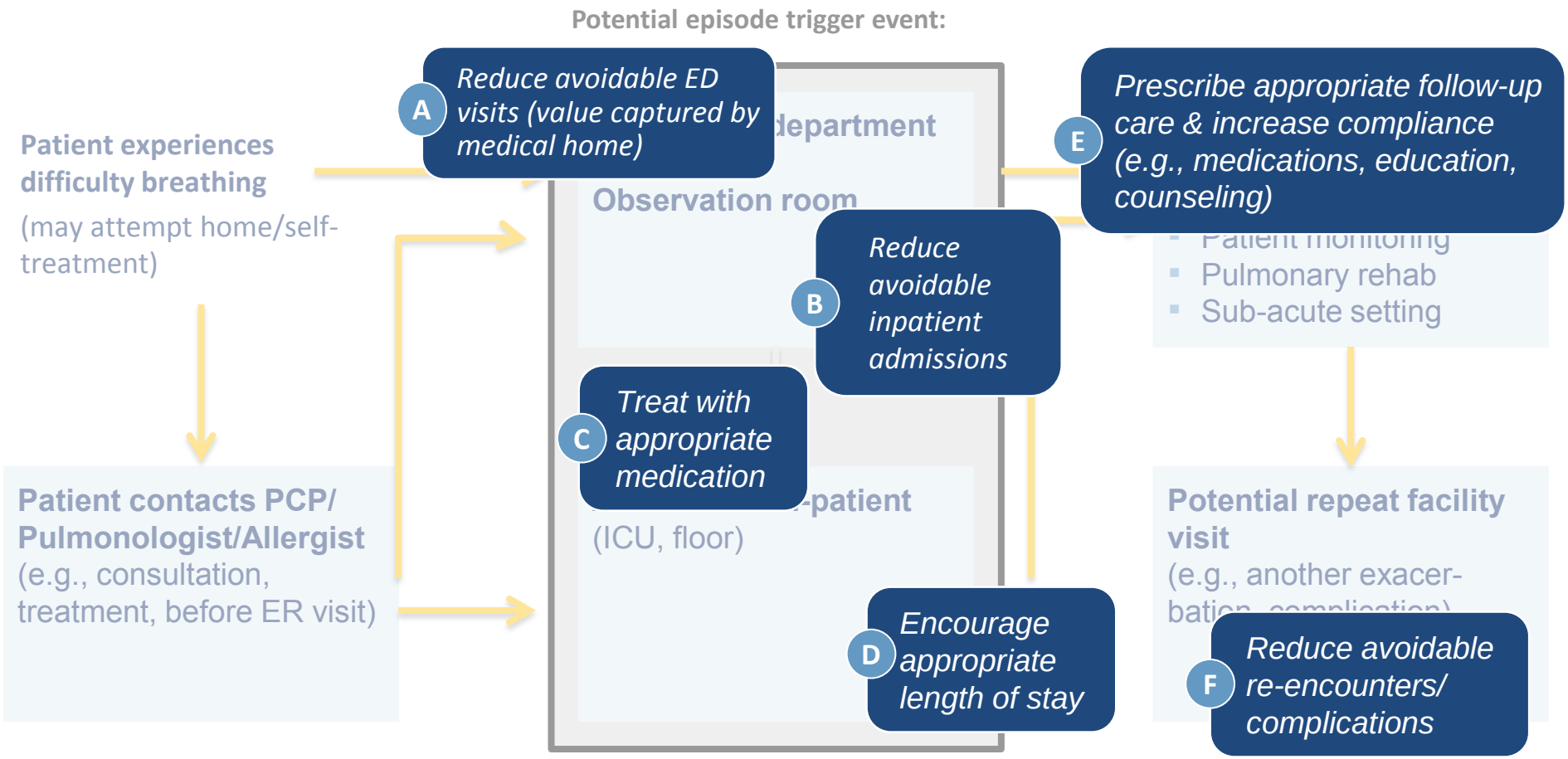
SOURCE: Ohio Episode-Based Payment Model Clinical Design Team.

Asthma Acute Exacerbation: Sources of Value



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SOURCE: Ohio Episode-Based Payment Model Clinical Design Team.

Elements of the episode definition

Category	Description
1 Episode trigger	▪ Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window 3 Claims included	▪ **Pre-trigger window:** Time period prior to the trigger event; relevant care for the patient is included in the episode ▪ **Trigger window:** Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included ▪ **Post-trigger window:** Time period following trigger event; relevant care and complications are included in the episode
4 Principal accountable provider	▪ Provider who may be in the best position to assume principal accountability in the episode based on factors such as decision making responsibilities, influence over other providers, and portion of the episode spend
5 Quality metrics	▪ Measures to evaluate quality of care delivered during a specific episode
6 Potential risk factors	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode
7 Episode-level exclusions	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted

Asthma Acute Exacerbation: Definitions (1/5)

Category	Episode base definition
1 Episode trigger	**An inpatient, outpatient ED visit (revenue codes 045x) or outpatient observation room visit (revenue codes 076x) with a diagnosis from the following list:**
2 Episode window	**The start of the trigger window through 30 days after the end of the trigger window**

ICD-9 Dx asthma-specific trigger codes:

- 493.00-493.02 – Extrinsic asthma, unspecified, with status asthmaticus and with (acute) exacerbation, respectively
- 493.10-493.12 – Intrinsic asthma, unspecified, with status asthmaticus and with (acute) exacerbation, respectively
- 493.20-493.22 – Chronic obstructive asthma, unspecified, with status asthmaticus and with (acute) exacerbation, respectively
- 493.81 – Exercise induced bronchospasm
- 493.82 – Cough variant asthma
- 493.90-493.92 – Asthma, unspecified type, unspecified, with status asthmaticus and with (acute) exacerbation, respectively
- 519.11 – Acute bronchospasm

ICD-9 Dx contingent trigger codes:

- 786.00 – Respiratory abnormality, unspecified
- 786.05 – Shortness of breath
- 786.07 – Wheezing
- 786.09 – Dyspnea and respiratory abnormalities; other
- 786.90 – Other symptoms involving resp. system and chest
- 519.8,9 – Respiratory disease NEC
- Respiratory failure – 518.8

- *Trigger window:* the day of admission for the trigger through the day of discharge from the trigger facility. When the trigger doesn't occur in an inpatient setting, the trigger window begins and ends on the day of the trigger
- *Post-trigger window:* 1 day after the end of the trigger window through 30 days after the end of the trigger window

Contingent trigger codes only act as a trigger if the patient had an asthma-specific trigger code on any claim within 365 days prior to or up to 30 days after the trigger claim

SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Definitions (2/5)

Category	Episode base definition
3 Claims included	**Included claims vary by time window** *Trigger window:* All claims *Post-trigger window[1]:* ▪ Relevant diagnoses – Examples include pneumonia, acute sinusitis, laryngitis, hyperventilation, apnea, cough, throat pain, acute respiratory failure, emphysema ▪ Relevant labs – Examples include chest x-rays, chest CT, chest MRI, lung function tests ▪ Relevant DME – Examples include oxygen delivery systems, nebulizers, ventilators, humidifiers, spirometers ▪ Relevant pharmacy – Examples include decongestants, antihistamines, smoking deterrents, analgesics, narcotics, glucocorticoids, proton-pump inhibitors ▪ Hospitalizations, except exclusions – Exclusion list includes cardiovascular, pulmonary, dermatological, ophthalmological, orthopedic, otolaryngological, digestive, renal, i.e., diagnoses and procedures not directly related to the asthma acute exacerbation or common complications thereof
4 Principal accountable provider	**Facility where the trigger event occurs** ▪ In case of a transfer, the first facility (i.e., the one from which the patient is transferred) is the PAP

SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Definitions (3/5)

Category	Episode base definition
5 Quality metrics	*Linked to gain sharing:* ▪ Percent of episodes with a follow-up visit within 30 days ▪ Percent of episodes with a filled prescription for controller medication (based on HEDIS list) *For reporting only:* ▪ Percent of episodes with a repeat exacerbation within 30 days – Same codes as trigger ▪ Percent of episodes in IP vs. ED/Obs treatment setting – IP identified by bill types – ED/Obs identified by revenue codes and bill types ▪ Percent of episodes with smoking cessation counseling ▪ X-ray utilization rate[1] ▪ Percent of episodes with a follow-up visit within 7 days

Potential quality metrics for v2

- Asthma action plan
- Reporting on utilization of spacers and peak flow meters
- Link to PCP / PCMH

SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Definitions (4/5)

Category	Episode base definition
6 Potential risk factors	Model to be consistent across all Medicaid plans, may vary for commercial

- Age less than 10
- Age between 10 and 19 (inclusive)
- Age between 40 and 49 (inclusive)
- Age between 50 and 59 (inclusive)
- Age greater than 59
- Atelectasis
- Blood disorders and anemia
- Cardiac dysrhythmias
- Developmental and intellectual disabilities
- Diabetes
- Epilepsy
- Esophageal disorders
- Heart disease
- Heart failure
- Malignant hypertension
- Obesity
- Pneumonia
- Pulmonary heart disease
- Respiratory failure (specific)
- Respiratory failure, insufficiency, and arrest
- Sickle cell anemia
- Substance abuse
- Suicide and intentional self-harm

SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Definitions (5/5)

Category	Episode base definition

7 Episode level exclusions

Clinical exclusions:

- Death
- Left against medical advice
- Age < 2 ; age > 64
- Comorbidities[1]
  - Cancer under active management
  - End stage renal disease
  - HIV
  - Organ transplant
  - Bronchiectasis
  - Cancer of respiratory system
  - Cystic fibrosis
  - ICU stay >72hrs
  - Intubation
  - Multiple sclerosis
  - Other lung disease
  - Oxygen during post-trigger window
  - Paralysis
  - Tracheostomy
  - Tuberculosis
  - Multiple other comorbidities

Business exclusions:

- Inconsistent enrollment
- Third party liability
- Dual eligibility
- Exempt PAP
- PAP out of state
- No PAP
- Long hospitalization (>30 days)
- Long-term care
- Missing APR-DRG
- Incomplete episodes (non-risk-adjusted spend is less than the low cost threshold)

Outliers:

- High outlier (risk-adjusted spend is greater than the high outlier threshold)

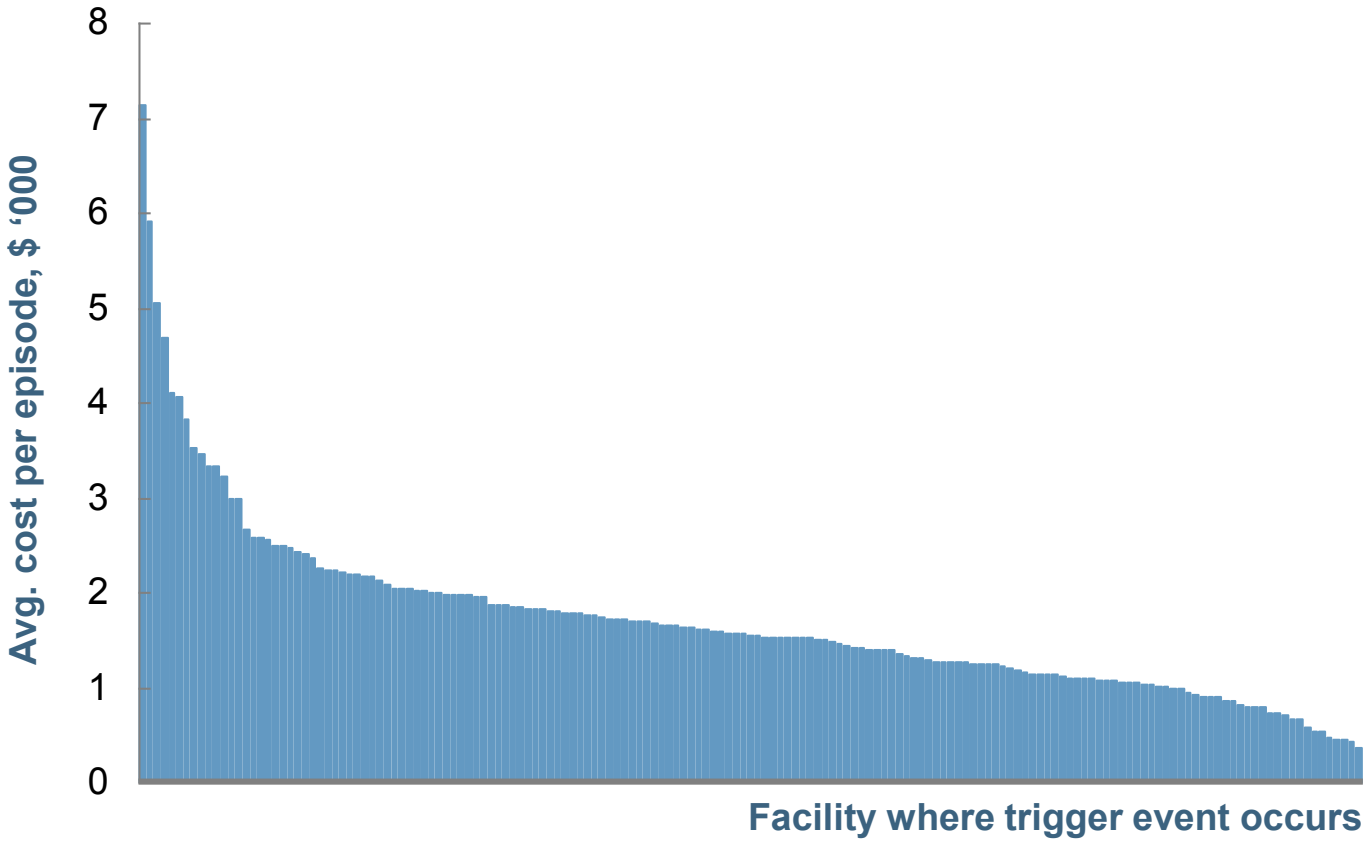
1 Comorbidities are identified in claims during the episodes and up to 365 prior to the episode start
2 Intubation and ICU stay are only an exclusion if occurring during the trigger window
3 Oxygen is only an exclusion in the post-trigger window

SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Provider Performance

Distribution of provider average episode cost

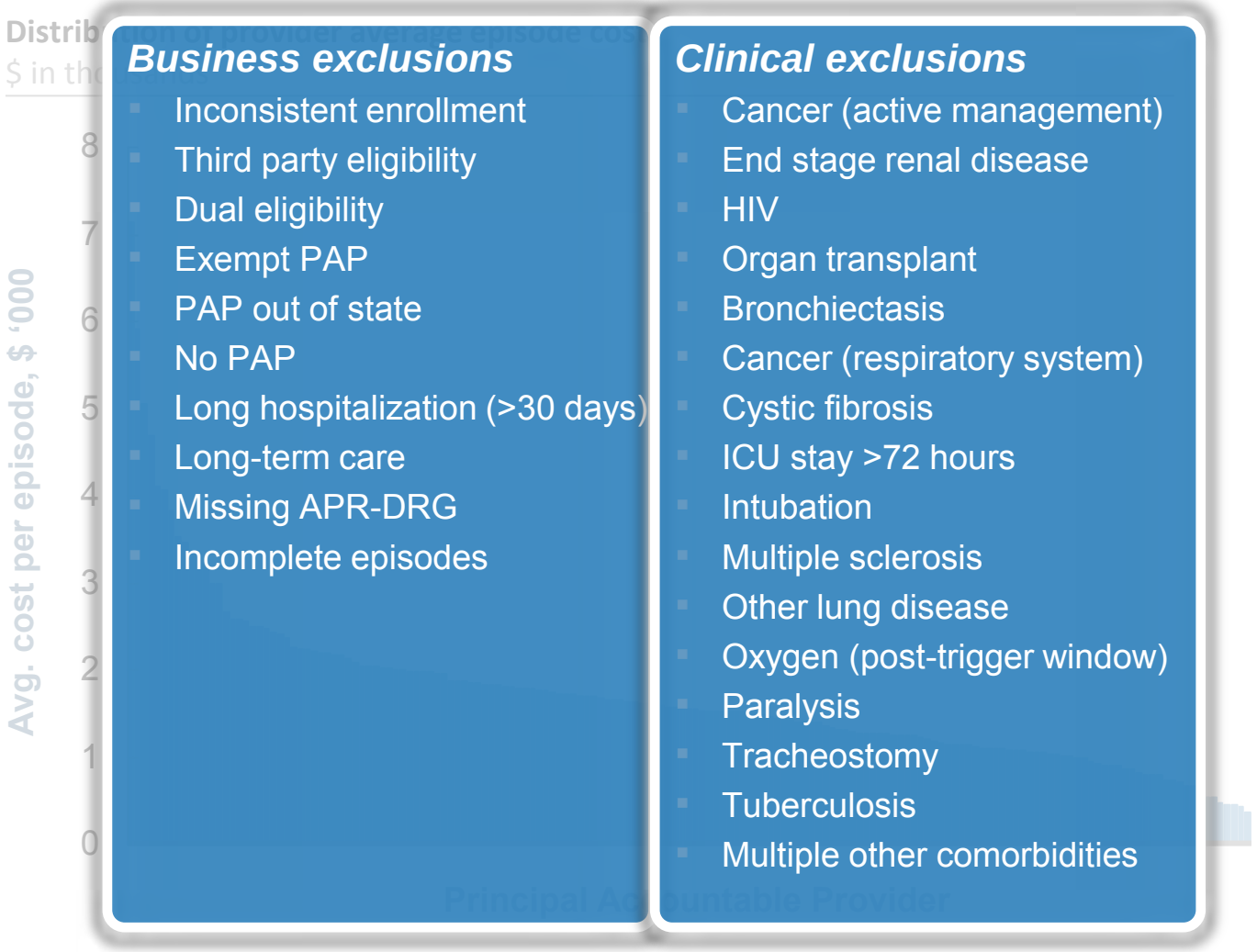
$ in thousands



- **Unadjusted episode cost, no exclusions**
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

SOURCE: Ohio Medicaid claims data, 2011-12.

Asthma Acute Exacerbation: Provider Performance



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- Long-term care
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- Incomplete episodes

Clinical exclusions

- Cancer (active management)
- End stage renal disease
- HIV
- Organ transplant
- Bronchiectasis
- Cancer (respiratory system)
- Cystic fibrosis
- ICU stay >72 hours
- Intubation
- Multiple sclerosis
- Other lung disease
- Oxygen (post-trigger window)
- Paralysis
- Tracheostomy
- Tuberculosis
- Multiple other comorbidities

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SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Provider Performance

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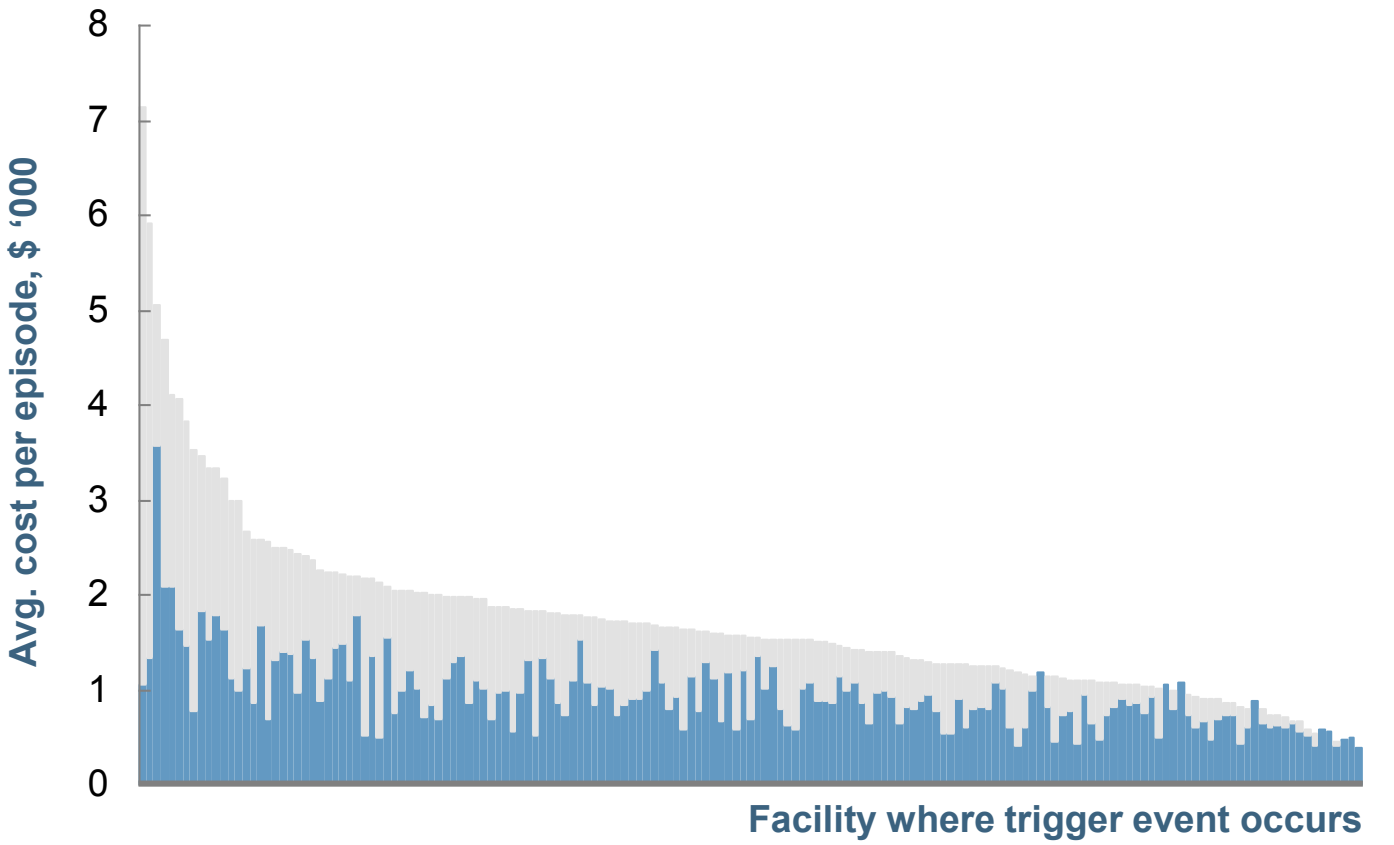

- Unadjusted episode cost – no exclusions
- **Average cost after episode exclusions (e.g., clinical, incomplete data)**
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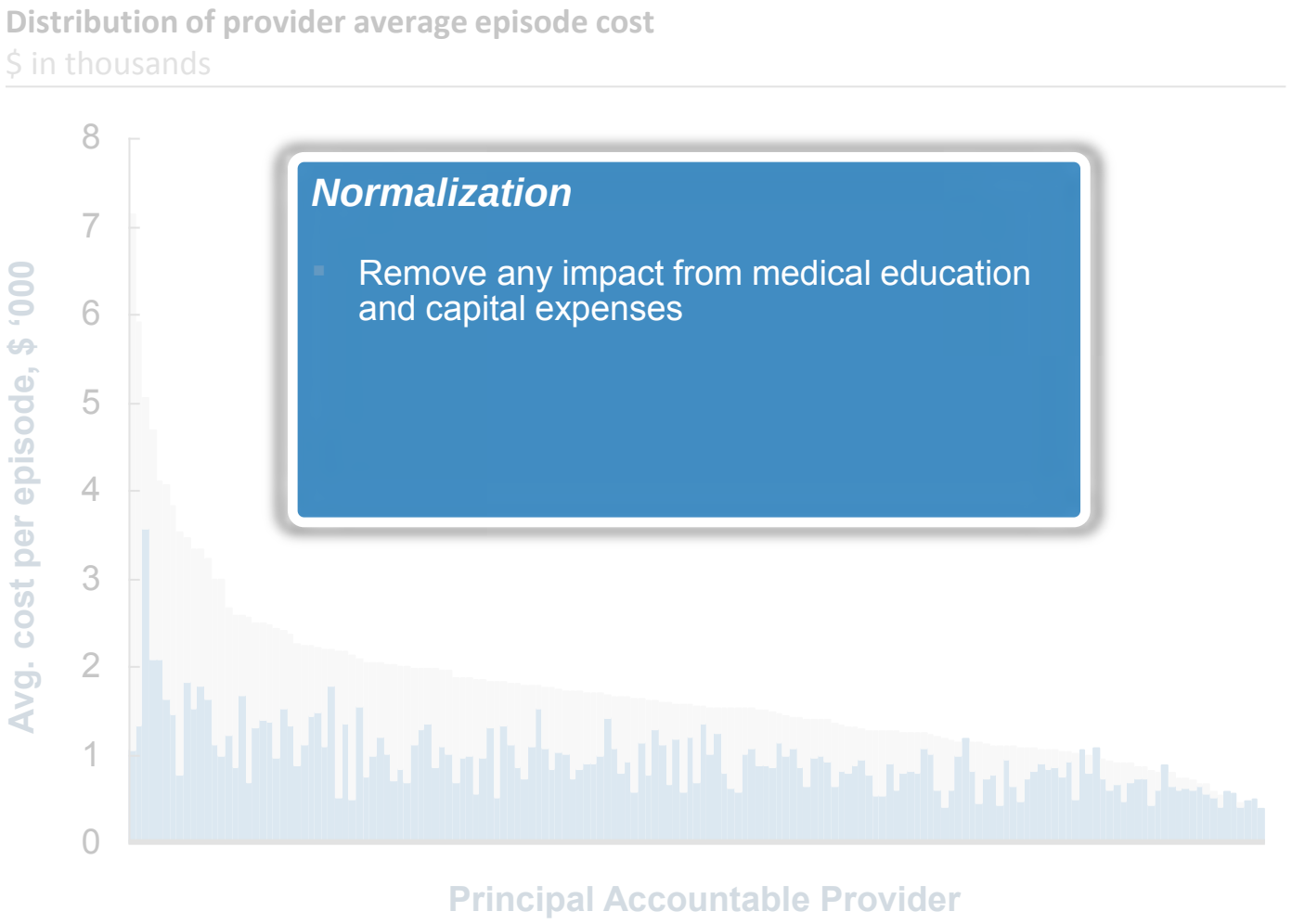
SOURCE: Ohio Medicaid claims data, 2011-12.

Asthma Acute Exacerbation: Provider Performance



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Asthma Acute Exacerbation: Provider Performance

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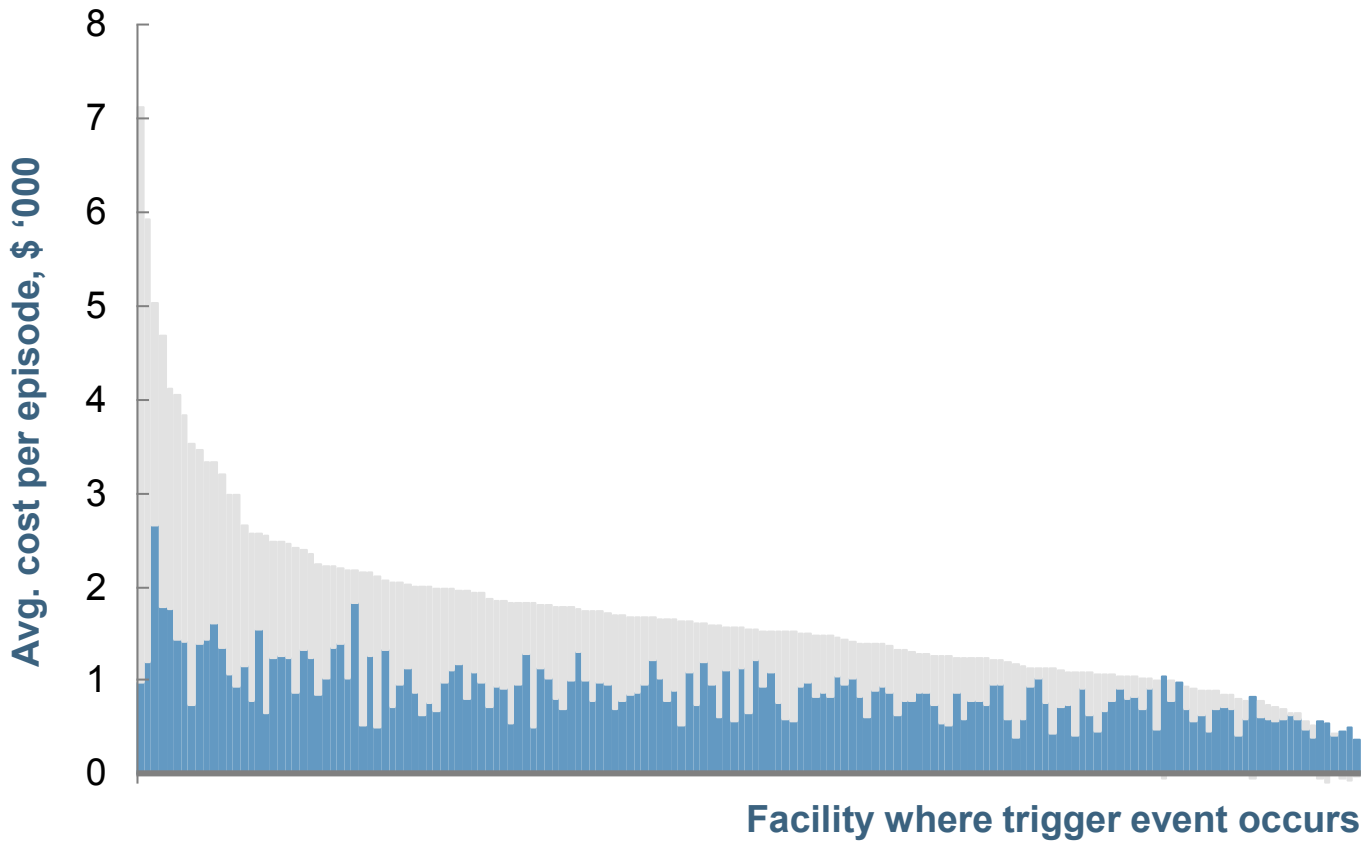

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- Average cost after episode exclusions (e.g., clinical, incomplete data)
- **Average cost after removal of impact of medical education and capital**
- Average cost after risk adjustment and removal of high cost outliers

SOURCE: Ohio Medicaid claims data, 2011-12.

Asthma Acute Exacerbation: Provider Performance

Risk adjustment

- Adjust average episode cost down based on presence of clinical risk factors including:
  - Heart disease
  - Heart failure
  - Malignant hypertension
  - Obesity
  - Pneumonia
  - Pulmonary heart disease
  - Respiratory failure (specific)
  - Respiratory failure, insufficiency, and arrest
  - Sickly cell anemia
  - Substance abuse

High cost outliers

- Removal of any individual episodes that are more than three standard deviations above the *risk-adjusted* mean

- Unadjusted episode cost – no exclusions
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

SOURCE: Ohio Episode-Based Payment Model Clinical Design Team definitions.

Asthma Acute Exacerbation: Provider Performance

Distribution of provider average episode cost

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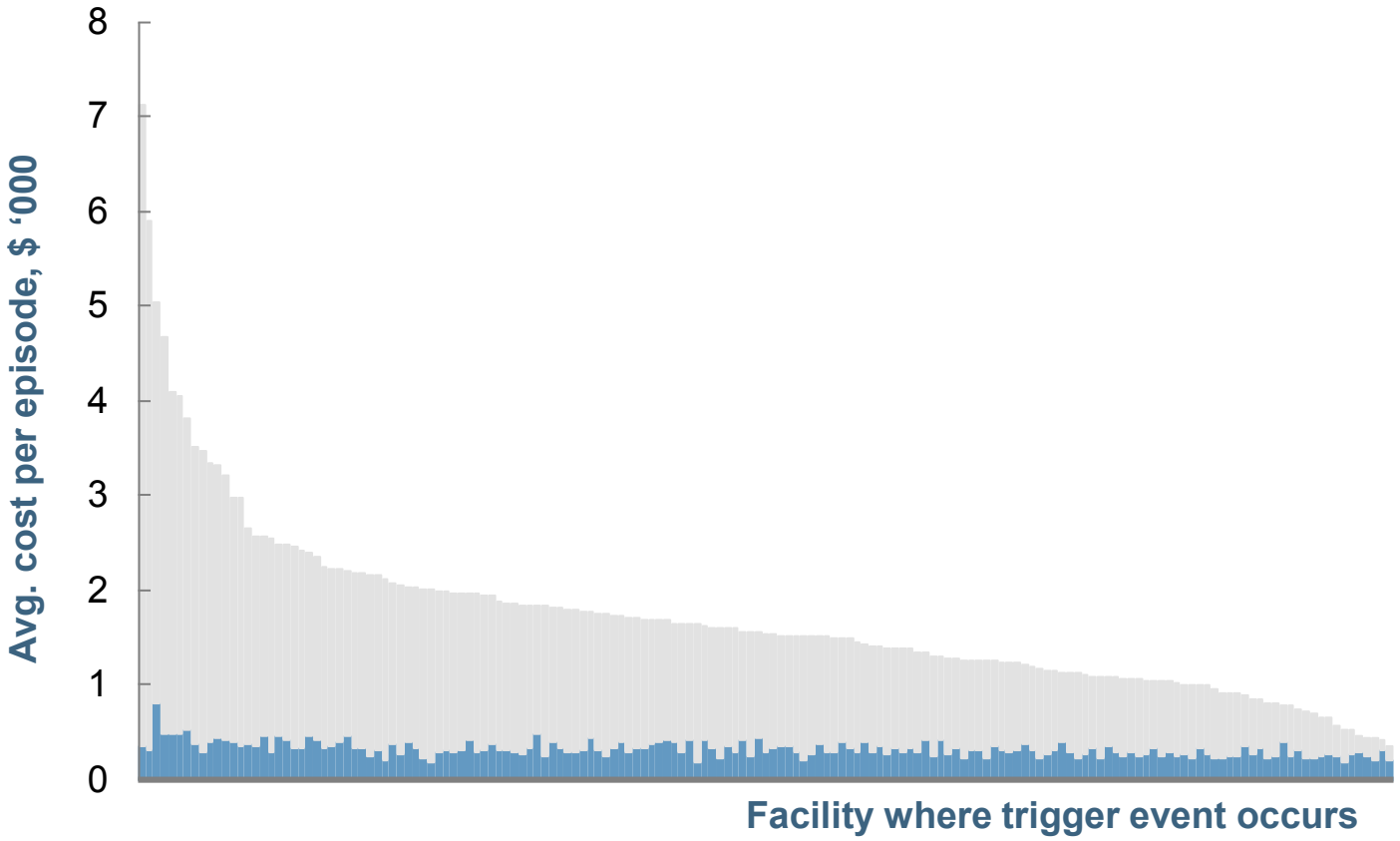
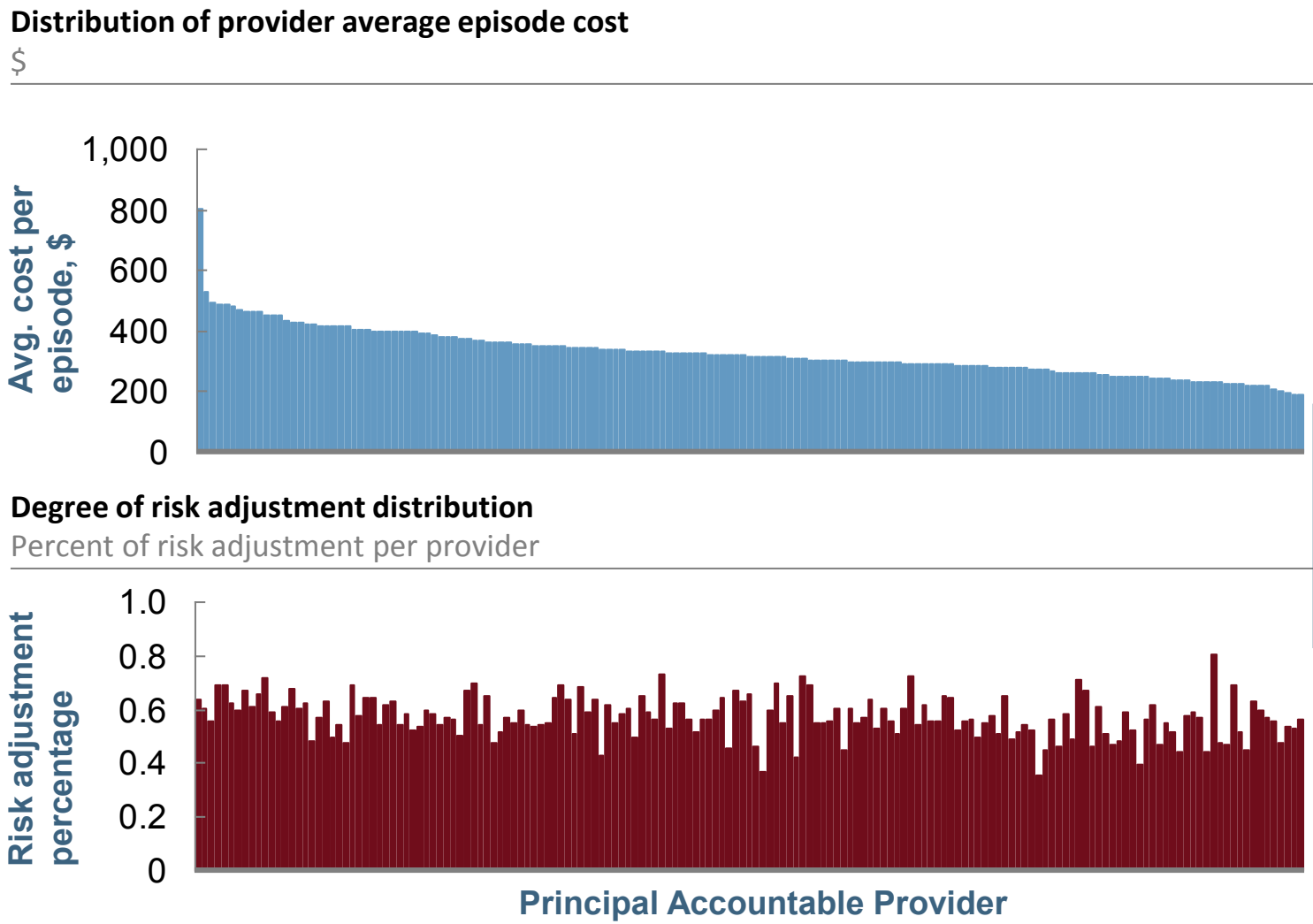


- Unadjusted episode cost, no exclusions
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
- **Average cost after risk adjustment and removal of high cost outliers**

SOURCE: Ohio Medicaid claims data, 2011-12.

Asthma Acute Exacerbation: Provider Performance



There is no correlation between average episode cost and level of risk

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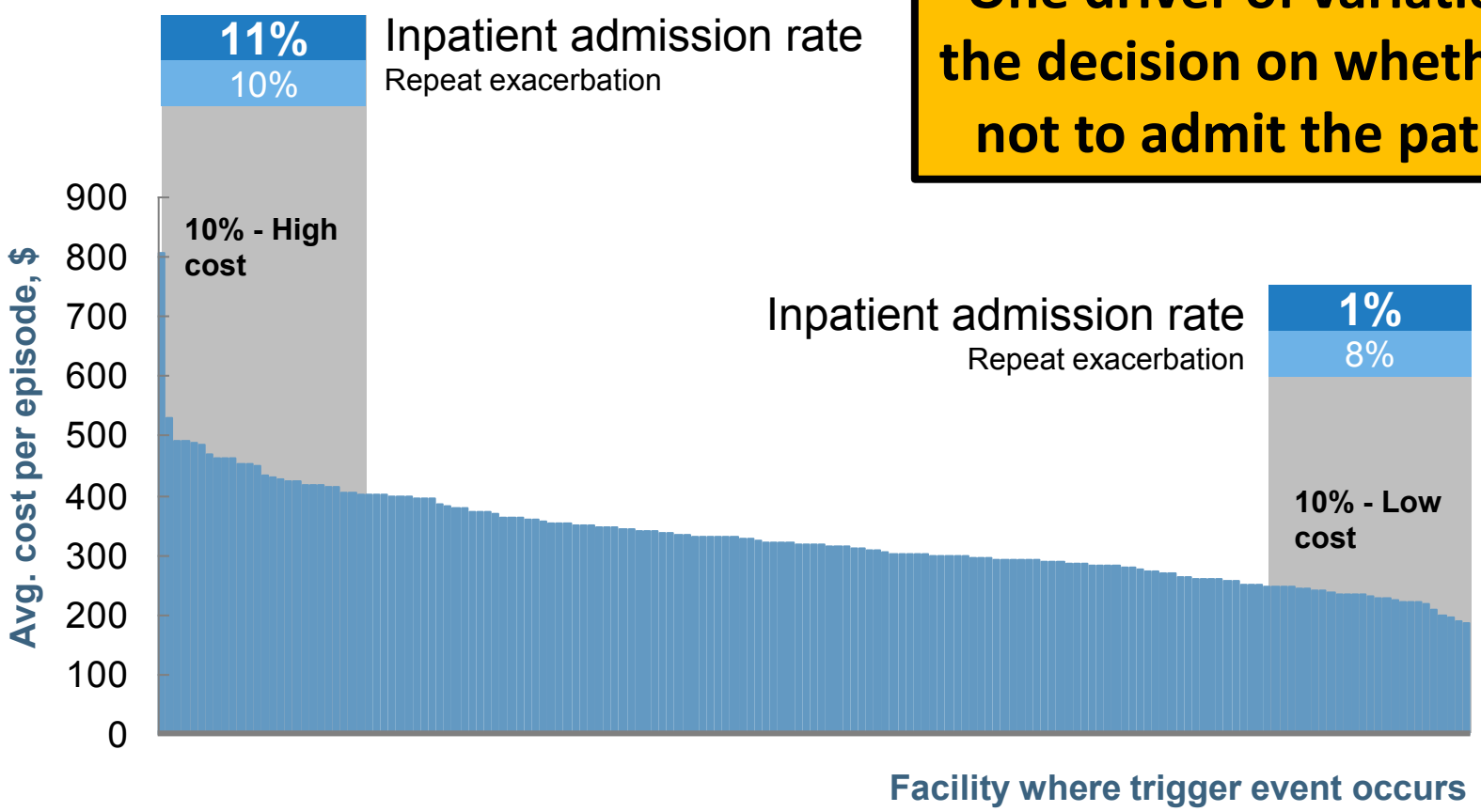
SOURCE: Ohio Medicaid claims data, 2011-12.

Variation across the Asthma Acute Exacerbation episode

Distribution of provider average episode cost

$



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NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.
SOURCE: Analysis of Ohio Medicaid claims data, 2011-12.

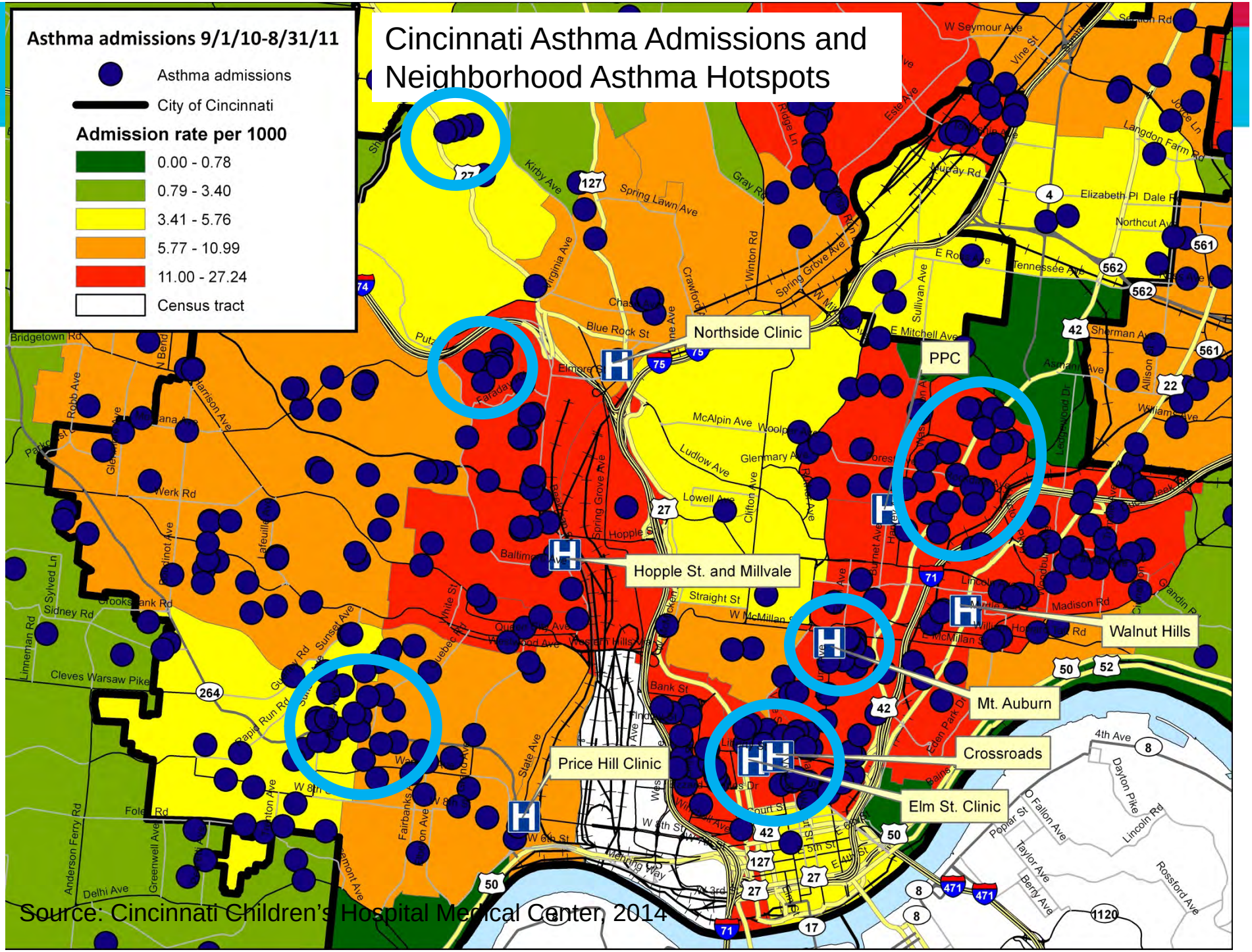
Prevention: Prioritizing health and safety

Amy Bush Stevens, HPIO

Our goal is that by the end of this talk, you will…

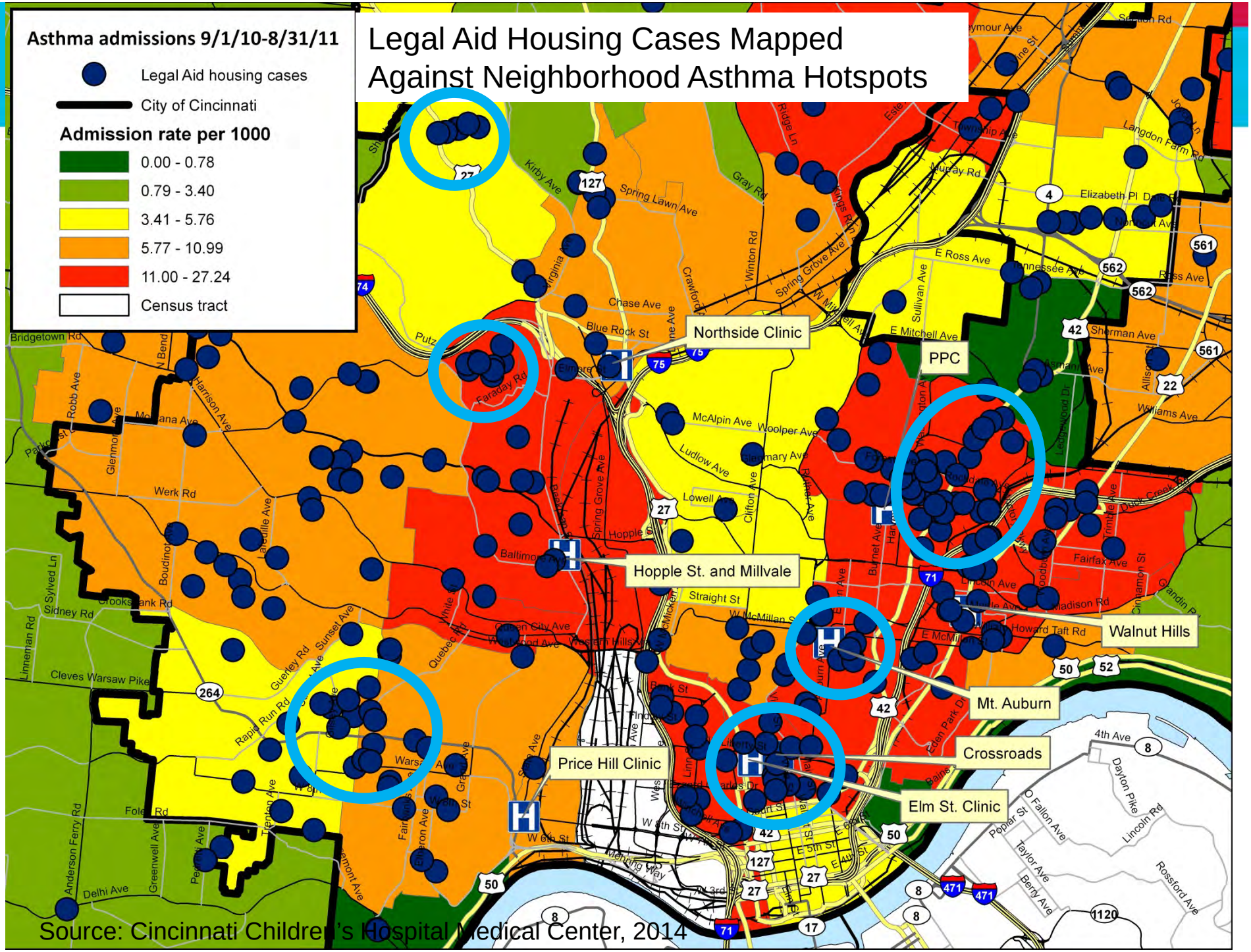
- Have a better understanding of population health and prevention
- Be more aware of emerging policy opportunities to accelerate the shift toward population health and to change how we pay for prevention

Cincinnati Asthma Admissions and Neighborhood Asthma Hotspots



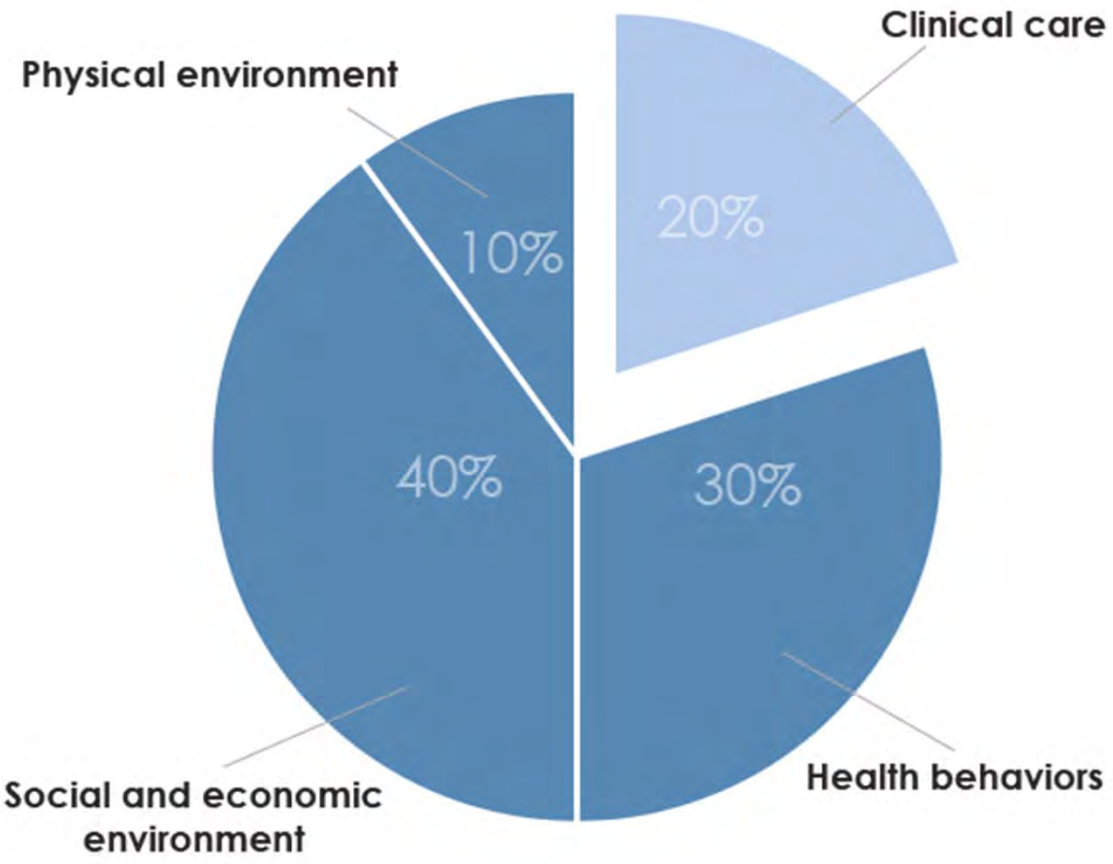
Source: Cincinnati Children's Hospital Medical Center, 2014

Legal Aid Housing Cases Mapped Against Neighborhood Asthma Hotspots



Source: Cincinnati Children's Hospital Medical Center, 2014

Factors that influence health

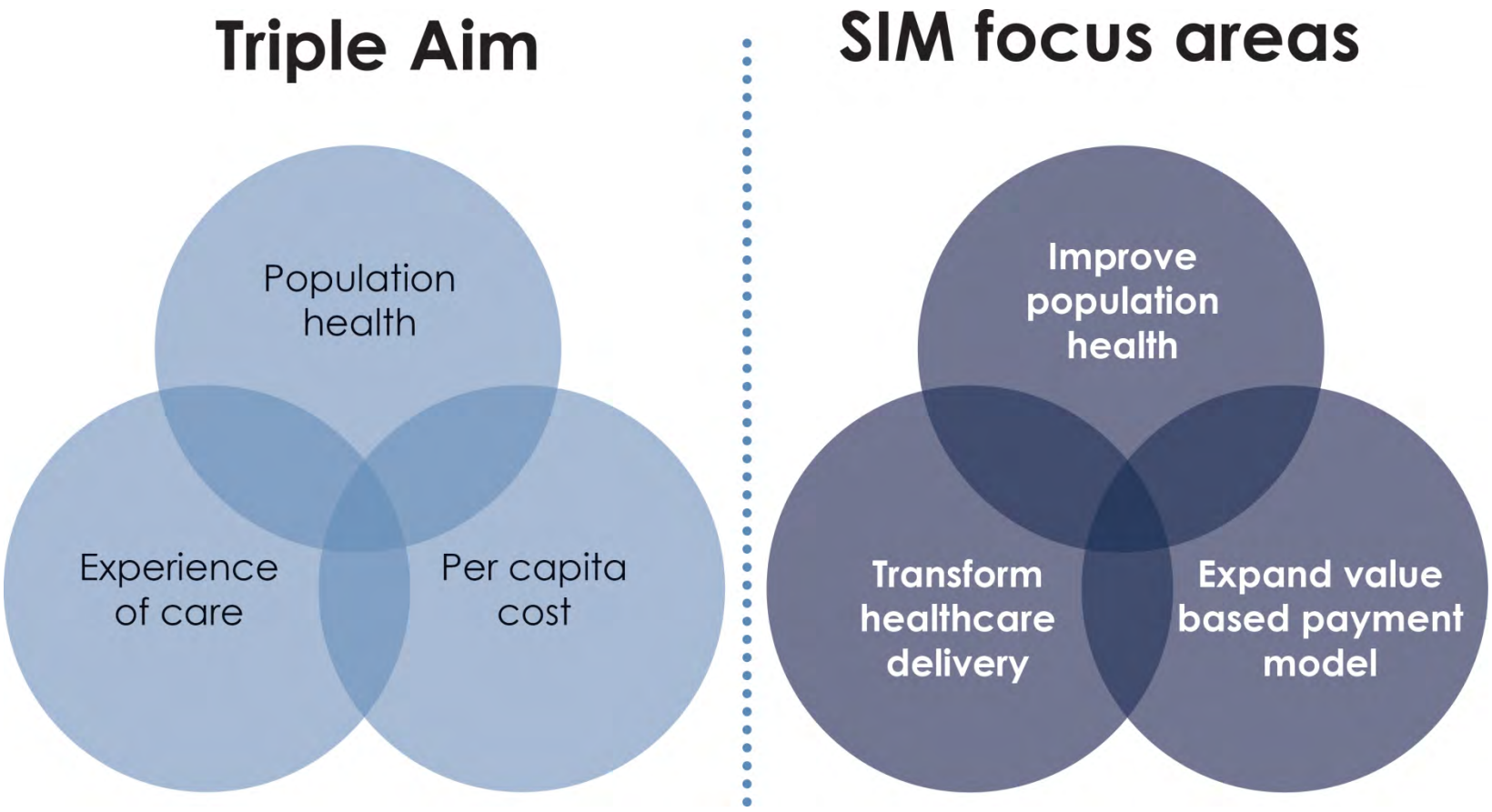


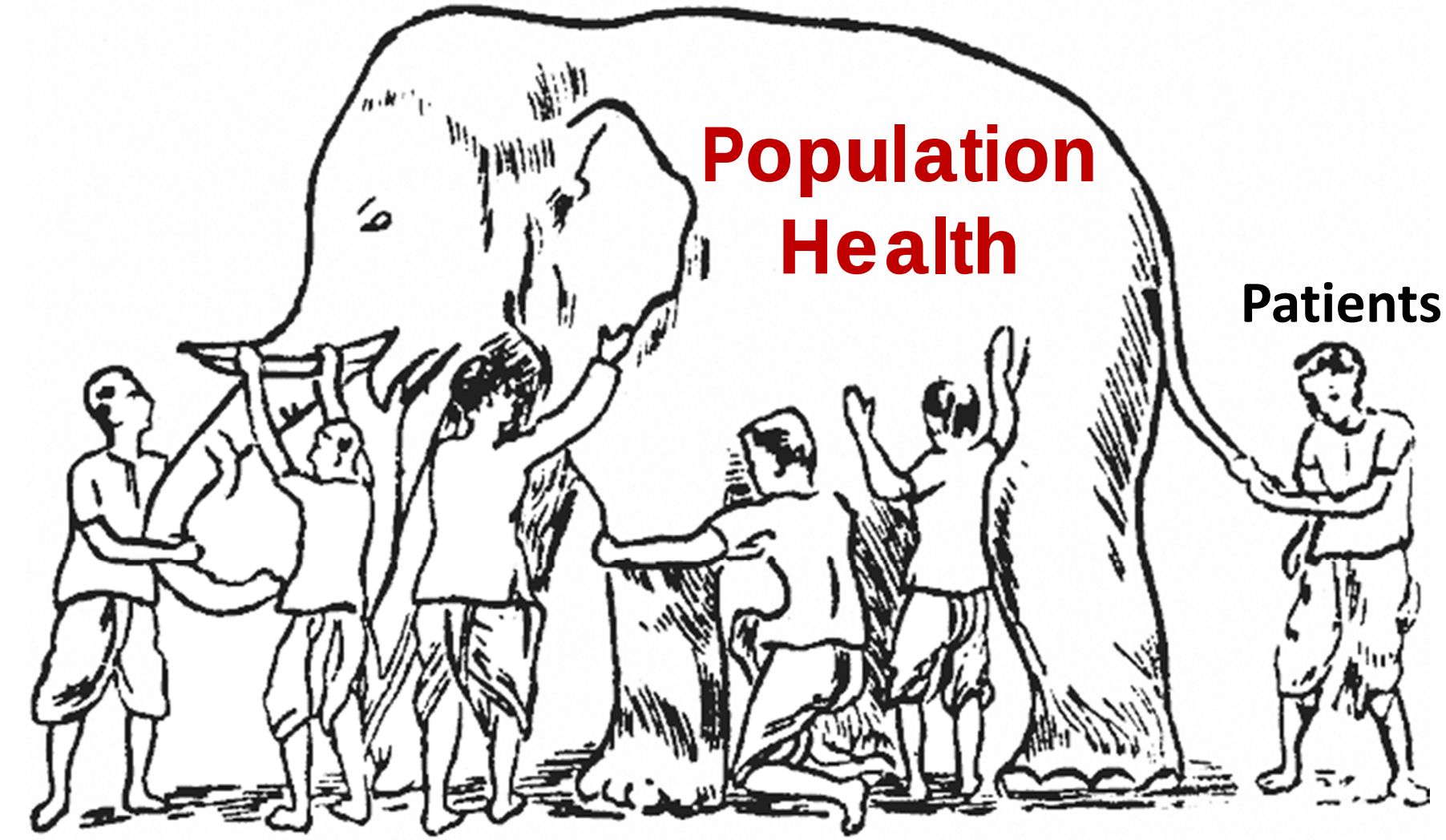
Source: County Health Rankings and Roadmaps

"It is no longer sufficient to expect that reforms in the medical care delivery system (for example, changes in payment, access and quality) alone will improve the public's health."

— Institute of Medicine

Triple Aim and State Innovation Model (SIM) focus areas



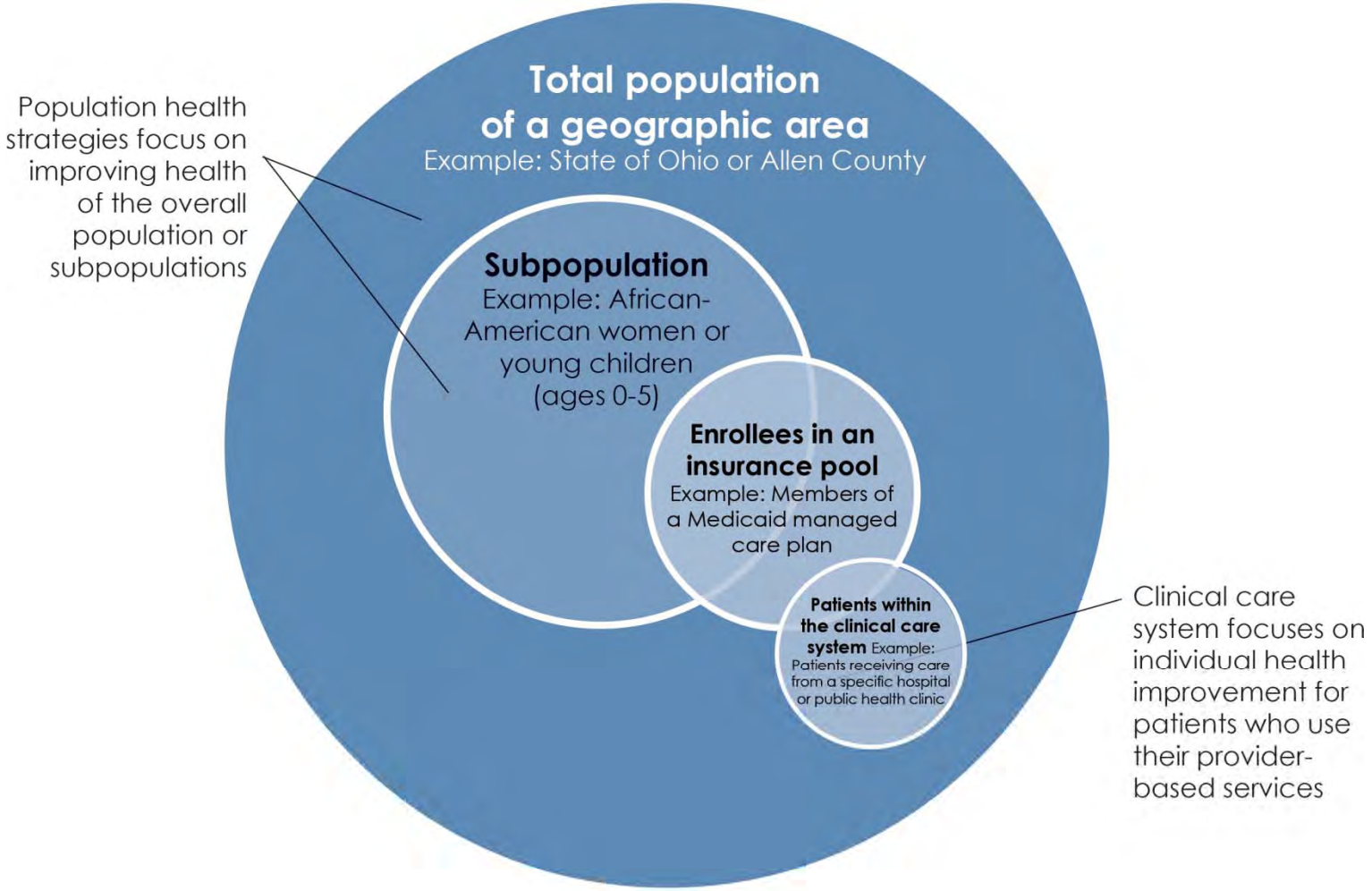


Source: Paul Wallace, Institute of Medicine, presentation at 2013 Ohio Public Health Combined Conference

Key characteristics of population health strategies

- Beyond the patient population
- Beyond medical care
- Measuring outcomes
- Closing gaps (improvement for all groups)
- Shared accountability

Beyond the patient population



Source: Adapted from "An Environmental Scan of Integrated Approaches for Defining and Measuring Total Population Health by the clinical care system, the government public health system, and stakeholder organizations." Public Health Institute and County of Los Angeles Public Health, 2012.

Beyond medical care

Patient care

Population health

Measuring outcomes

Indicator	Ohio's rank	Data value		Trend	Best state
		baseline	most recent		
Overall health and wellbeing	**39**				
Limited activity due to health problems Average number of days in last 30 with limited activity	34	1.5	1.6	-	0.9 ND
Overall health status Percent of adults who report fair or poor health	35	18%	18.3%	-	11.7% MN
Life expectancy Life expectancy at birth, in years	37	77.5	77.8	+	81.3 HI
Premature death Years of potential life lost before age 75	38	NA	7,294	NA	4,869 MN

Reducing disparities and promoting health equity

GREATER COLUMBUS INFANT MORTALITY REPORT CARD

In 2011…

- 18,045 babies were born in Franklin County
- 174 of these babies died before their first birthday, 22 were sleep-related
- 2,462 were born prematurely at less than 37-weeks gestation

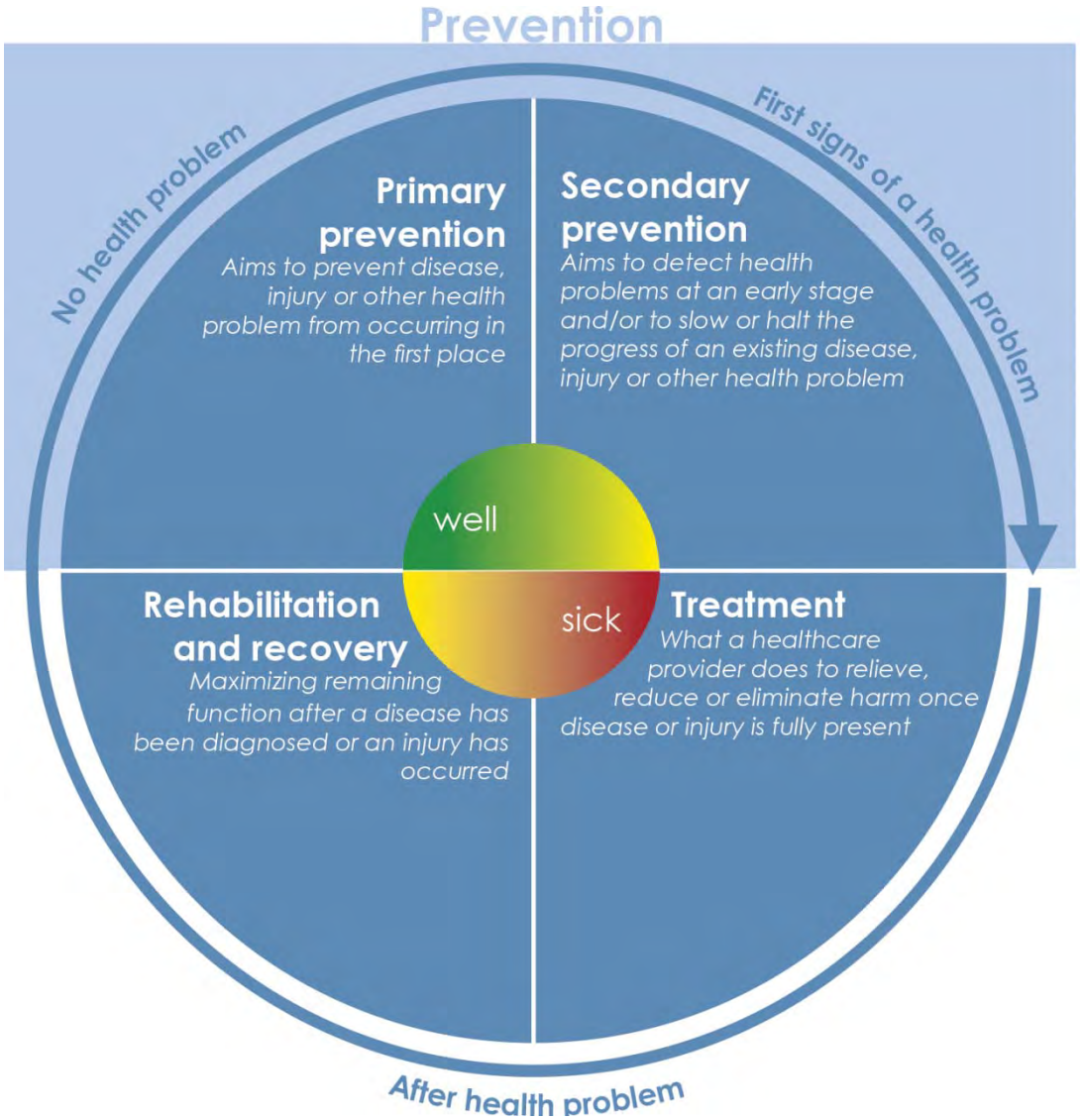
Tracking Our Progress . . .

Achieving our 2020 goals means that 65 more babies in our community will celebrate their first birthdays.

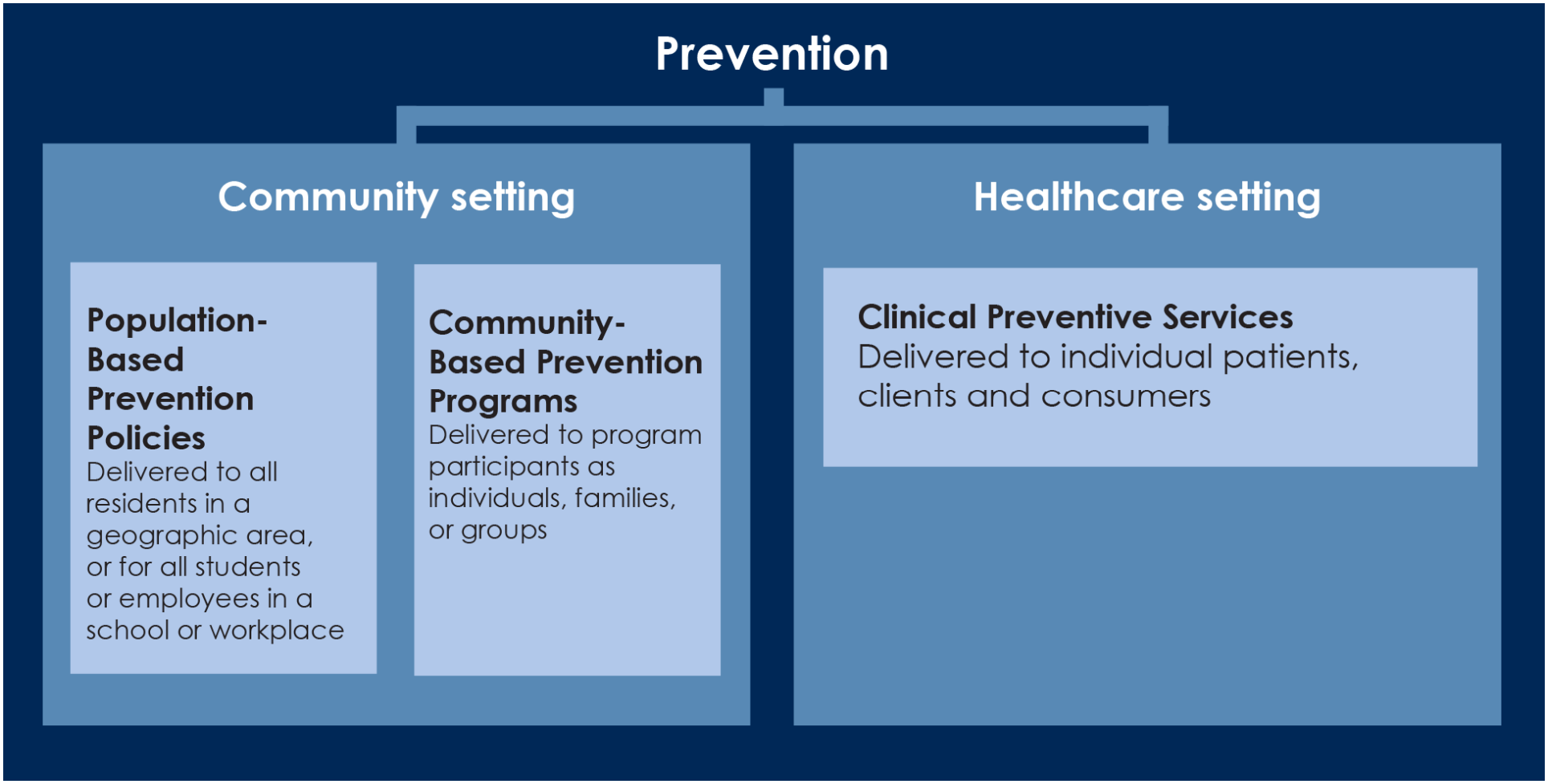
Franklin County Indicator			Baseline*	2020 Goal**	Reporting Year
Outcomes and Key Drivers					
Infant Mortality[1] (# infant deaths/ 1,000 live births)		Total	9.6	6	*To be reported annually.* *Will include notation if progress is "on track" or not.*
		White	7.5	5.8	
		Black	17.1	6.6	
		Hispanic	5.3	4.9	
Sleep-related infant deaths[2] (# infant deaths/ 1,000 live births)		Total	1.3	0.94	
		White	1.1		
		Black	2.2		
Prematurity[3]	Preterm Birth (% babies born <37-weeks gestation)	Total	13.6%	9.6%	
		White	11.8%		
		Black	17%		
	Low birthweight (% of babies born <2,500 grams)	Total	9.3%	7.8%	
		White	7.7%		
		Black	12.8%		
Strategy Implementation					


Shared accountability

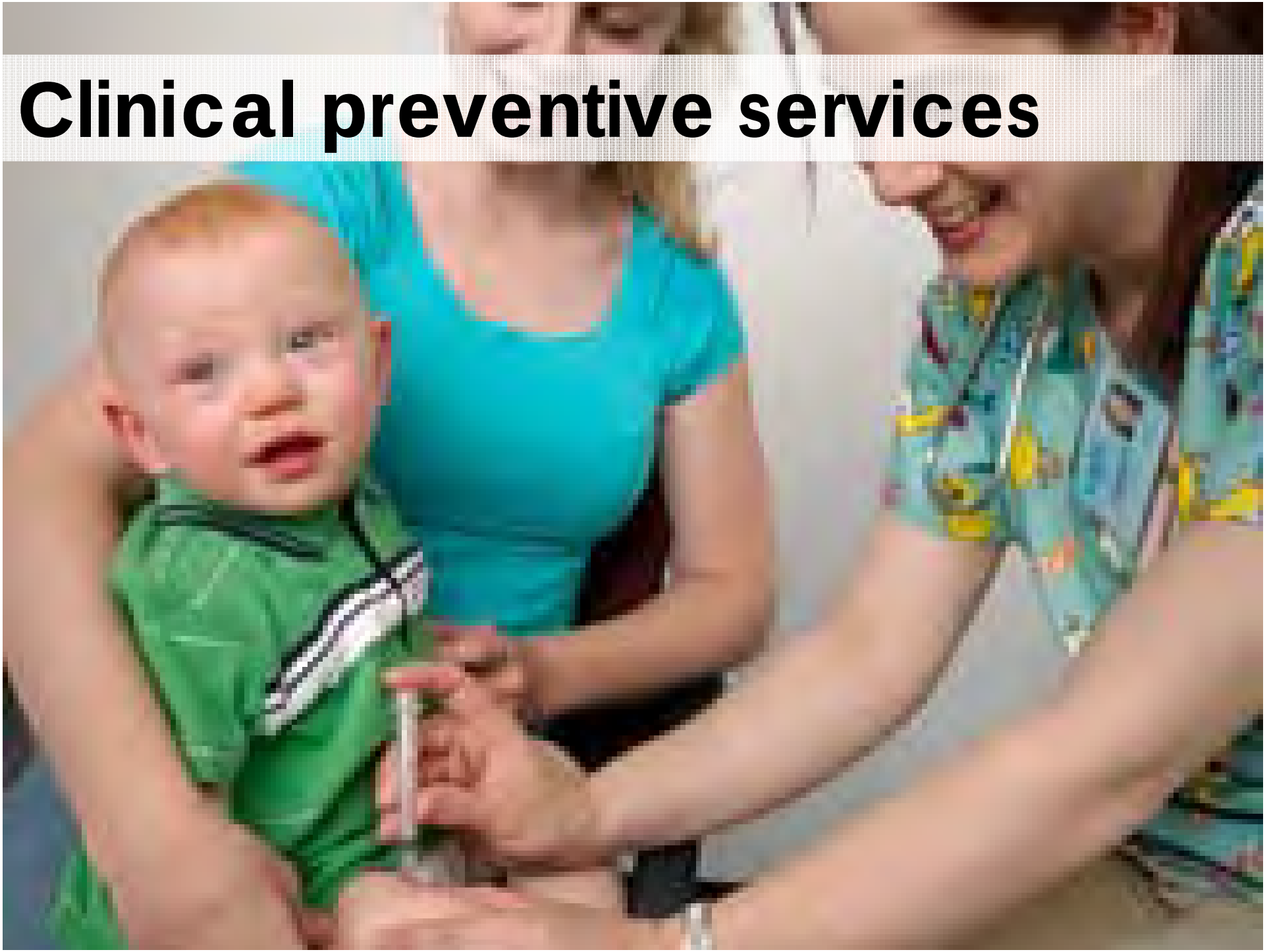
What is prevention?



Types of prevention strategies



Clinical preventive services



Community-based prevention programs

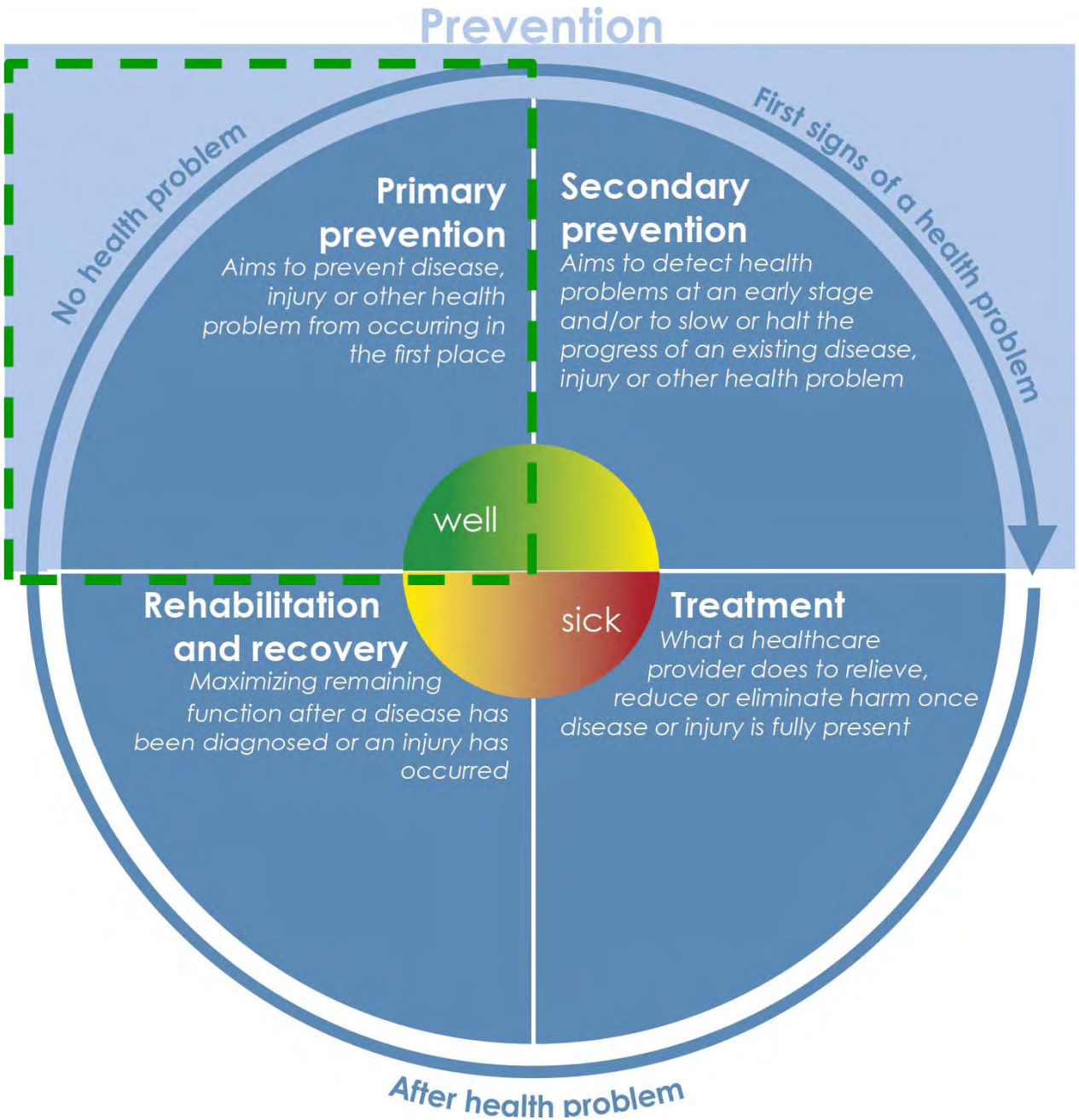
Population-based policy change

How do we pay for prevention?

	Prevention		
	Population-level policy strategies	**Community-based prevention programs**	**Clinical preventive services**
Payer/ Funder	• Federal, state, and local government • Philanthropy • Non-health sectors (transportation, education, regional planning, housing, etc.)	• Federal, state, and local government • Philanthropy	• Medicaid and Medicare • Private insurance • Individual consumers
Dominant payment mechanism	• Grants • Inspection fees (for environmental health) • Public funding for non-health sectors (transportation, education, regional planning, housing, etc.)	• Grants	Reimbursement (fee-for-service model, managed care, etc.)

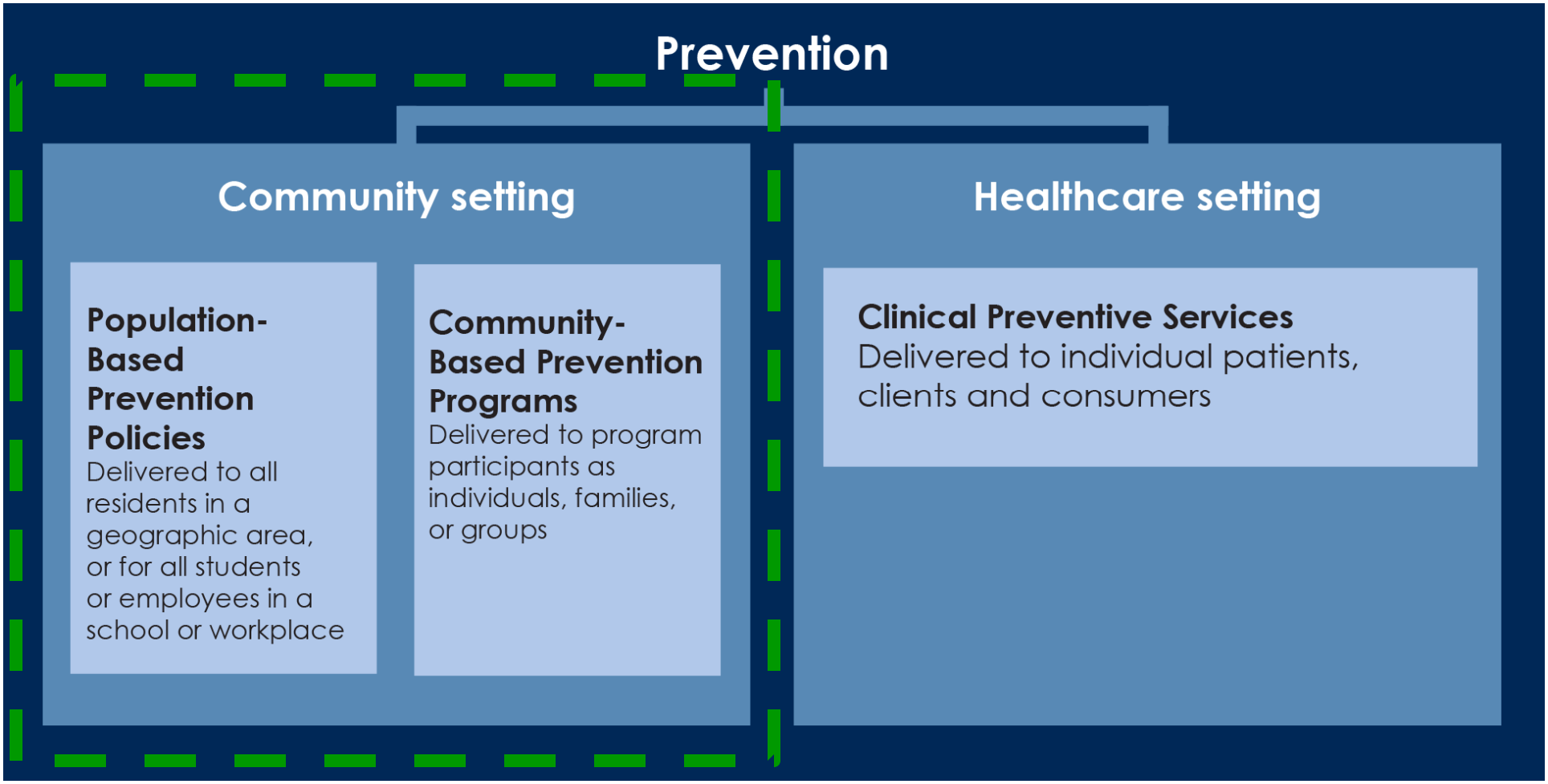
Health

Health care



hpio
health policy institute of ohio

Types of prevention strategies




sick care
wellness and prevention


wellness and prevention
sick care
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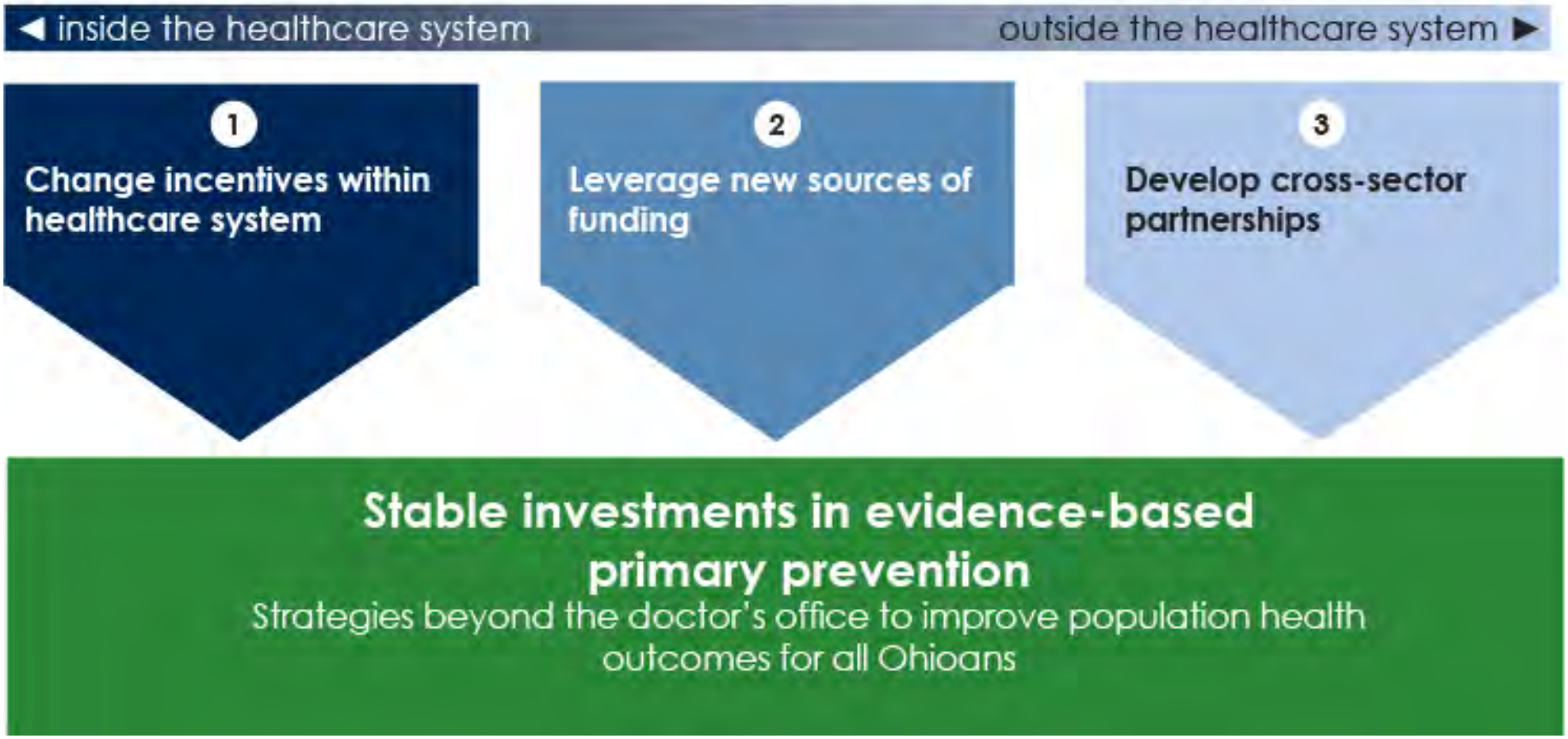
Emerging opportunities to advance prevention



#1. Change incentives

Payment and deliver reform

Medicaid waivers

Clinical-community partnerships

SIM Pop. Health Plan

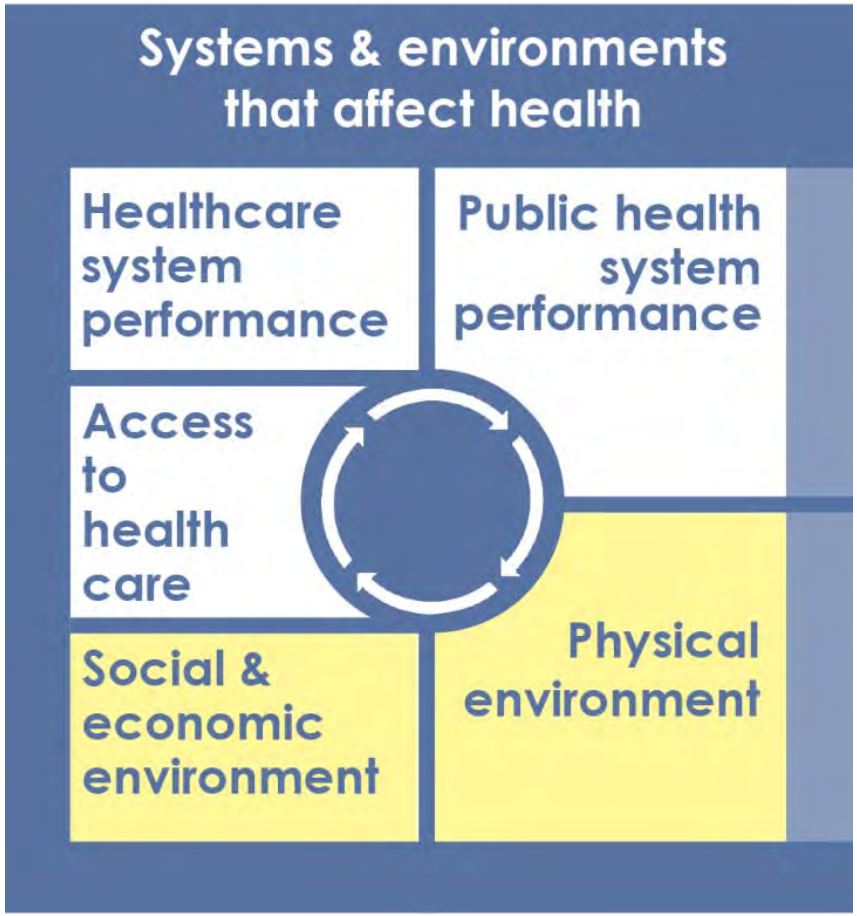
#2. New sources of funding

Wellness Trust

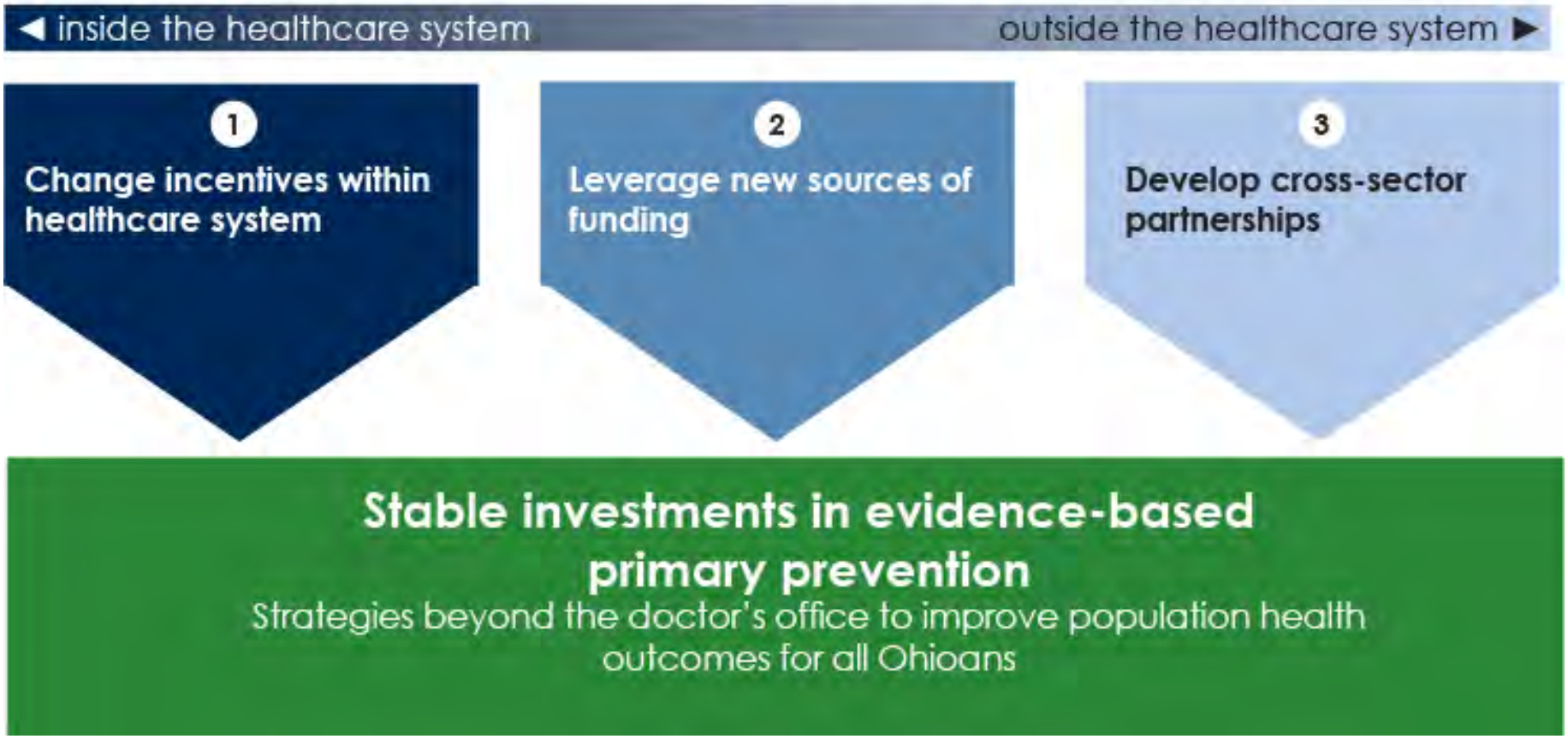
Hospital Community Benefit

Pay for Success financing

#3. Cross-sector partnerships for health in all policies



Emerging opportunities to advance prevention



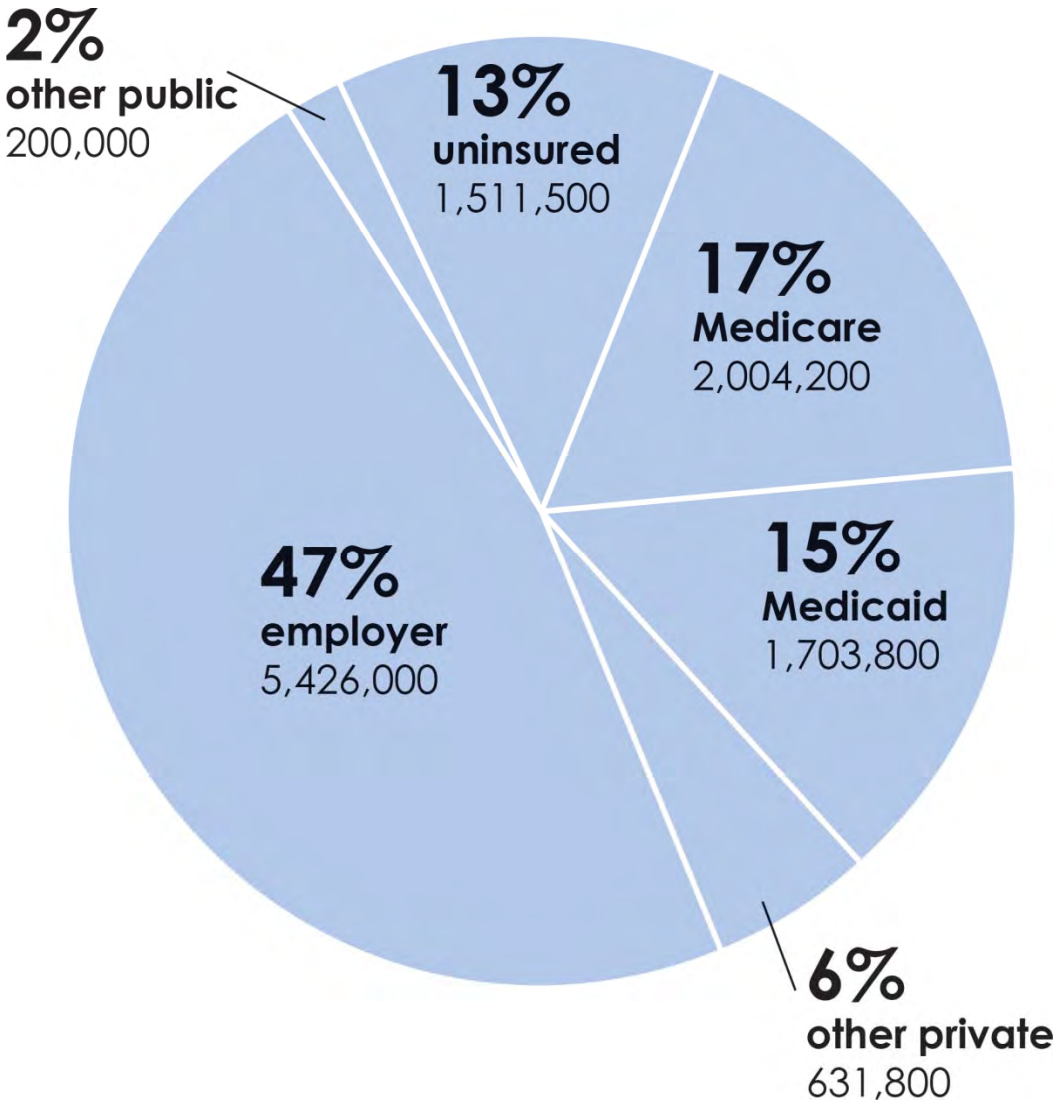
Insurance basics: Provisions of the Affordable Care Act and how Ohioans are covered

Reem Aly, HPIO

Our goal is that by the end of this talk, you will…

- Have a sense of the potential impact of the ACA on how Ohioans are covered
- Understand how ACA reforms impact coverage
- Understand emerging issues and trends in coverage

How were Ohioans covered in 2013?



Source: Kaiser Family Foundation State Health Facts

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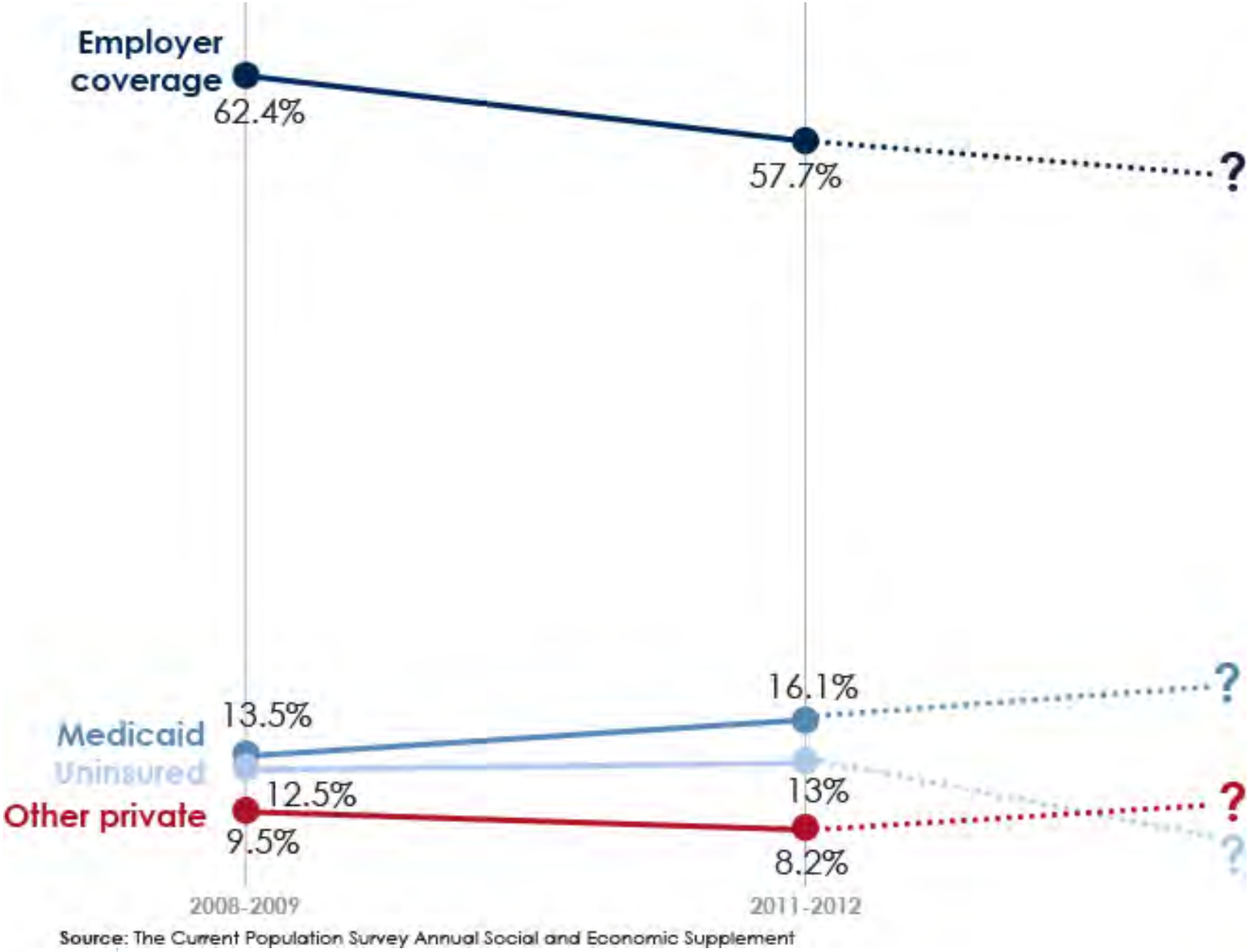
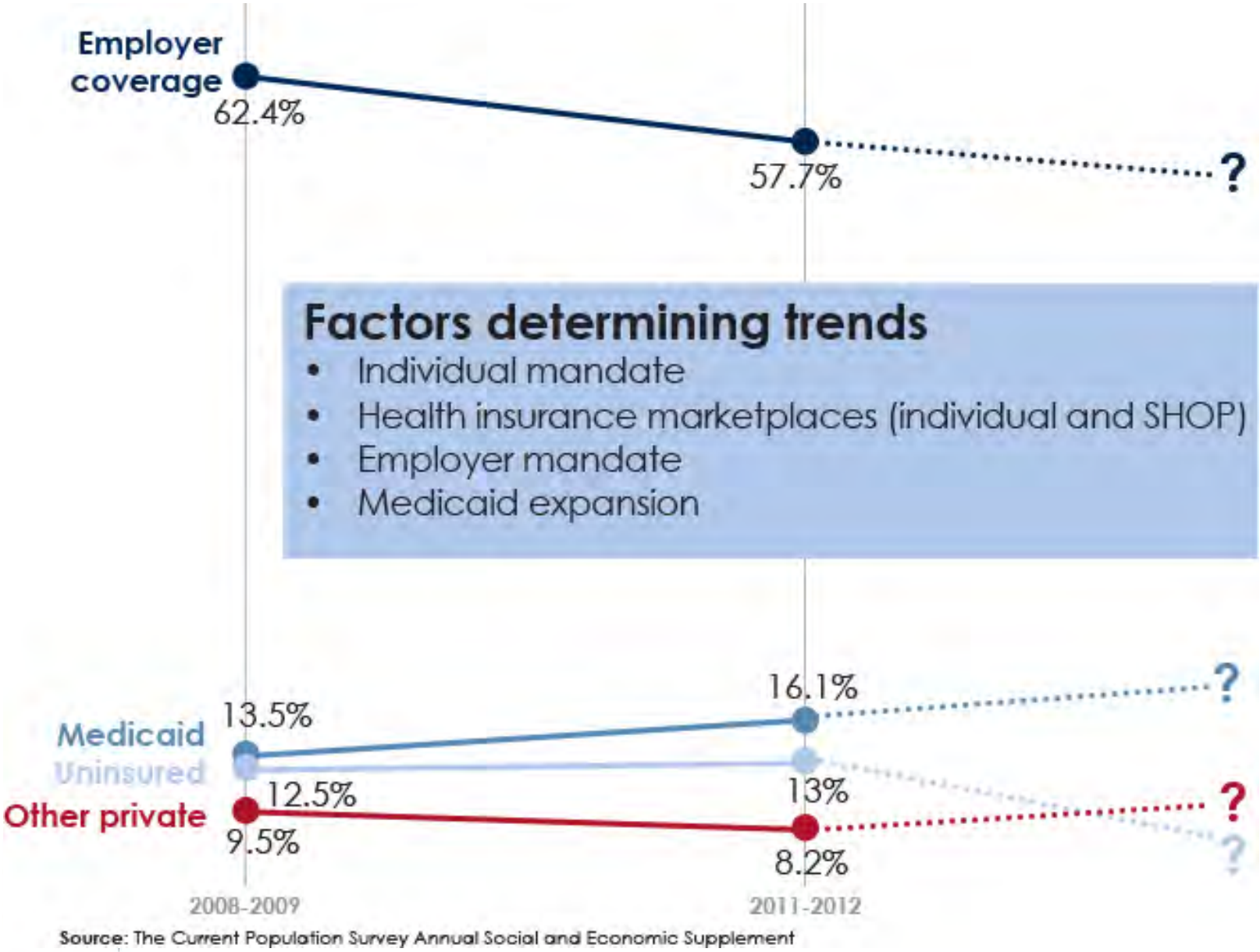
How will Ohioans be covered in 2014 and beyond?



Source: The Current Population Survey Annual Social and Economic Supplement

Impact of ACA on how Ohioans are covered



Source: The Current Population Survey Annual Social and Economic Supplement

ACA reforms impacting coverage

Snapshot of ACA coverage reforms, 2010-2014

Increased consumer protection

- Prohibition on rescissions
- Elimination of lifetime and annual limits
- Coverage of pre-existing health conditions
- Guaranteed issue and renewability
- Restriction on rating variation

More comprehensive health benefits

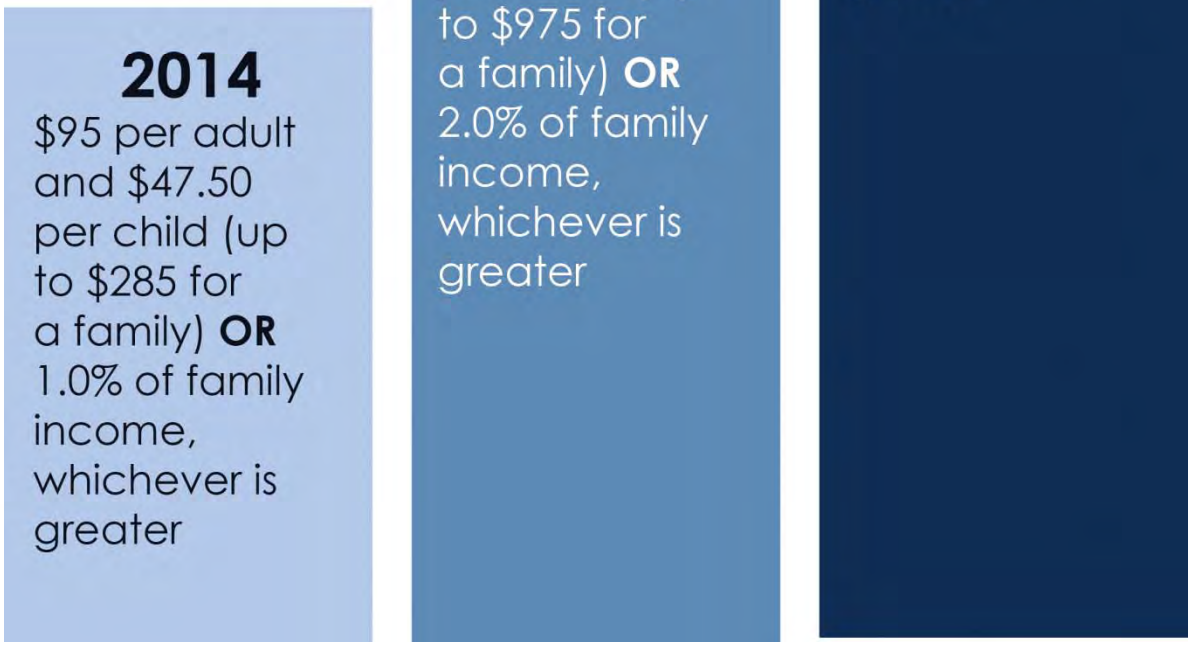
- Implementation of essential health benefits
- Coverage of preventive health services with no cost-sharing

Cost regulation

- Implementation of medical loss ratio
- Prevention of unreasonable insurance rate hikes

Individual mandate

Tax penalty under the individual mandate



- Income is defined as total income above the tax filing threshold
- The penalty for 2016 and beyond is indexed based on the cost of living
- Penalty cannot exceed the national average premium for the lowest cost bronze plan in the marketplace

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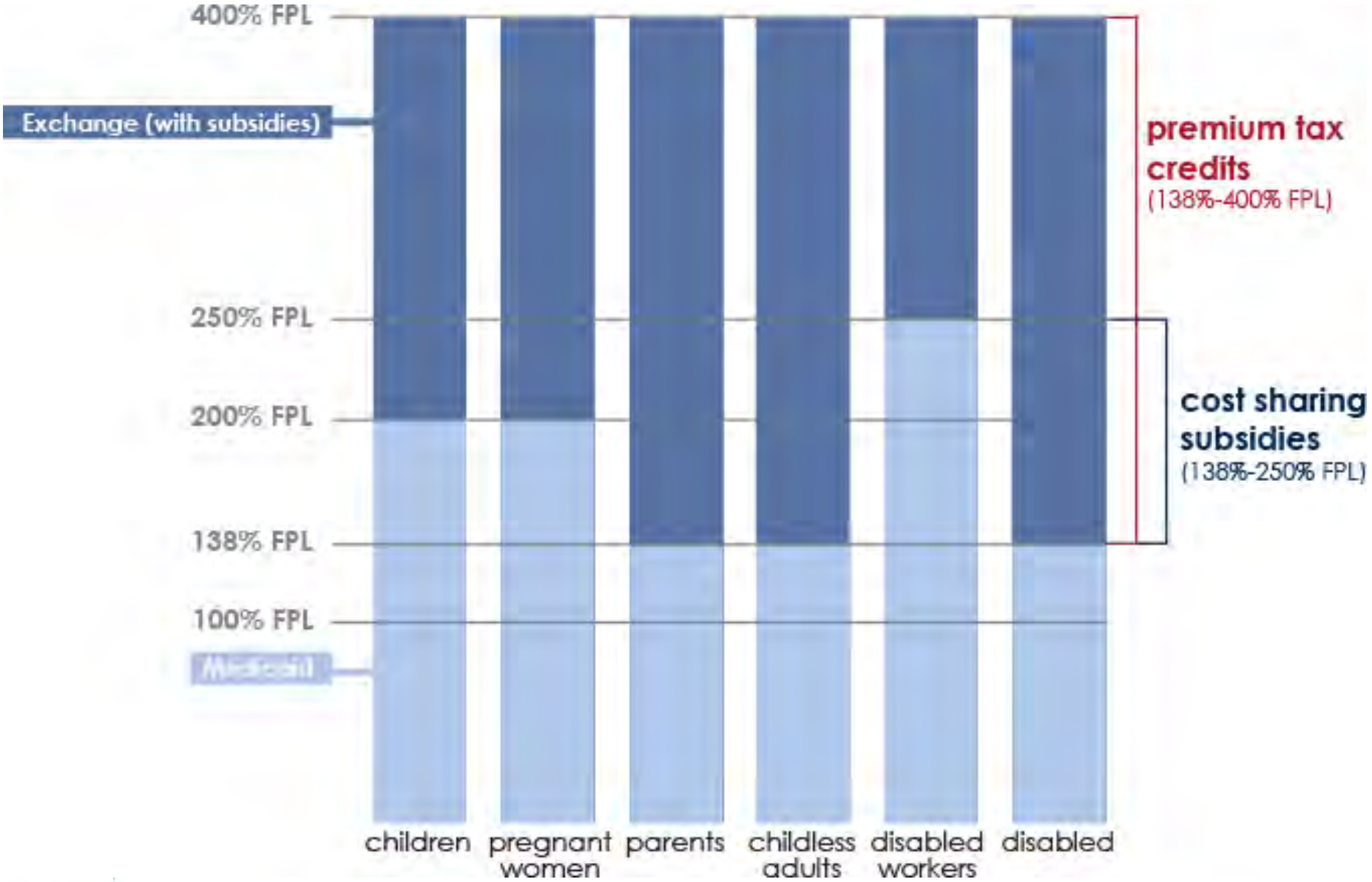
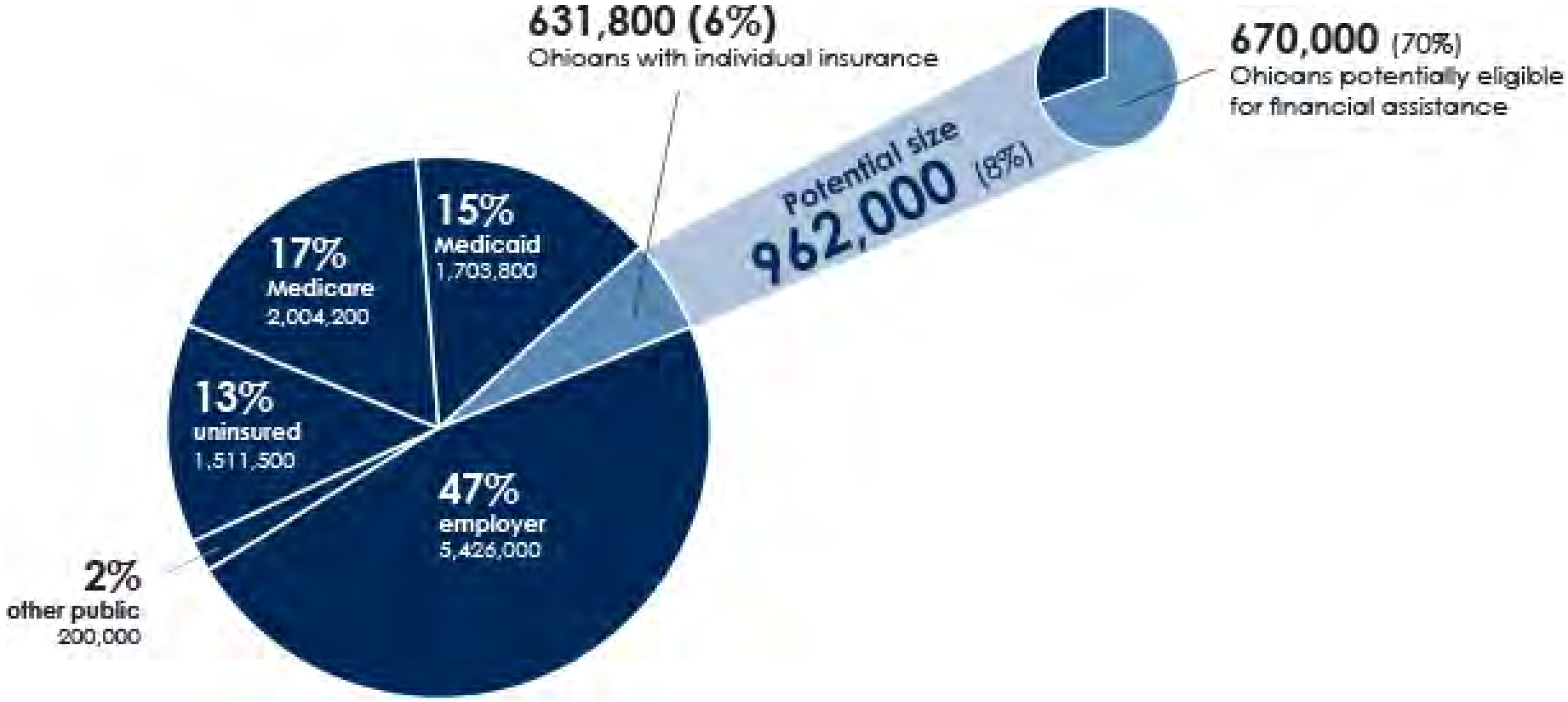
Health Insurance Marketplaces

Subsidized health coverage eligibility for Ohioans in 2014



Potential Ohio enrollment in the individual marketplace



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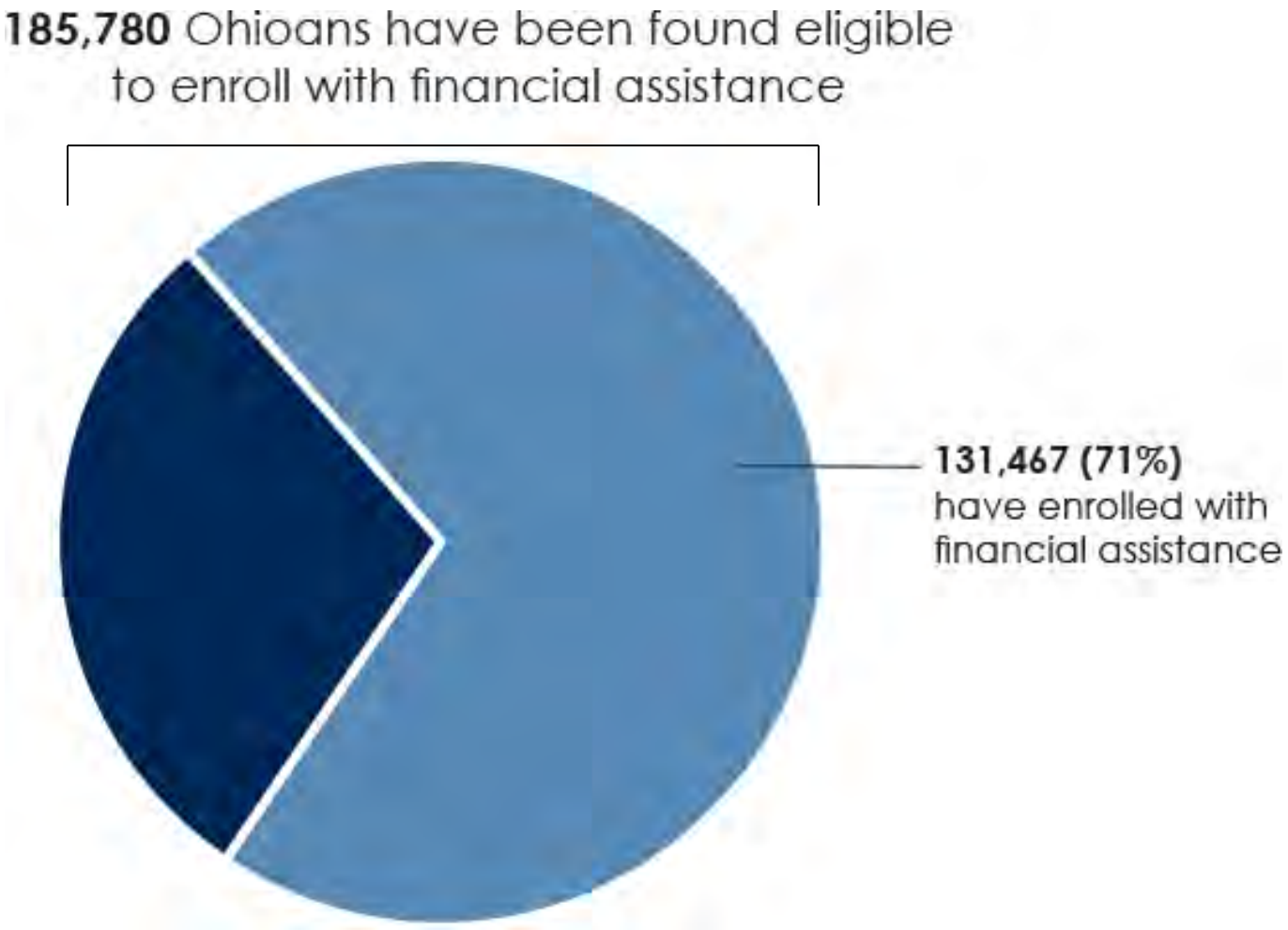
Source: Kaiser Family Foundation State Health Facts

Current Ohio enrollment in the individual marketplace



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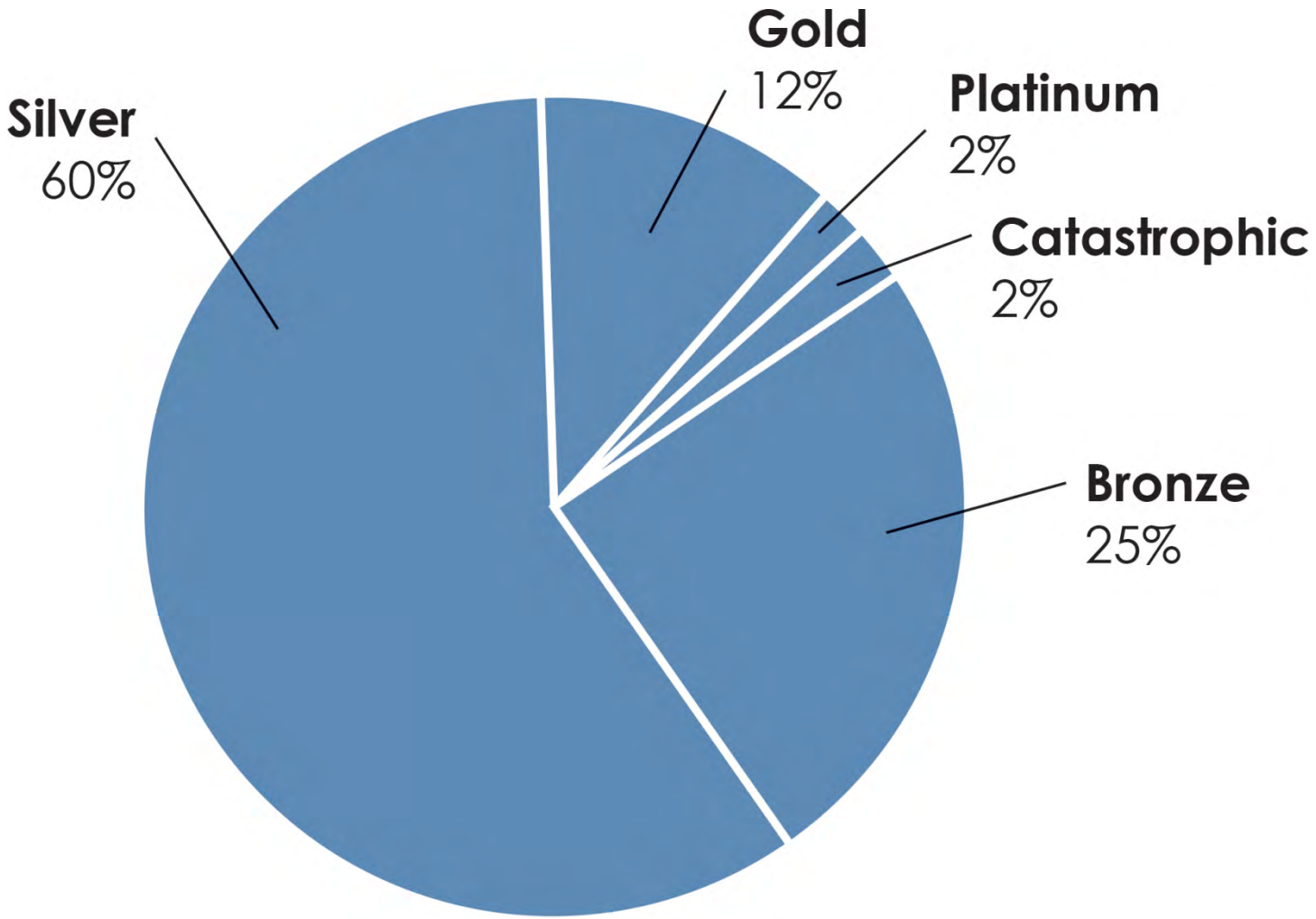
Source: Kaiser Family Foundation State Health Facts

Individual marketplace coverage in Ohio

Source: Kaiser Family Foundation State Health Facts

Individual marketplace coverage in Ohio

Enrollees in marketplace, by plan type (2014)



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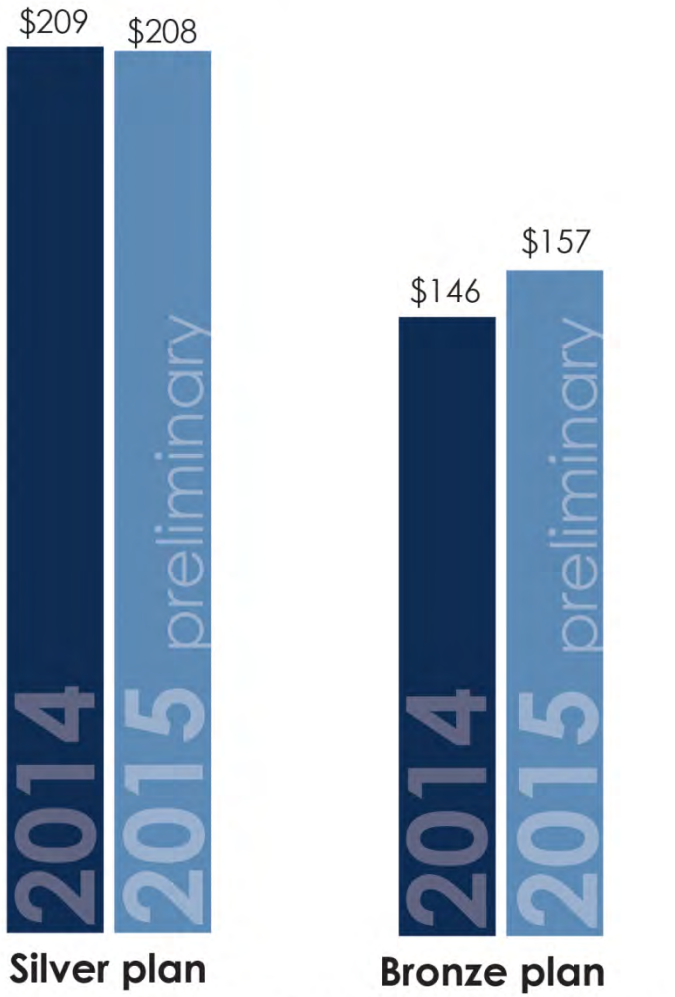
Source: Kaiser Family Foundation State Health Facts

Individual marketplace coverage in Ohio

Average premiums



Monthly premiums after tax credits, 40 year old non-smoker making $30,000/year

Source: Kaiser Family Foundation State Health Facts

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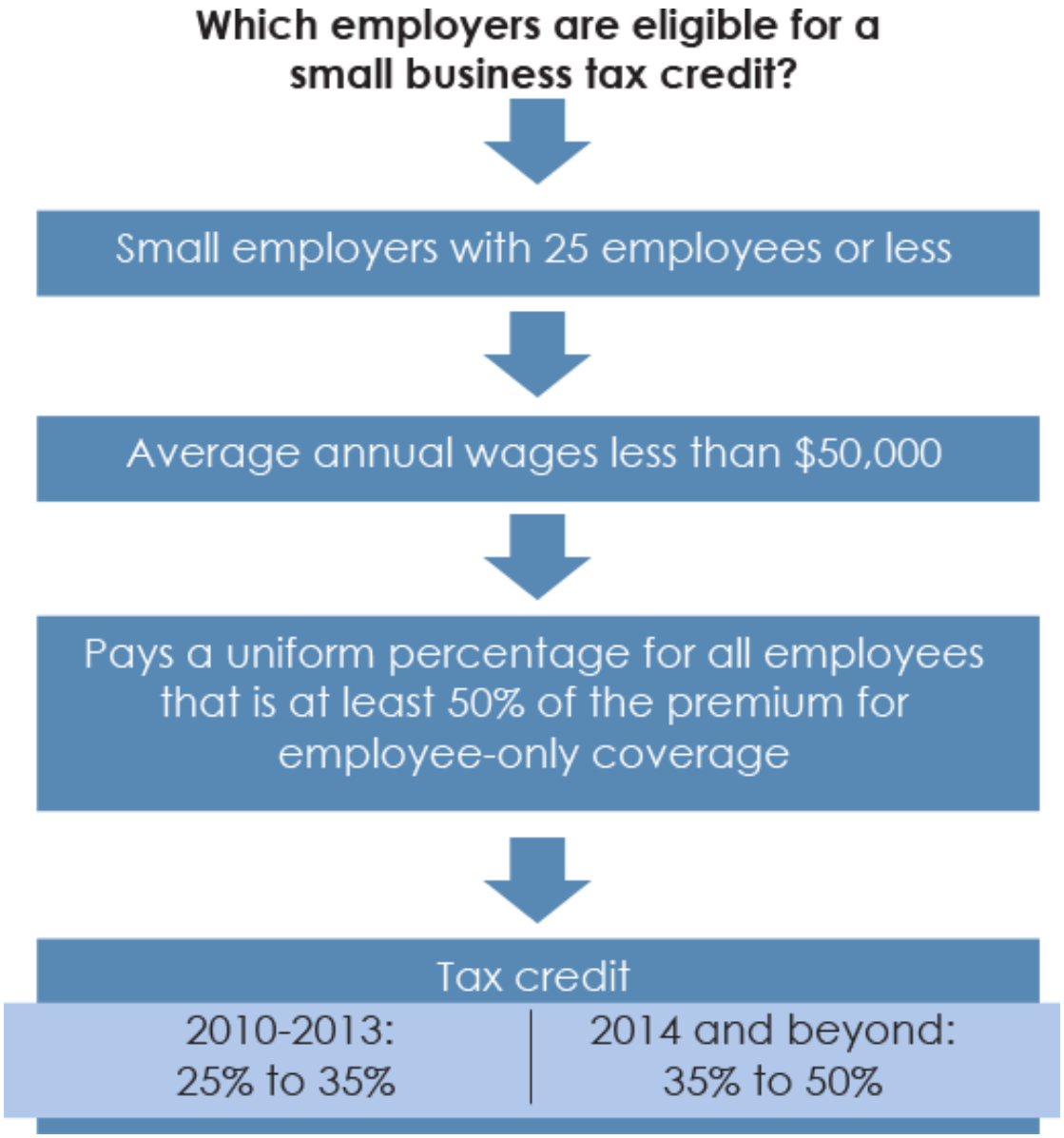
Small Business Health Options Program

- Open to employers with 50 or fewer FTEs
- No restricted enrollment period
- Online shopping for 2015



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Employer mandate

- To avoid a penalty, employers with 100 or more (50 or more in 2016) FTE employees in the previous year are required to **offer coverage that is affordable and provides minimum value.**

Affordable

- Employees do not have to pay more than 9.56% of family income (measured against safe harbor amounts) for employer coverage

Minimum value

- Insurance pays for at least 60% of the covered health expenses for typical population

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Employer mandate

- Penalties are triggered when a full-time employee receives a premium tax credit or cost-sharing subsidy on the marketplace.

Penalty for not offering coverage

- 2015: $173 per month times the number of full-time employees minus 80
- 2016: $173 per month (updated by growth in insurance premiums) times the number of full-time employees minus 30

Penalty for not offering coverage that is affordable and provides minimum value

- 2015: $260 per month for each full-time employee receiving a premium tax credit or cost sharing subsidy that month up to a maximum of $173 times the number of full-time employees minus 80
- 2016: $260 per month (updated by growth in insurance premiums) for each full-time employee receiving a premium tax credit or cost sharing subsidy that month up to a maximum of $173 times the number of full-time employees minus 30

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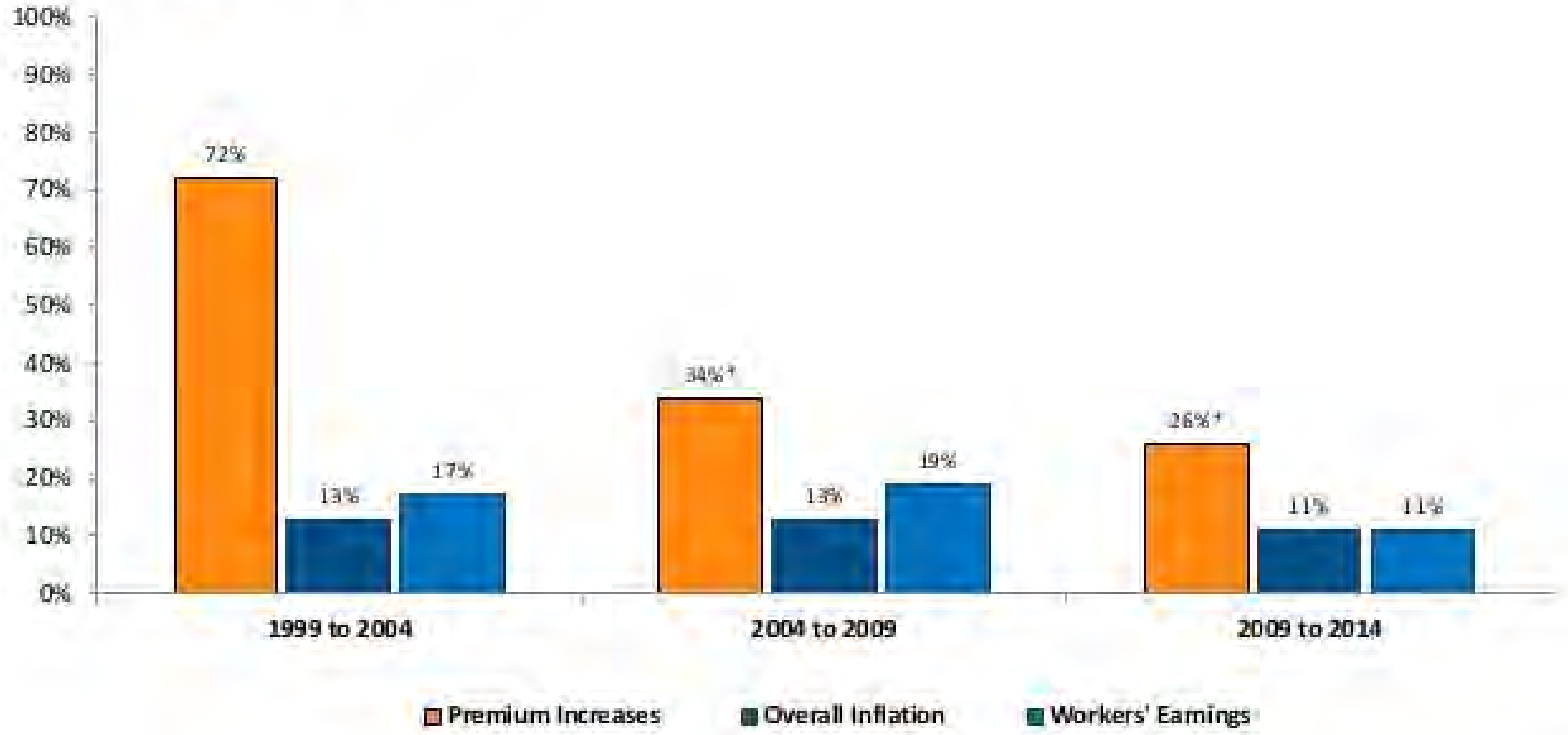
Emerging issues and trends in coverage

SCOTUS case on premium tax credits

Average Premium Increases for Covered Workers with Family Coverage, 1999-2014



* Premium Change is statistically different from previous period shown (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2014; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2014 (April to April).

Average Annual Premiums for Single and Family Coverage, 1999-2014

* Estimate is statistically different from estimate for the previous year shown (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014.

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Increase in high deductible health plans

NOTE: Note: Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2014.

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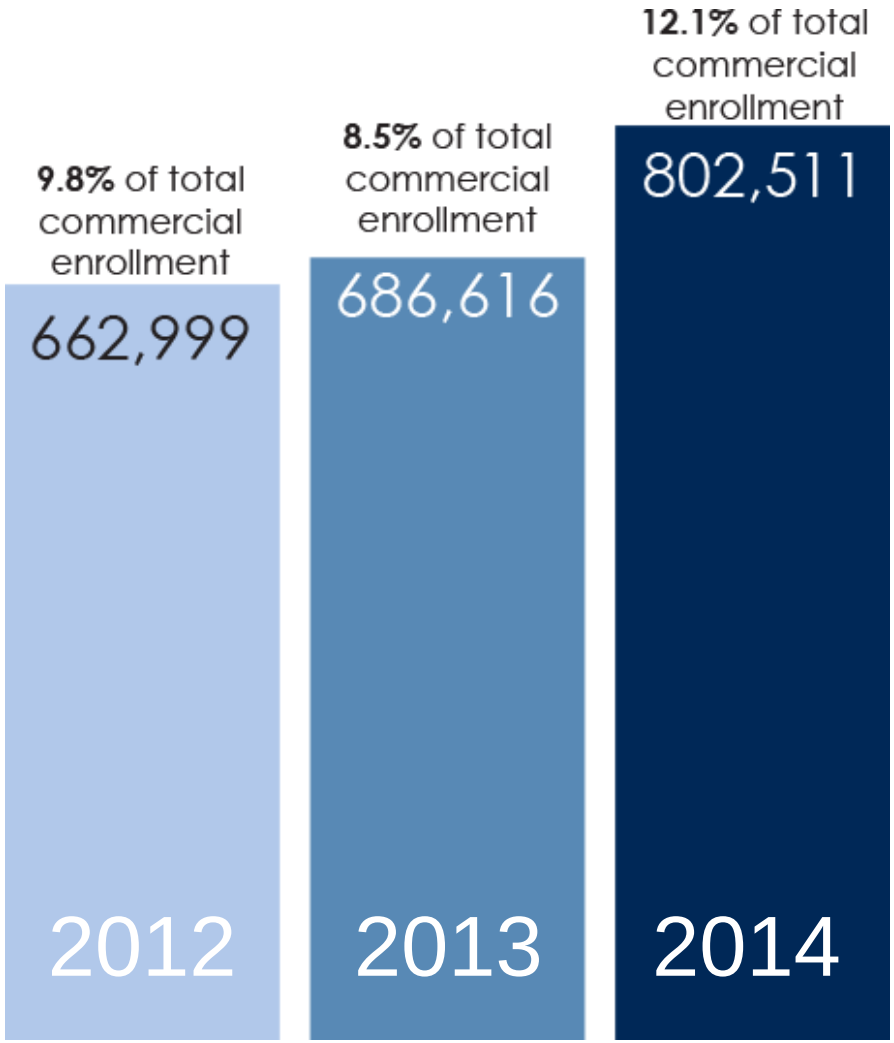
Increase in high deductible health plans

Ohio enrollment in HSA-Qualified high-deductible health plans, 2012-2014



Source: AHIP Center for Policy and Research

Private health insurance exchanges


Network adequacy

2014 Ohio Medicaid Enrollment Trends and Impact Analysis

Amy Rohling McGee and Stephanie Gilligan, HPIO
William Hayes, OSU Wexner Medical Center

Our goal is that by the end of this talk, you will…

- Understand how new Medicaid eligibility levels and other efforts have impacted enrollment trends in Ohio
- Have a sense of newly eligible enrollment projection ranges for the next biennium
- Understand how county enrollment has tracked with original estimates
- Be aware of implications for future study and research

Figure 2. **Medicaid eligibility in Ohio**

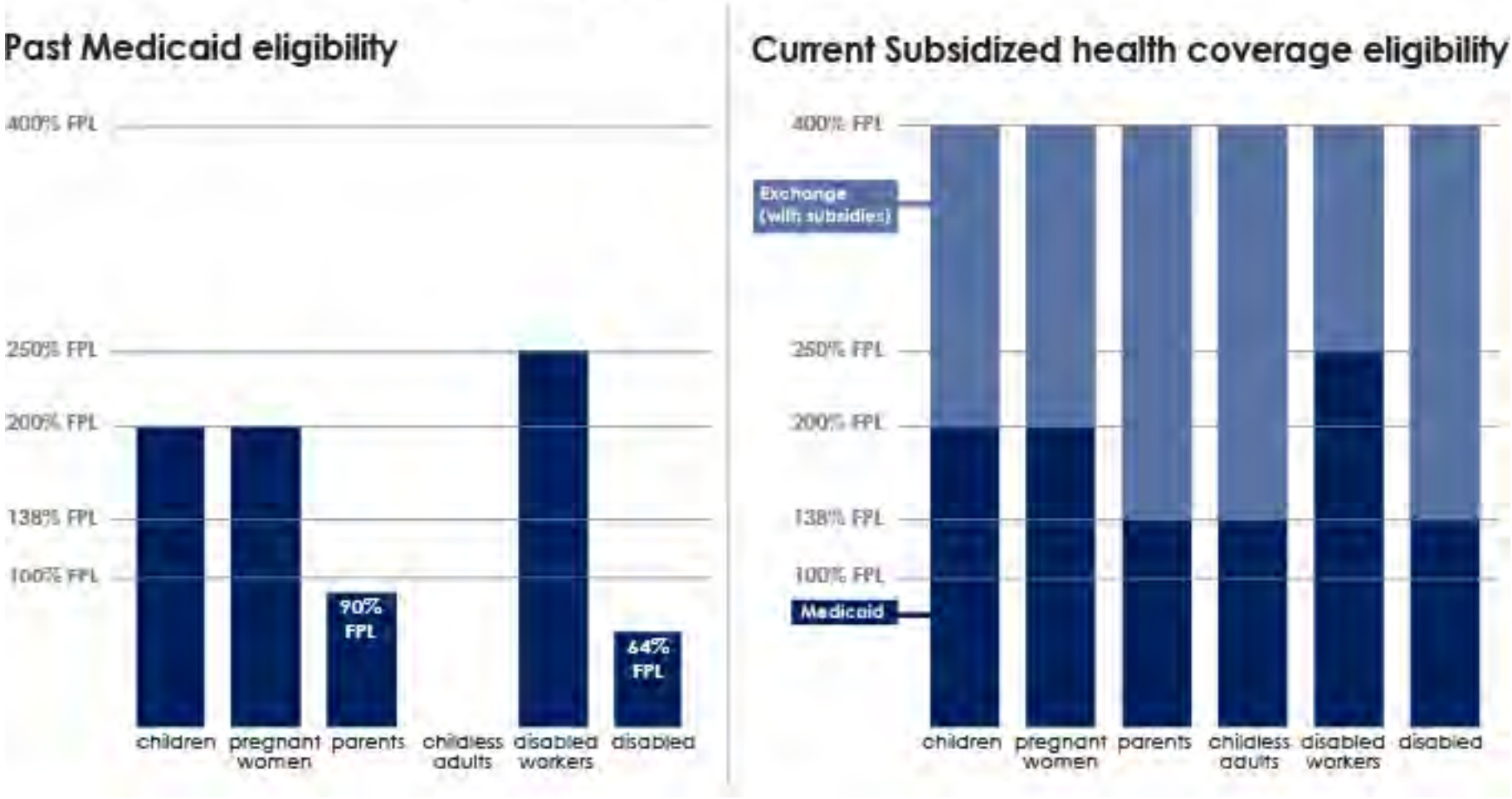
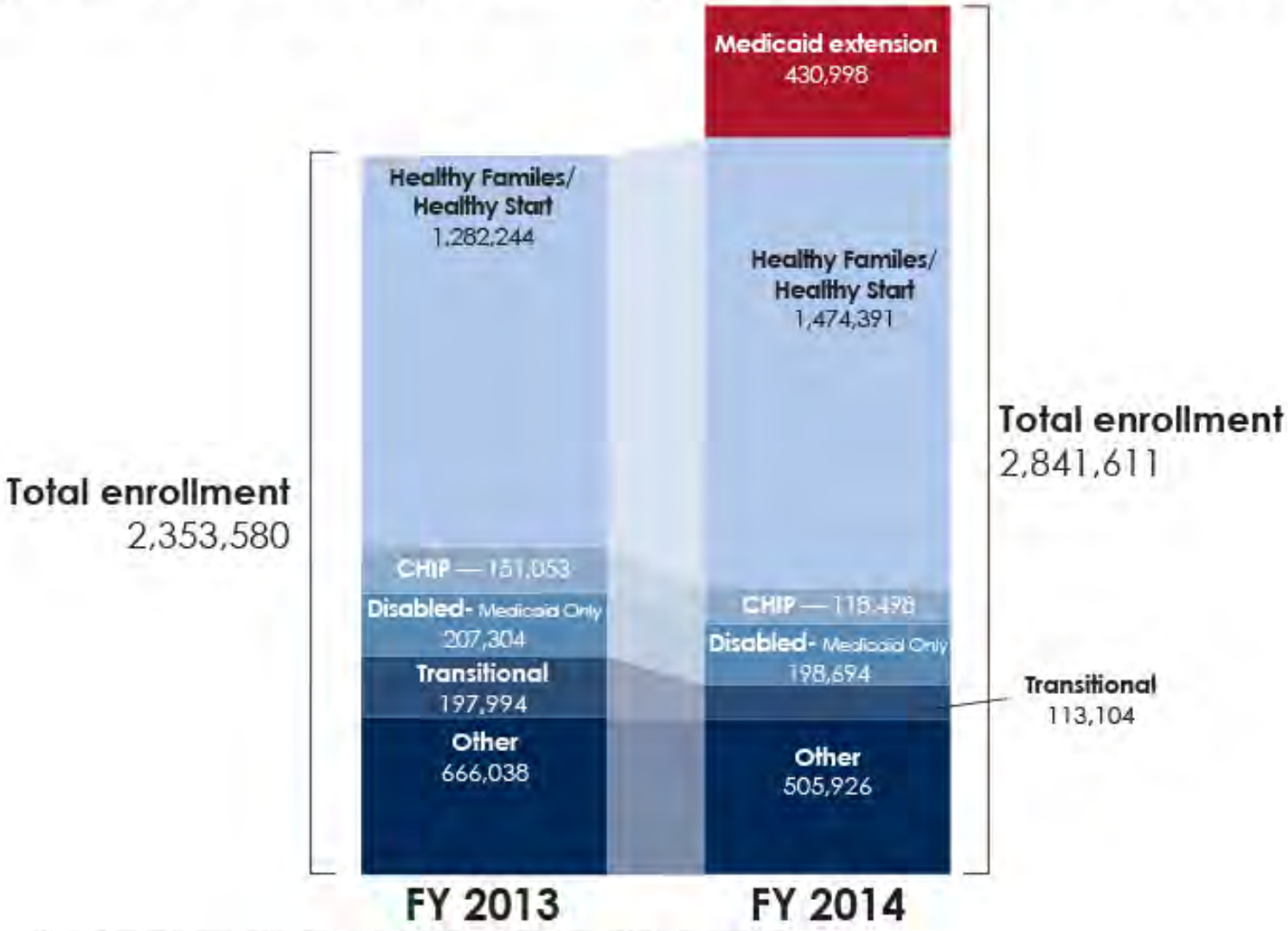


Figure 3. **Original Medicaid Expansion Study enrollment projections, Ohio State University (OSU) and Urban Institute (UI) models**

Medicaid enrollment increases as a result of expansion				
Fiscal year	Previously eligible people not enrolled in Medicaid pre-ACA		Newly eligible adults	
	UI	OSU	UI	OSU
2014	11,551	17,011	153,959	260,360
2015	27,036	37,084	380,313	550,050
2016	33,271	43,270	497,799	609,264
2017	36,100	46,624	570,399	642,354
2018	37,150	47,090	603,111	648,777
2019	38,121	47,561	612,562	655,265
2020	38,932	48,036	621,051	661,817
2021	39,782	48,516	629,540	668,436
2022	40,571	49,003	638,244	675,120

Figure 4. **Actual Medicaid enrollment by category, October 2013 and October 2014**

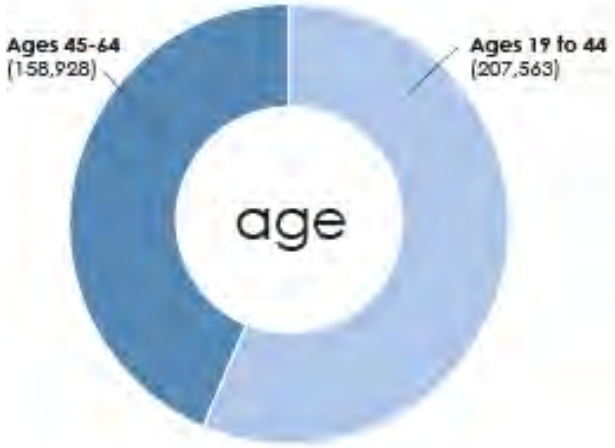


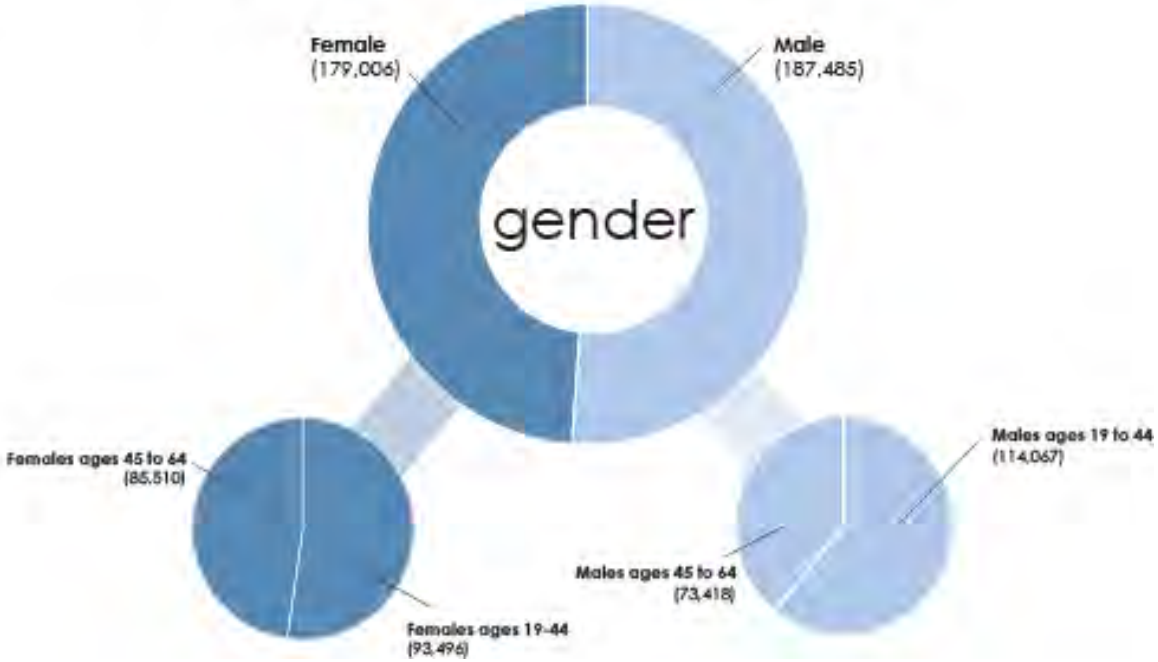
Source: Ohio Department of Medicaid Expenditures and Eligibles report

Figure 5. **Monthly Medicaid extension eligibility category enrollment, 2014**

Source: Ohio Department of Medicaid monthly caseload report

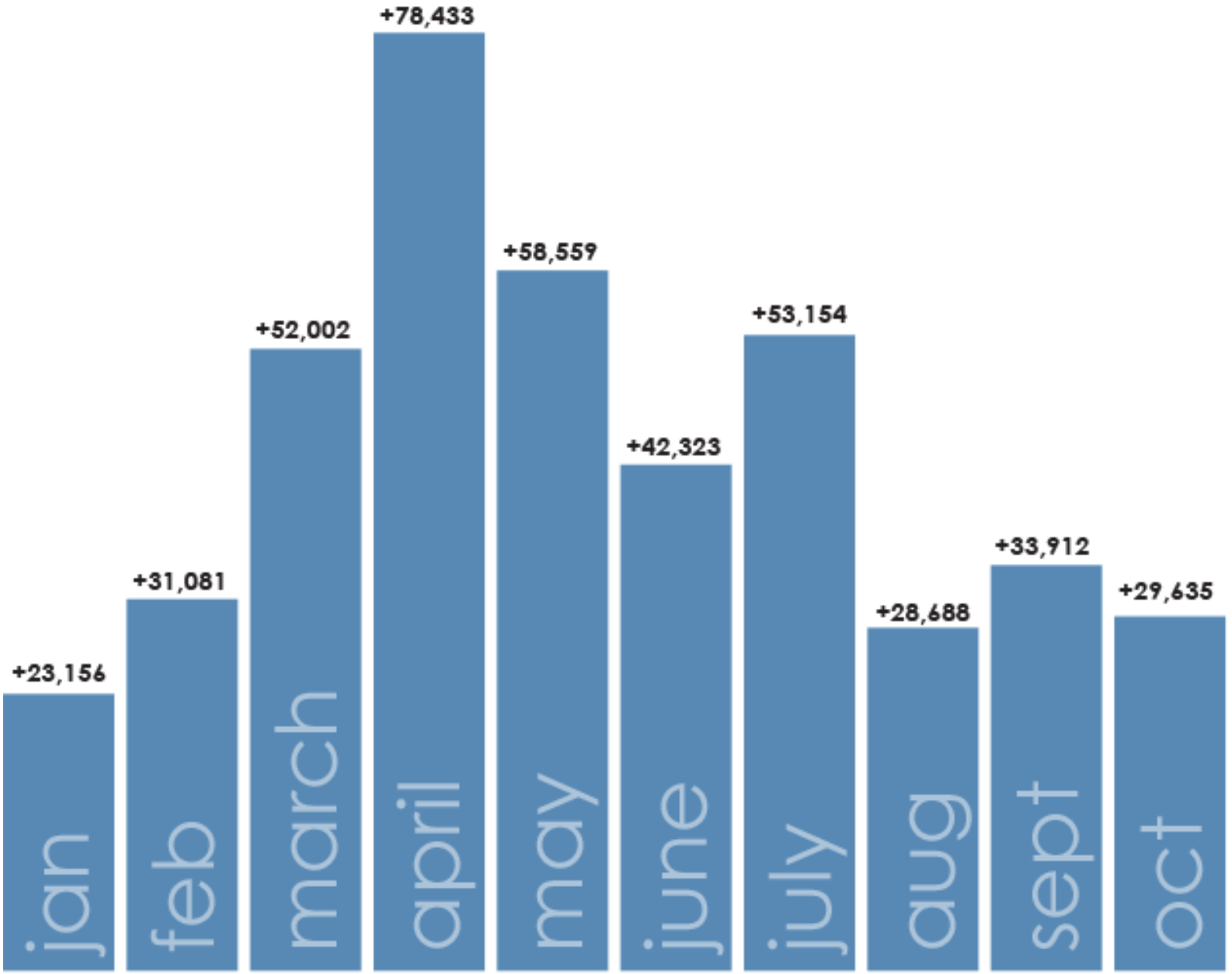
Figure 6. **Medicaid extension enrollment by age and gender, from August 2014**





Source: Ohio Department of Medicaid

Figure 7. **Monthly increase in total Medicaid enrollment due to Medicaid extension, 2014**



Source: Ohio Department of Medicaid monthly caseload report

Ohio Benefits

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Are you eligible for Medicaid?

CHECK YOUR ELIGIBILITY

VIEW YOUR ACCOUNT

System Improvements

Due to planned system improvements, residents will not be able to apply for Medicaid benefits from

- 8 pm on Saturday (12/6/2014) until 6 am on Monday (12/8/2014)
- 8 pm on Saturday (12/13/2014) until 6 am on Sunday (12/14/2014)

Thank you for your patience.

Benefits.Ohio.Gov

Helping Ohio residents find and apply for benefits. Learn more.


GETCOVERED

Figure 8. **Original OSU and UI models projections of newly eligibles compared to actual data for SFY 2014 (January – June 2014)**

	Actual	OSU model	UI Model
SFY 2014 (Jan-June 2014)	363,306*	260,360 (72% of actual)	153,959 (42% of actual)
CY 2014 (Jan-Dec 2014**)	492,432**	520,720 (106% of actual)	307,918 (63% of actual)

Figure 9. **Previously eligible but not enrolled estimate comparison of OSU model to SFY 2014 data**

	Actual	OSU model	UI Model
SFY 2014 (Jan-June 2014)	69,476*	97,203 (140% of actual)	67,177 (97% of actual)
CY 2014 (Jan-Dec 2014**)	169,526**	194,386 (115% of actual)	134,354 (79% of actual)

Figure 10. **OSU original Medicaid newly eligible enrollment projection compared to re-based projections**

	Original OSU Projection	Re-based OSU Projection
SFY 2015	550,050	593,361
SFY 2016	609,269	664,565
SFY 2017	642,357	703,667
CY 2014	520,720	492,432
CY 2015	579,380	628,963
CY 2016	639,158	664,565

Figure 11. **Medicaid extension as a percent of county population — Top 10 highest and lowest county rates**

Highest percent of population covered	Lowest percent of population covered
Meigs — 9.3%	Delaware — 2.0%
Fayette — 9.2%	Geauga — 2.1%
Muskingum — 9.2%	Holmes — 2.5%
Pike — 9.2%	Warren — 2.7%
Cuyahoga — 9.0%	Medina — 3.0%
Morgan — 9.0%	Mercer — 3.0%
Adams — 8.8%	Putnam — 3.0%
Scioto — 8.2%	Wood — 3.0%
Vinton — 8.2%	Union — 3.0%
4 Counties at 8.1%*	Auglaize — 3.3%

* Jackson, Jefferson, Marion and Perry

Source: 2013 U.S. Census Bureau data and Ohio Department of Medicaid

Implications for future study

- Are people with Medicaid coverage, including people with mental health and/or substance use issues, able to **access care**? If not, what barriers do they encounter?
- Do people with Medicaid coverage **utilize care appropriately**?
- Do they access primary care and **avoid unnecessary emergency department utilization** and how do these patterns compare to those of people who are privately insured or uninsured?
- What is the impact of coverage on **continuity of care**?, health behaviors and outcomes?
- Why do **county enrollment levels** vary? What practices lead to higher enrollment levels?

Implications for future study

- How do **local alcohol, drug and mental health boards** redeploy resources as a result of Medicaid expansion? What impacts are there to local health departments?
- What **types of jobs** do people on Medicaid typically have? Do these jobs offer full time hours and health insurance benefits? What is the impact of Medicaid expansion on job shift and income level?
- How do Ohioans on Medicaid rate their **satisfaction with the program**, as well as health and financial security?
- What impact does expansion have on hospitals in terms of **uncompensated care** and financial stability? What impact is there on the safety net?
- What savings does the state realize as a result of the policy change? What other **fiscal impacts** happen over time?