Ohio Association of Child Caring Agencies (OACCA)

National Health & Human Service Briefing: Industry Trends Affecting Ohio Providers

Howard Shiffman, Senior Associate

OPEN MINDS

April 29, 2014
Agenda

I. Health & Human Services Environmental Landscape
II. What are The Trends in Human Services
III. The Ohio Marketplace
IV. Implications Of Environmental Changes On Ohio Provider Revenue & Reimbursement
V. Provider Sustainability
I. Health & Human Services Environmental Landscape
Achieving the Triple Aim of Health Care

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of children and families
- Reducing the per capita cost of health care
“Bend the cost curve” is the theme

Focus on complex high-cost consumers

Entering the “consumer-centric” era

“Value-based purchasing” is the new model
A. National Health & Human Services Landscape
National Trends Relevant To Strategy

1. Payer focus on high-needs complex consumers – with preference for coordinated care across medical, behavioral, and social domains
2. More use of managed care across all payers
3. Blurring role of payers and provider organizations
5. Technology changing nature of service and of competition and focus on consumer needs
Payer Focus On Reducing Health Care Costs High-Needs Complex Consumers

- 5% of U.S. population account for half (49%) of health care spending
  - $11,487 per person

- 50% of population account for only 3% of spending
  - $664 per person
Coordination of Care & Integrated Services: A New Payer Focus

Integration of Primary Care & Behavioral Health

Coordination of behavioral health services and primary care services to improve consumer services and outcomes.

Integration of Primary Care & Chronic Disease Management

Coordination of services to manage and address multiple chronic disease states within or parallel to primary care.

Coordination more important than integration

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Who Is In This 5% Using 50% Of Resources?

- Services to support chronic illnesses contribute to 75% of the $2 trillion in U.S. annual spending.

- Patients with co-morbid chronic conditions costs 7x as much as patients with one chronic condition.

Nine Highest-Cost Chronic Conditions

1. Arthritis
2. Cancer
3. Chronic pain
4. Dementia
5. Depression
6. Diabetes
7. Schizophrenia
8. Post traumatic conditions
9. Vision/hearing loss

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For The 95%: Primary Care–Focused Models Spend Less Via Consumer Engagement

- Management via ACOs, medical homes, and primary care
- Specialist role is secondary
- Focus on prevention and wellness
- Consumer self-care and consumer convenience is key
- Web presence (optimization, reputation, etc.) critical for consumer referrals
- Health information exchange a requirement

- Primary care relationships with clearly defined specialty service
- Consumer ‘experience’ (and preference) critical
- Web presence key referral mechanism
- Health information exchange capabilities

Services for 95% of consumers via primary care–directed models
For the 5%: Intensive Coordinated Care Models Spend Less By Investing More

- Coordination of medical, behavioral, and social service needs by specialty group within larger system
  - Health homes
  - Waiver-based HCB programs
  - Programs of all inclusive Care for Elderly (PACE)
  - Specialty care management programs
- Assumption of performance risk (with or without financial risk)

Specialty coordinated care systems for ‘high needs’ consumers -- the new ‘carve out’ model

- Cross-specialty and cross-system care coordination capability
- EHR system and HIE with real-time care management metrics
- Performance-based contracting and risk-based contracting capabilities
1. Consumers have more choices of health plans
   - “Safety net” taking on a whole new meaning in states with Medicaid expansion
2. Consumers pay more...
   - “Penalties” for lack of consumer participation in health management
   - More coinsurance
   - More in copayments, deductibles, and non-covered services
3. Internet brings transparency to provider fees and provider performance
4. Focus on consumer self management, consumer-directed care, strengths-based approaches, and consumer recovery
Consumer Choice: Reputation Matters

Consumer Health Ratings.com
- Mission: dedicated to providing consumers with information they can use to make better informed decisions
- Provides a comprehensive listing of organizations that rate or report performance on specific hospitals, health plans, physicians, nursing homes, home health agencies

Healthgrades.com
- Data Base of states in USA of Doctors, Dentists, Hospitals….ratings included
- View specialists like psychologists

Vitals.com
Source for comprehensive medical information on 830,000 doctors nationwide
Doctors Examined Today: 624,000
**Vitals.com** rates health care professionals on:
- Ease in getting an appointment
- Waiting time during a visit
- Courtesy and professionalism of office staff
- Accuracy in diagnosing a problem
- Bedside manner (caring)
- Time spent with patient
- Follow-up after a visit

On The **Healthgrades** site, facilities were ranked using these questions:
- Would patients recommend the hospital to friends and family?
- How often did health professionals communicate with patients?
- How often did patients receive help quickly from program staff?
- How often did staff explain medicines before giving them to patients?
- Were patients given information about what to do during their recovery?
- Was the facility clean and quiet?
We found 422 Clinical Psychologists near Denver, CO

Claire C. Poole, PSY
Clinical Psychology
3801 E Florida Ave Suite 700, Denver, CO 80210

- Office Location
- Insurance Carrier

Dr. Gratia L. Meyer, PHD
Clinical Psychology
8000 E Prentice Ave Suite 13, Greenwood Village, CO 80111

- Office Location
- Insurance Carrier
Technology Changing Nature Of Service & Of Competitive Advantage

**What**
- New science changes treatment
- Pharmaceuticals, neurotech devices, computer-based cognitive retraining, etc.

**How**
- Use of technology to connect consumer to professional
- Ehealth and remote monitoring make ‘place’ less critical to service delivery

**When**
- “Big Data” and decision support
- Determines when professionals should do something – and when consumers are likely to choose something
Aetna offers free Aetna mobile apps
• DocFinder online provider director
• Urgent care finder
• Price-a-Drug
• Claims search

Cenpatico partners with myStrength.com
• Partnership adds myStrength.com individualized mental health wellness tools to redesigned Cenpatico website

ValueOptions partners with American Well
• Partnership to develop a national network of telehealth-enabled behavioral health professionals

Optum partners with RiteAid
• National partnership to provide NowClinic online care services to Rite Aid customers

Aligne Health Resources (now MD Aligne)
• Aligne Health Resources, now MD Aligne, offers insurers and HMOs remote-based telephone and online doctor consultations, medical advice, diagnoses, prescriptions, and testing – no health insurance needed

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<table>
<thead>
<tr>
<th>Insurer Use of Risk-Based Contracting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna/Sharp ACO</td>
</tr>
<tr>
<td>* Aetna and Sharp Community Medical Group (SCMG) launch an ACO for Aetna members in San Diego</td>
</tr>
<tr>
<td>Aetna/ Aurora Health Care</td>
</tr>
<tr>
<td>* Aetna partners with Wisconsin provider Aurora Health Care to create Aurora Accountable Care Network and a price guarantee for employers</td>
</tr>
<tr>
<td>Wellmark BCBS of Iowa/Genesis Health System</td>
</tr>
<tr>
<td>* Wellmark Blue Cross and Blue Shield of Iowa collaborating with Iowa–based Genesis Health System to create an ACO</td>
</tr>
<tr>
<td>Blue Shield of CA/John Muir Health ACO</td>
</tr>
<tr>
<td>* Blue Shield of California and integrated delivery system John Muir Health partnering on an ACO to cover plan members using a John Muir PCP</td>
</tr>
<tr>
<td>Blue Shield and San Francisco Health Service System</td>
</tr>
<tr>
<td>* Blue Shield ACO partnership created between Brown &amp; Toland Physicians Group and California Pacific Medical Center (a Sutter Health affiliate)</td>
</tr>
</tbody>
</table>
## Insurer Backward Integration To Acquire Service Capacity

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Acquisitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Humana</strong></td>
<td>- Acquired SeniorBridge Family Cos., a New York-based chronic-care provider with about $72 million in sales in 2012</td>
</tr>
<tr>
<td></td>
<td>- Acquired Texas-based work injury clinic operator and drug-screening business Concentra Inc. in 2012</td>
</tr>
<tr>
<td></td>
<td>- Concentra has since acquired 2 primary care operations, Mid America Medical Associates and Garcia, Rosenberg &amp; Associates, in Illinois</td>
</tr>
<tr>
<td><strong>UnitedHealth Group</strong></td>
<td>- Acquired Monarch HealthCare, a California physician group that includes 2,300 physicians in a range of specialties – and assumed management of AppleCare Medical Group and the Memorial HealthCare Independent Practice Association</td>
</tr>
<tr>
<td><strong>WellPoint</strong></td>
<td>- Acquired CareMore, a multispecialty clinic and insurance company with 26 offices in the Los Angeles area with expertise in managing seniors with chronic conditions</td>
</tr>
<tr>
<td><strong>Highmark</strong></td>
<td>- Acquired Jefferson Regional and Premier Medical Associates in Pennsylvania; acquisition of West Penn Allegheny Health System just completed</td>
</tr>
</tbody>
</table>
Distribution of Medicaid Enrollment in Managed Care – 1995 to 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee-for-service</th>
<th>Managed care</th>
<th>Total Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>70.6%</td>
<td>29.4%</td>
<td>33.4 million</td>
</tr>
<tr>
<td>2000</td>
<td>44.2%</td>
<td>55.8%</td>
<td>33.7 million</td>
</tr>
<tr>
<td>2005</td>
<td>37.0%</td>
<td>63.0%</td>
<td>45.4 million</td>
</tr>
<tr>
<td>2010</td>
<td>28.5%</td>
<td>71.5%</td>
<td>54.6 million</td>
</tr>
</tbody>
</table>

Fee-for-service  Managed care

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Optum Provider Network Changes

Network Referrals Geared by Provider Performance

We have three distinct approaches to steering members toward high-performing providers:

<table>
<thead>
<tr>
<th>Provider Tjering</th>
<th>Specialty Networks</th>
<th>Centers for Excellence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage use of in-network preferred providers, facilities or places of service</td>
<td>High-performing network-specific population or specific modality</td>
<td>Superior performing providers that advance evidence-based practices, targeted at high-cost, high-risk populations</td>
</tr>
<tr>
<td>• No changes to network; preserves choice</td>
<td>• Requires specific criteria (e.g., certified suboxone providers)</td>
<td>• Practice based on experts and research regarding best practices</td>
</tr>
<tr>
<td>• Requires high level of consumer engagement and understanding of benefit plan</td>
<td>• Network typically created from a subset of our broader Choice Network</td>
<td>• Requires specific criteria for participation and ongoing system sustainability</td>
</tr>
<tr>
<td>• Provides consumers with information and/or transparency tools (cost and quality) which enable more informed decisions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Cost and quality ratings available online at LiveandWorkWell

Disability, EAP, Peer Support, Substance Use Disorder, Autism

Eating disorders

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Transition of the Model

In selected provider arrangements, we will be transitioning and supporting financial risk, accountability and utilization management practices.

Compensation Continuum
(Level of Financial Risk)

Small % of financial risk
- Fee-for-service

Moderate % of financial risk
- Performance-based Contracting
- Bundled and Episodic Payments
- Shared Savings

Large % of financial risk
- Shared Risk
- Capitation
- Capitation + Performance-based Contracting

No Accountability

Moderate Accountability
- 100% case by case UM
- Utilization stats review supplemented by case review
- Data management and system Modifications to achieve targets

Full Accountability
- Internal ownership of performance using data management

Basic Q and U measurements
- Max quality process and outcomes driven measurements

Passive involvement
- Provider engaged
- Provider active in management
- Assumes accountability
Service Delivery Models Moving To Value-Based Financing: More P4P & Risk-Based Reimbursement

**FFS Financing**
- Payer maintains risk for unit cost and quantity of services used
- Consumers request services
- Provider organizations deliver services and are reimbursed based on volume

**Value-Based Financing**
- Payer contracts with provider organizations to deliver services to a population for a fixed amount of dollars
- Consumers request services
- Provider organizations determine type and amount of service, delivers service, and manage pool of dollars
More Organizations Are “Rating” Performance In Health & Human Services

<table>
<thead>
<tr>
<th>CMS Quality Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Committee for Quality Assurance (NCQA)</td>
</tr>
<tr>
<td>National Quality Forum (NQF)</td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
</tr>
<tr>
<td>The Joint Commission</td>
</tr>
<tr>
<td>Center For Excellence in Assisted Living</td>
</tr>
<tr>
<td>Payer and care management organizations (states, counties, HMOs, MCOs, PPOs, ACOs, etc.)</td>
</tr>
<tr>
<td>Consumer–driven open–source rating organizations</td>
</tr>
</tbody>
</table>
Step Up To Quality... Ohio Early Childhood Initiative

### Standards for Programs

#### STAR RATING SYSTEM

One-, two-, and three-star programs must meet all standards at the lower levels before advancing to the next. Beyond three stars, programs will be awarded points based on their adherence to three-star requirements and their ability to earn additional points. Programs must achieve a minimum of at least one point in each of the four domains and can earn extra points for accreditation, lower staff-child ratios, and group size.

<table>
<thead>
<tr>
<th>Domain</th>
<th>ONE STAR</th>
<th>TWO STARS</th>
<th>THREE STARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum &amp; Planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program engages in a process to select a curriculum, development(s) and/or appropriate screening instrument(s) for the age group served. (Does not apply to staff-child ratios.)</td>
<td>Program engages in a process to select a curriculum, development(s) and/or appropriate screening instrument(s) for the age groups served (appropriate to the age groups served.)</td>
<td>Program engages in a process to select a curriculum, development(s) and/or appropriate screening instrument(s) for the age groups served. (Appropriate to the age groups served.)</td>
<td></td>
</tr>
<tr>
<td>Program identifies staff to be trained in curriculum, screening, and uses the instrument(s) appropriately.</td>
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<td></td>
</tr>
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**FOUR AND FIVE STARS**

Steps 4 and 5: Programs must score at least one point in each of the four domains. They can score additional points by meeting the standards below.

**To achieve a Step 4 designation, programs must score 5.5-7 points.**

**To achieve a Step 5 designation, programs must score 7.5-9 points.**

#### ADDITIONAL POINTS

- **Accreditation:** Accredited from an approved accrediting body (3 points)
- **Staff/Child Ratios and Group Size:**
  - Birth to 16 months: 1:2 (2 points) or 1:3 (2 points)
  - 17 to 30 months: 1:3 (2 points) or 1:4 (2 points)
  - 31 months and older: 1:5 (2 points)
- **Teachers:**
  - Birth to 30 months: 1:1 (2 points) or 1:2 (2 points)
  - 31 months and older: 1:2 (2 points)
- **Mixed Age Groups:** Follow the ratio for the youngest child in the group.
- **Staff:**
  - Child care workers and teachers who meet the needs of children's in all developmental domains (5 points)
- **Teacher supports children's active engagement through opportunities for exploration and learning (2 points).**

### FOUR AND FIVE STARS

- Programs use a written, research-based, cumulative curriculum aligned with the Early Learning and Development Standards and/or Ohio’s K-4 Standards (appropriate to the age groups served.)
- Each teacher has access to a copy of the Early Learning and Development Standards and/or Ohio’s K-4 Standards (appropriate to the age groups served.)
- Teachers utilize a written, descriptive plan of activities that is aligned to all development domains in the Early Learning and Development Standards and/or Ohio’s K-4 Standards (appropriate to the age groups served.)
- Program or an educational organization, develops a research-based, cumulative curriculum aligned with the Early Learning and Development Standards and/or Ohio’s K-4 Standards (appropriate to the age groups served.)
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Will Treatment Foster Care be next?
What Is Happening?
Disruptive Innovation In Health & Human Services – The “Decentralization” Of Expertise

Disruption of professionals ‘less skilled’ professionals and consumers provide more
Disruption of institutions service delivery in less intensive settings

Disruptive innovation brings crisis to established institutions -- market leaders before a period of innovation are rarely the market leaders afterward

Performance that consumers want or need

Complexity of diagnosis and treatment

Hospital and intensive residential services
Outpatient clinics and focused-care centers
In-home care
Consumer self-care

Time
In health and human services, new innovations very slow to be adopted. . .

- Push back on telehealth due to licensure requirements and tech infrastructure
- Slow approval of new treatment technologies
- Slow uptake of patient guidelines (i.e. lab monitoring)
- Slow adoption of EHRs
- Regulatory impediment to health care exchange

The “autoimmune response” of special interests and protectionism causing a 17-year science-to-service gap
But, Cost Drivers Speeding Adoption

Patient care coordination focused on complex high-cost consumers

The New Rules

Provider organization relationships to consumer via care management organizations

Pay for volume
Pay for value

These changes creates incentives -- and the ability -- to use technology
Technology Has Changed The Playing Field...

New Technologies Allow Greater (& More Effective) Integration & Coordination Of Care

Telehealth and virtual consultation changing geographic market boundaries

Participation in health information exchange programs provides cross-organization data exchange

Interoperable electronic recordkeeping systems capture health information

Smartphone and other technologies for inexpensive consumer-directed disease management
Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.

Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and wireless communications.
The Internet & Social Media

Today’s Internet is rapidly growing

Expanding options for communicating and service delivery

Websites have new expanded capabilities

Providing professional education and publishing capacity

Communication via Blogs & Social Media sites

Use of the internet for health care is growing rapidly
Assistive Technology

- Smartphones
- Companion robots
- Remote monitoring systems
Features of the robot include strengthening communication channels among family members through video messages and the ability to interact with its owner through dance, games, reminders, clock functions and the remote operation electrical appliances in the home.

Researchers in Georgetown University, Washington DC, have published several findings on the benefits of robotic pets to humans or ‘robotherapy' or 'robopsychology,' stating that stroking robotic pets like NeCoRo the cat is beneficial to health, and that these companion machines could even be improved to perform more specific tasks, such as reminding patients to take their medication.
Remote Monitors: Mood

M3 (my mood monitor)
T2 Mood Tracker is a mobile application that allows users to self-monitor, track and reference their emotional experience over a period of days, weeks and months using a visual analogue rating scale. Users can self-monitor emotional experiences associated with common deployment-related behavioral health issues like post-traumatic stress, brain injury, life stress, depression and anxiety.
II. What Are The Trends In Human Services?
Payer Trends

State use of Medicaid managed care

New provider relationships with managed care

State waiver demonstration programs such as IV–E (ProtectOhio… 18 counties)…serves 33% of foster care population

New methods of reimbursement such as pay–for–performance and quality, case rates, capitation.
Trends In Service System

Reduction of residential use and length of stay (IV–E Waivers)

Movement to more community-based and in-home care

Focus on prevention and aftercare

Integrated Service Approach… physical health, mental health and substance abuse…. Also education/vocational

More engagement and involvement of family and consumer using technology
Trends in Service

Short term, outcome oriented, evidenced-based programming

Integration and coordination of mental health, physical health, substance abuse and eventually education (children on Medicaid)

Trauma-informed environment and trauma specific treatment

Co-occurring services
An Emerging Child Welfare Model.

Tech–Enabled Medical Home For Children
- Facilitated by PHR, EHR, HIE, and RHIO – with specialty primary care

Tech–Enabled Supports To Foster Family, Biological Family, & Kinship Arrangements
- On–line and in–home services and supports for foster families and kinship arrangements
- On–line and in–home services and supports for biological families to support family reunification
- Mobile supports for case workers

Shift in Residential Arrangements For Children
- Increased kinship care and family preservation
- Foster care increasingly intensive
- Reduced use of residential and group home services
III. The Ohio Marketplace
## Ohio Population Demographics

<table>
<thead>
<tr>
<th>Category</th>
<th>Population (#)**</th>
<th>Population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total State Population</td>
<td>11,326,800</td>
<td>100.00%</td>
</tr>
<tr>
<td>Size/SMI Population*</td>
<td>493,962 (90,0000 transition Youth &amp; YA with SMI)</td>
<td>4.36%</td>
</tr>
<tr>
<td>Gender: Male</td>
<td>5,484,300</td>
<td>48.42%</td>
</tr>
<tr>
<td>Gender: Female</td>
<td>5,842,500</td>
<td>51.58%</td>
</tr>
<tr>
<td>Race: White</td>
<td>9,181,000</td>
<td>81.06%</td>
</tr>
<tr>
<td>Race: Black</td>
<td>1,371,100</td>
<td>12.10%</td>
</tr>
<tr>
<td>Race: Hispanic</td>
<td>366,100</td>
<td>3.23%</td>
</tr>
<tr>
<td>Race: Others</td>
<td>408,600</td>
<td>3.61%</td>
</tr>
<tr>
<td>Age: 18 and Under</td>
<td>2,842,700</td>
<td>25.10%</td>
</tr>
<tr>
<td>Age: 19 – 64 Years</td>
<td>6,890,800</td>
<td>60.84%</td>
</tr>
<tr>
<td>Age: 65+ Years</td>
<td>1,593,400</td>
<td>14.07%</td>
</tr>
<tr>
<td>Age: 65-74 Years</td>
<td>875,700</td>
<td>7.73%</td>
</tr>
<tr>
<td>Age: 75+ Years</td>
<td>717,700</td>
<td>6.34%</td>
</tr>
</tbody>
</table>

*OPEN MINDS source data  
**Kaiser State Health Facts
## Ohio Payer Distribution By Health Coverage

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Population #</th>
<th>Population % of State Total</th>
<th>SZ/SMI Population #</th>
<th>SZ/SMI Population % of State Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid (FFS, MC)*</td>
<td>2,279,866</td>
<td>20.13%</td>
<td>113,993</td>
<td>1.01%</td>
</tr>
<tr>
<td>Medicare</td>
<td>2,654,851</td>
<td>23.44%</td>
<td>230,956</td>
<td>2.04%</td>
</tr>
<tr>
<td>Commercial Plans</td>
<td>4,740,183</td>
<td>42.79%</td>
<td>33,181</td>
<td>0.29%</td>
</tr>
<tr>
<td>Other Public</td>
<td>103,800</td>
<td>0.94%</td>
<td>727</td>
<td>0.01%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>1,548,100</td>
<td>13.98%</td>
<td>115,105</td>
<td>1.02%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
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*Dual eligibles included in Medicaid and Medicare
## Ohio Mental Health System Overview

### Health Insurance Status of SZ/SMI Population

<table>
<thead>
<tr>
<th>Plan Category</th>
<th>Estimated SZ/SMI Population</th>
<th>Est. SZ/SMI % of Total Population</th>
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<tr>
<td>Medicaid (FFS, MC)*</td>
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</table>

*OPEN MINDS source data

*Dual eligibles included in Medicaid and Medicare
## Largest Health Plans By Estimated SZ/SMI Enrollment

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Type</th>
<th>Enrollment*</th>
<th>Est. SZ/SMI Enrollment*</th>
<th>Est. SZ/SMI % of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicare</td>
<td>Medicare FFS</td>
<td>1,880,459</td>
<td>163,600</td>
<td>1.44%</td>
</tr>
<tr>
<td>2. CareSource</td>
<td>Medicaid MC</td>
<td>968,448</td>
<td>48,422</td>
<td>0.43%</td>
</tr>
<tr>
<td>3. Medicaid</td>
<td>Fee-For-Service</td>
<td>576,040</td>
<td>28,802</td>
<td>0.25%</td>
</tr>
<tr>
<td>4. Humana Insurance Company</td>
<td>Medicare Advantage</td>
<td>185,950</td>
<td>16,178</td>
<td>0.14%</td>
</tr>
<tr>
<td>5. Molina Healthcare of Ohio</td>
<td>Medicaid MC</td>
<td>258,726</td>
<td>12,936</td>
<td>0.11%</td>
</tr>
<tr>
<td>5. Aetna Life Insurance Company</td>
<td>Medicare Advantage</td>
<td>116,147</td>
<td>10,105</td>
<td>0.09%</td>
</tr>
<tr>
<td>6. Community Insurance Company</td>
<td>Medicare Advantage</td>
<td>110,813</td>
<td>9,641</td>
<td>0.09%</td>
</tr>
<tr>
<td>7. United Healthcare of Ohio</td>
<td>Medicare Advantage</td>
<td>99,860</td>
<td>8,688</td>
<td>0.08%</td>
</tr>
<tr>
<td>8. Buckeye Community</td>
<td>Medicaid MC</td>
<td>170,279</td>
<td>8,514</td>
<td>0.08%</td>
</tr>
<tr>
<td>9. United Healthcare Community</td>
<td>Medicaid MC</td>
<td>166,292</td>
<td>8,315</td>
<td>0.07%</td>
</tr>
<tr>
<td>10. Paramount Advantage</td>
<td>Medicaid MC</td>
<td>140,081</td>
<td>7,004</td>
<td>0.06%</td>
</tr>
</tbody>
</table>

**STATE OF OHIO TOTAL POPULATION**: 11,326,800

*OPEN MINDS source data

**Kaiser State Health Facts
## Medicaid System Overview

### Service Financing & Delivery

<table>
<thead>
<tr>
<th>System</th>
<th>Medicaid Managed Care</th>
<th>Medicaid Fee-For-Service</th>
<th>Medicare-Medicaid Duals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Enrollment</strong>*</td>
<td>1,703,826</td>
<td>576,040</td>
<td>297,654</td>
</tr>
<tr>
<td><strong>Size/SMI Enrollment</strong></td>
<td>85,191</td>
<td>28,802</td>
<td>83,045</td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Medicaid Managed Care Plans</td>
<td></td>
<td>Department of Medicaid</td>
<td>(1) Medicaid FFS / Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(2) PACE – 2 MCOs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(3) IDCS Demonstration Project - 5 MyCare Ohio MCOs selected</td>
</tr>
<tr>
<td><strong>Payment Model</strong></td>
<td>Full Risk Capitation</td>
<td>Fee-For-Service</td>
<td>Full Risk Capitation (for demonstration project)</td>
</tr>
<tr>
<td><strong>Anti-Psychotic Drug Coverage</strong></td>
<td>Included in MC pharmacy benefit</td>
<td>Included in FFS pharmacy benefit</td>
<td>Medicare Part D pharmacy benefit</td>
</tr>
<tr>
<td><strong>Operations</strong></td>
<td>MCOs Operating Statewide</td>
<td>ODM Operating Statewide</td>
<td>MCOs Operating in 3 Regions As Assigned</td>
</tr>
</tbody>
</table>

*OPEN MINDS source data / dual eligibles included*
Ohio Medicaid Reform

In January 2011, Governor Kasich created the Office of Health Transformation to control Medicaid spending and improve health outcomes. The new Office implemented an aggressive package of Medicaid reforms.

- **Privatize Medicaid** - today over 70 percent of Ohio’s Medicaid beneficiaries receive coverage through private managed care plans vs. 30 percent nine years ago;
- **Link payment to performance** - Ohio Medicaid now pays hospitals, nursing homes, and health plans based in part on how well they perform on quality and outcome measures;
- **Fight fraud and abuse** - aggressive new reforms are on track to save Ohio taxpayers $74 million over the next two years; and
- **Provide better choices** - today Ohio Medicaid serves more seniors and people with disabilities in their own home or other community setting than in nursing homes.
Ohio Medicaid Focus in 2013

Ohio remains focused on improving overall health system performance. Highlights include:

✓ Fighting Medicaid fraud and abuse,
✓ Capping Medicaid managed care spending at three percent annual growth,
✓ Reducing avoidable hospital readmissions,
✓ Targeting direct medical education funds toward workforce priorities,
✓ Assisting nursing facility residents with mental illness who want to move,
✓ Increasing provider rates for home and community based services,
✓ Committing Ohio to spend 50 percent of its Medicaid long-term care budget on home and community services (vs. 43 percent today),
✓ Creating a new cabinet-level Ohio Department of Medicaid, and
✓ Consolidating mental health and addiction services in a single agency.
Ohio Focus on Medicaid 2014+

Priorities for future Ohio Medicaid reforms include:

- Resetting the basic rules of health care competition so the financial incentive is to keep people as healthy as possible;
- Making information about price and quality transparent, and getting the right information to the right place at the right time to improve care and cut costs;
- Transforming primary care from a system that reacts after someone gets sick to a system that keeps people as healthy as possible;
- Preventing chronic disease whenever possible and, when it occurs, coordinating care to improve quality of life and help reduce chronic care costs; and
- Enabling seniors and people with disabilities to live with dignity in the setting they prefer, especially their own home, instead of a higher-cost setting like a nursing home.
Ohio Medicaid Reform Savings

In the three years prior to Governor Kasich taking office, Ohio Medicaid spending increased 8.9% per year on average (2009-2011).

Original Trend: 8.9% Annual Growth

Kasich Medicaid Reform: 3.3% annual growth

The Kasich Administration held Medicaid spending to 3.3% per year on average, saving Ohio taxpayers $3.0 billion (2012-2013).

SOURCE: Ohio Department of Medicaid; original trend based on 8.9% actual average annual spending growth 2008-2010 projected through 2015. ACA impacts include the woodwork effect, physician fee increases, eligibility system upgrades, and care coordination for Medicare-Medicaid enrollees, disabled children, and people with serious mental illness.
2013 Ohio Health Care Accomplishments

1. Modernized Medicaid

2. Prioritized Home and Community Services

3. Streamline Health and Human Services

4. Focused on Children

5. Paid for Value
1. Modernized Medicaid

• **Extended Coverage to More Individuals**
  ◦ Additional 275,000 eligible for health coverage

• **Overhauled Managed Care**
  ◦ Consolidated health plan regions from 8 to 3 regions
  ◦ Combined coverage for families and children and aged, blind and disabled populations
  ◦ Created an Integrated Care Delivery System (ICDS) for Dual Eligible’s …in 7 pilot regions…114,000 people
  ◦ More accountable care for children with disabilities .. now enrolled in managed care plans…37,000 children… chronic health focus

• **Fight Fraud & Abuse**
  ◦ Targeted at saving taxpayers $74 million over two years

• **Coordinated Workforce Programs**
  ◦ Identify health sector workforce needs, enhance primary care
Medicaid Managed Care Program

Effective July 1, 2013

Managed Care Plans for All Regions:
- Buckeye
- CareSource
- Molina
- Paramount
- UnitedHealthcare
2. Prioritized Home and Community Services

- **Provide More Community Options**
  - Ohio joined the federal Balancing Incentive Payment Program (BIP) ...requires 50% of Medicaid long term budget spent on home and community based services by 2015...will receive $169 million over 2 years.

- **Increase Community Options**
  - Recovery Requires a Community initiative for nursing home residents under age 60 with mental illness...1200 residents back to the community saving $44 million over 2 years

- **Lead the Nation in Transitioning Individuals into Community Settings**
  - National leader transitioning residents out of institutions

- **Requires Background Checks for Home–Health Workers**
  - $2.1 million grant to improve criminal background checks

- **Define Direct Care Worker Core Competencies**
  - Defined core competencies for anyone providing care in the home

- **Prevent Falls Among Older Ohioans**
  - Steady U initiative ... # 1 cause of deaths, emergency visits and hospital stays
3. Streamline Health and Human Services

- Created a Cabinet-level Medicaid Agency
- Simplified and Integrated Eligibility
- Consolidated Mental Health and Addiction Services
  - Dept. of Mental Health and Addiction Services (MHAS)
- Coordinated Services to Reduce Recidivism
  - $1.5 million to local communities for mental health services to reduce recidivism
- Restricted Opiate Prescribing
- Identified and Prevent Human Trafficking
- Provided Employment First for Ohioans with Disabilities
  - Initiatives to remove barriers for individuals with disabilities
Focus on Children

• **Reduced Infant Mortality and Low Birth Weight Babies.** focused birth, birth defects, and sleep–related death account for 95 percent of infant deaths

• **Treated Babies Born to Mothers Addicted to Opiates or Heroin.** $4.2 million to launch a cross–agency Maternal Opiate Medical Support (MOMS) program

• **Fight Childhood Obesity.** $1 million grant for the Ohio Department of Health to coordinate messages about physical activity and nutrition in communities with the highest rates of childhood obesity.

• **Provided Crisis Stabilization Funding.** OHT provided a $5 million grant to the Ohio Department of Mental Health and Addiction services to coordinate support for families with children in crisis.

• **Included Autism Services as an Essential Health Benefit.** directive to include autism services in the definition of “essential health benefits” for commercial insurance, and amended state employee health plan benefits to cover autism services.

• **Step Up To Quality in Child Care.** Step Up To Quality rating program for child care providers. five–star rating system to assess early childhood programs above the minimum–required health and safety standards.

• **Connecting the Dots for Foster Children.** eight–county pilot program that brings together foster care caseworkers, OhioMeansJobs staff, Big Brothers Big Sisters mentors, and Ohio employers to help teens in foster care prepare for work, vocational training or college, and independent living.

• **Engaged Older Ohioans as Reading Mentors.** Retired Senior Volunteer Program to engage Ohioans 55–plus as reading tutors and mentors to improve childhood literacy, support Ohio’s third grade reading guarantee,
Pay For Value

- **Rewarded Better Value Not More Volume in Health Services.** $3 million federal State Innovation Model (SIM) grant to design payment models that increase access to patient-centered medical homes (PCMH detail) and support episode-based payments for most acute medical events (episode detail). The purpose of both payment reform models is to align financial incentives to achieve better health, better care, and cost savings through improvement (will eventually hit behavioral health).

- **Established a Clear Path for Health Care Payment Innovation.** Developed a comprehensive State Health Care Innovation Plan. Provides a roadmap for health system transformation, specific recommendations for payment reform, and the importance of coordinating health information technology and workforce priorities to support reform.
IV. Implications Of Environmental Changes On Ohio Provider Revenue & Reimbursement
Key Effects Of Environmental Changes On Ohio Provider Revenue & Reimbursement

1. Increased use of competitive bidding for state services
2. Market-based reimbursement rates and reference rates
3. Value-based purchasing (pay-for-performance and risk-based reimbursement)
4. Emerging role of the board in an era of value-based contracting
5. Likely effects of health care reform and future of safety net funding
6. Increased need for Trauma informed environment and trauma specific treatment
7. Tax-exempt status issues raised by health care reform
1. Increased Use of Competitive Bidding For State Services

- States are moving to competitive bidding to reduce expenses
- Bundle services and get competitive proposals
- Existing negotiated or cost-based contracts may be replaced

EXAMPLE:

- **Permedion Selected For Ohio Medicaid Behavioral Health Utilization Management For Health Homes, Inpatient, & Community Support Services**
- News Report | July 8, 2013
- On July 1, 2013, Permedion started a two-year contract valued at $4.3 million with the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to oversee a statewide utilization management program for specified Medicaid behavioral health care services, including health homes, inpatient services, and community support services. The contract period started July 1, 2013, and runs through June 30, 2015
## 2. Market-Based Reimbursement Rates

<table>
<thead>
<tr>
<th>Service</th>
<th>FY2012 Rate</th>
<th>Managed Care Rate</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Consult</td>
<td>$88.60</td>
<td>$79.74</td>
<td>($8.86)</td>
</tr>
<tr>
<td>Outpatient Medical (FQHC)*</td>
<td>$164.73</td>
<td>$148.26</td>
<td>($16.47)</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td>$83.06</td>
<td>$74.76</td>
<td>($8.30)</td>
</tr>
<tr>
<td>Children’s Day Treatment</td>
<td>$75.99</td>
<td>$68.40</td>
<td>(7.59)</td>
</tr>
<tr>
<td>Partial Hospitalization (4hrs)</td>
<td>$128.40</td>
<td>$115.56</td>
<td>($12.84)</td>
</tr>
</tbody>
</table>

Medicaid managed care reimbursement rates are almost always based on fixed fee schedule – and often end up approximately 10% lower than previous fee-for-service
# Ohio: Medicaid Care In & Carve Out

<table>
<thead>
<tr>
<th>Mental Health Service</th>
<th>Fee Schedule Carve Out</th>
<th>Managed In Rate (Est.)</th>
<th>HCPCS/CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Assessment</td>
<td>$129.99 hr</td>
<td>$92–103 hr</td>
<td>H0031</td>
</tr>
<tr>
<td>BH Counseling–Group</td>
<td>$39.24 hr</td>
<td>$19-26 hr</td>
<td>H0004</td>
</tr>
<tr>
<td>BH Counseling–Individual</td>
<td>$90.00 hr</td>
<td>$79-82 hr</td>
<td>H0004</td>
</tr>
</tbody>
</table>
3. Value-Based Purchasing (Pay-For-Performance & Risk-Based Reimbursement)

1. Increase transparency of performance
   ◦ Increase ‘pressure’ for improvement
   ◦ Facilitate consumer-directed care

2. Link professional, service provider organization, and care manager reimbursement to desired performance
   ◦ Improved access to care
   ◦ Increase care integration and coordination
   ◦ Person-centered planning and recovery focus

3. Control costs of care
   ◦ Financial incentives to help consumers become and remain healthy for longer periods of time
   ◦ Increase lower-cost interventions for ‘not yet seriously ill’ population
   ◦ Reduce unnecessary use of high-cost services
Member Transparency To Provider Cost and Quality

- Members can compare clinicians by cost (actual out-of-pocket expenses) as well as clinical performance ratings on quality and efficiency.

Preferred clinicians “star-rated” for quality can earn a second star rating for meeting cost-efficiency standards.

“This looks a lot like picking a flight…it is already feeling familiar.”

“Ratings matter.”
— Consumer Testing Responses
4. Emerging Role Of The Board In An Era Of Value-Based Contracting

1. With provider organizations assuming more financial risk, the role of the board shifts
2. Need process and parameters to enter into P4P arrangements
3. Expertise to prospectively manage Incurred but not reported reserve (IBNR) and other reserve funds
4. Policies regarding risk management
5. Likely Effects Of Health Care Reform & Future Of Safety Net Funding

- Decrease available funding ‘earmarked’ for uninsured
- Parity + health care reform (even limited to cost containment) = decreasing ‘safety net’ funding
  - Increase proportion of funding of behavioral health provider organizations coming from health plans
- Increase in audits and ‘program integrity’ activities
- Need to establish policies for access to charitable services – and quantify dollar value of charitable services
6. Likely Effects of Increased Need for Trauma Informed Environment and Trauma Specific Treatment

- Providers spending more dollars on creating trauma informed environments and purchasing trauma specific treatment programs
- Payers requiring providers to operate within a trauma informed environment and to assess and provider services for the trauma needs of all clients
- Providers will have to make provisions for the secondary trauma experienced by their staff through organizational programs or EAP’s
7. Tax–Exempt Status Issues Raised By Health Care Reform

• “Community benefit” when most services are ‘paid services’
• Federal, state, and local issues with tax–exempt status
• “Gold standard” of community benefit standard is services provided with no expectation of payment
• Not considered – lower rates, contractual allowances, bad debt, service losses, etc.
• Need to establish policies for access to charitable services – and quantify dollar value of charitable services
Plan To Defend Tax Exempt Status

- Proactively prepare a plan of documentation of charitable care or community benefit
- Quantify the costs and sources of funds for each of your services
- Quantify the charitable contribution your organization receives
- Know what portion of raised funds is distributed to each of your programs
- Have written guidelines for the use of charitable funds to supplement the cost of delivering services
- Track and benchmark executive salaries and benefits
V. Provider Sustainability
The competition for control of patient care coordination

- Patient coordination = control of patient referrals
- Patient coordination by consumer type, not service type (the ‘new’ carve-out)
- Patient coordination goes to organizations accepting value-based (risk and/or P4P) reimbursement
A. Sustainability Framework
Sustainability = the ability to endure

Sustainability = the ability of an organization to secure and manage sufficient resources to enable it to fulfill its mission effectively and consistently over time without excessive dependence on any single funding source, including maintaining its ability to continue offering quality services and having an impact.

Sustainability is all about resources – getting needed resources and using them effectively
Four Key Competencies For Future Sustainability

1. A market–oriented strategic plan and market positioning for an increasingly competitive market
   ◦ Organizational identify–vision; mission; values; branding; messaging; strong leadership
   ◦ Long–range strategic planning – goals; objectives; benchmarks
2. A marketing and fundraising plan that is ‘up for the task’ in today’s competitive economic climate
3. A structured plan for innovation– design and implementation of new service lines
4. Enhanced effectiveness and efficiency through adoption of best practices in operational excellence and financial management
   ◦ Annual operational plan – objectives, activities and timelines; staffing; program needs; committed resources
   ◦ Financial management system – billing; cash flow analysis; compliance; audit; IRS reporting
   ◦ Board development plan – needs assessment; evaluation; recruitment; orientation; maintenance/team building
   ◦ Staff development plan – needs assessment; competency development; evaluation and review; training; team building
Strategy Is Not Enough

Performance Matters

Performance Management Is The Key To Maintaining Strategic Advantage
The Challenge... 

- Previous relationships with payer changing
  - Role of mission-based, tax-exempt organizations evolving
- More competition
- Technological substitution reducing price point on rates

“Specialist” organizations need strategic repositioning to maintain competitive advantage

“To win, create what is scarce”
Three Big Strategic Challenges For Service Provider Organizations.

- Challenge #1: Developing administrative competencies need to succeed in a model with care management intermediary.

- Challenge #2: Developing management competencies (and infrastructure) to accept value-based payment.

- Challenge #3: Creating service program models – and an organizational management model – for financial sustainability in new environment.
## Provider Organization Administrative Capabilities For A Managed Care Environment

<table>
<thead>
<tr>
<th>Challenge #1: Administrative Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketing and contracting functions – payer contracting, referral development, and consumer choice</td>
</tr>
<tr>
<td>Systems to facilitate administrative processes of FFS managed care and value-based purchasing – preauthorization, continued stay review, documentation</td>
</tr>
<tr>
<td>Revenue cycle management -- billing and collections for both payer and consumer</td>
</tr>
<tr>
<td>Development of services that are customer-preferred in terms of value – both payer and consumer</td>
</tr>
</tbody>
</table>
Push-Pull Marketing Strategy In A Managed Care Market

Approaching the payer

Use push strategies to gain endorsement of the payer and promote services through the payer

Marketing to customer

Use pull strategies to market directly to the consumer

Three levels in strategy: payers, referral sources, and consumers
The Changing Reimbursement Landscape – Away From Pay For Volume

Pay For Performance (P4P)
Capitation & Subcapitation
Case Rates & Bundled Rates
FFS

Challenge #2: Value-Based Purchasing Capabilities
**Care Management Administrative Capabilities**

<table>
<thead>
<tr>
<th>Clinical treatment planning and utilization management system</th>
<th>– with care tracking and automated clinical decision support tools across all chronic disease states</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member and customer service functions</strong> (including eligibility determination)</td>
<td>– with systematic approach to consumer engagement and improving the consumer experience</td>
</tr>
<tr>
<td><strong>Robust health record keeping</strong> and the ability to do health information exchange</td>
<td></td>
</tr>
<tr>
<td>Ability to produce <strong>real-time organizational performance metrics</strong> for management of clinical, consumer, and financial performance</td>
<td></td>
</tr>
<tr>
<td><strong>Financial management system</strong></td>
<td>– tracking of prepayments and liabilities</td>
</tr>
<tr>
<td><strong>Legal and financial requirements</strong></td>
<td>– risk reserves, licensure, accreditation, reinsurance</td>
</tr>
<tr>
<td><strong>Provider relations and network management</strong></td>
<td>– if not going to provide all services</td>
</tr>
<tr>
<td><strong>Claims management and payment system</strong></td>
<td>– if not going to provide all services</td>
</tr>
<tr>
<td><strong>Infrastructure and resources to locate and coordinate both health-related services and non-health social services</strong></td>
<td></td>
</tr>
</tbody>
</table>
The Sustainability Issue
Finding Alignment In Three Domains

- Programmatic offering for service delivery and positioning of services (horizontal)
- Role in care management and structural positioning (vertical)
- Financing options

Balancing these three elements is key to specialist organization market positioning

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How To Maintain Competitive Advantage & Financial Sustainability?
Address Three Strategic Questions

1. What is your organization’s “vertical strategy” to engage emerging patient care coordination organizations?
2. What is your “next generation” service line?
3. How does your organization create that “next generation” service line and stay a market leader?
### Question #1: What Is Your Organization’s “Vertical Strategy” To Engage Emerging Patient Care Coordination Organizations?

<table>
<thead>
<tr>
<th>Structural Positioning Options</th>
<th>Reimbursement Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO/MCO Partner (FFS P4P Or Risk-based)</td>
<td>FFS, FFS with P4P, Case Rate, Episodic/Bundled Payment, Capitation</td>
</tr>
<tr>
<td>Specialty ACO/MCO Provider Or Partner</td>
<td>FFS, FFS with P4P, Case Rate, Episodic/Bundled Payment, Capitation</td>
</tr>
<tr>
<td>Medical/Health Home Provider</td>
<td>FFS, FFS with P4P, Case Rate, Capitation</td>
</tr>
<tr>
<td>Medical/Health Home Partner</td>
<td>FFS, FFS with P4P</td>
</tr>
<tr>
<td>Case Rate–Reimbursed Specialty Program (By Population)</td>
<td>Case Rate, Episodic/Bundled Payment, Capitation</td>
</tr>
<tr>
<td>High–Performing Network Provider And/Or “Center Of Excellence”</td>
<td>FFS, FFS with P4P, Case Rate, Episodic/Bundled Payment, Capitation</td>
</tr>
<tr>
<td>Network Provider</td>
<td>FFS</td>
</tr>
</tbody>
</table>
Question #2: What Is Your “Next Generation” Service Line?

### Characteristics Of The “Next Generation”

- **Deploy new neurotech advances** – for better outcomes and improved consumer preference
- **Embrace consumer self-service technology** – to reduce costs and improve consumer engagement
- **Incorporate e-health and remote monitoring** – to lower labor costs and improve consumer preference
- **Use analytics-based decisionmaking** – to optimize organizational planning, consumer care management, and financial management
- **Demonstrate better outcomes and reduced resource use** – to support competitive value proposition and marketing
- **“Plug into” patient care coordination initiatives** – to increase reimbursable consumer population
- **Accept value-based reimbursement: risk-based and/or P4P** – to attract payer

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Question #3: How Does Your Organization Create That “Next Generation” Service Line & Stay A Market Leader?

Make service line development decision: adaptation versus innovation

Embrace the concept of transient competitive advantage

Adopt disciplined ‘rules’ for new service line development
Rule #1. Identify Core Competencies – In Customer-Centric Terms

- Unique capabilities contribute to value and are hard to imitate – the basis of competitive advantage
- Must be valued by customer and sustainable
- Shifts in technology ‘devalue’ some previous market advantages – location, basic knowledge, etc.

<table>
<thead>
<tr>
<th>Typical Core Competencies in Competitive Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost</td>
</tr>
<tr>
<td>Unique service or treatment capability</td>
</tr>
<tr>
<td>Regulatory requirements</td>
</tr>
<tr>
<td>Convenient and/or easy</td>
</tr>
<tr>
<td>Licensure or degree</td>
</tr>
<tr>
<td>High value (cost * performance * ease of use)</td>
</tr>
<tr>
<td>Facility or physical plant</td>
</tr>
<tr>
<td>Unique technology application</td>
</tr>
<tr>
<td>Defers or prevents higher expense</td>
</tr>
</tbody>
</table>

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Rule #2: Deploy Technology Into New Service Models

1. Automate everything that is automatable

2. Deploy consumer self-service with the patient as your new workforce

The age old question – Can old dogs really learn new tricks?

Can your team really embrace the possibilities of new technology?
Rule #3. Compare How Your Organization Stacks Up Against the Competition

- Performance
- Reputation
- Customer convenience
- Customer positioning
- Cost

The New Value Equation

\[ \frac{\text{Product Benefit} + \text{Brand Equity} + \text{Marketing Benefit}}{\text{Price}} = \text{Value} \]
Rule #4. Assess Realities Of Organization’s Assets Available For Repositioning

1. Historical mission and vision – organizational charter
2. Regulatory limitations
3. Competition in market
4. Management team competencies and expertise
5. The CEO’s leadership qualities
6. Organizational culture
7. Financial resources
8. Time

This assessment – core competencies, competitive benchmarking, and organizational assets – should drive decision making about strategic advantage and positioning.
The New Normal – Competition in Era Of Transient Advantage

A Common Theme – *Everything Keeps Changing. There Are Lots of Unknowns. When Will This Be Over? When Will Things Get Back to Normal?*

This is the new normal!

- Normal is state of transient competitive advantage
- Competitive advantage no longer possible to maintain long-term with “status quo” services
- Shorter product life cycle
- Need to embrace concept of managing a portfolio of many new strategic initiatives simultaneously – and faster!
- Rapid repositioning and innovation – a key organizational competency
Strategy In An Era Of Transient Competitive Advantage: The New Rules

1. Embrace the need for speed
2. Fall in love with the problem you are trying to solve – not your solution
3. Learn healthy disengagement – to avoid brutal restructuring
4. Get systematic about early stage innovation
5. Get better with metrics – and use them faster to make decisions
Making New Models A Sustainable Reality Takes New Management Practices & Management Discipline

1. Develop vision of future competitive advantage and market positioning

2. Scenario-based strategic plan incorporating alternate future positioning options

3. Detailed plans – marketing, financial, operational, capital, HR, etc. – to implement strategy and future vision

4. Key performance metrics and metrics-based management to track strategy implementation (and allow mid-course adjustments)

5. Optimization of current operations to keep current programs as competitive (and profitable) as possible as long as possible

6. New service model development to support future vision

7. Collaborations as needed to facilitate new market vision
Is Strategy Dead?

- No, but strategy is different...
- Tough choices still required – what to do and what not to do – and strategy sets the frame
- The cycle of strategic analysis needs to be faster and more frequent – data driven with frequent updates
- Strategy is a “real time” executive team function
Staying Informed: What’s on the Horizon in Ohio?

• How the Dual Eligible Program (MyCareOhio) will change the delivery system of programs?
  ◦ Plan is to encourage single point of contact and person centered care
  ◦ Initially voluntary and then mandatory

• When will Ohio roll out the full State Health Home Program and how will the requirements or rates change?

• Growth of the Ohio Patient–Centered Primary Care program and opportunities to partner with their 48 pilot sites under HB 198

• HB 316: Rep. Wachtmann. Medicaid–Covered Community Behavioral Health Services
  ◦ The Medicaid program + the Managed Care Company) shall not limit the number of hours, or visits for Medicaid recipients who are eligible for community behavioral health services.
  ◦ Managed Care companies if requested can provide an array of community and inpatient care including community psychiatric supportive treatment, health home comprehensive care coordination, individual and group counseling, Intensive outpatient treatment for alcohol and drug addiction etc.
Upcoming Education Events

2014 Planning & Innovation Institute
June 3–5, 2014 – New Orleans, Louisiana

2014 California Planning & Performance Management Institute
August 20–21, 2014 – San Diego, California

2014 Executive Leadership Retreat
September 9–12, 2014 – Gettysburg, Pennsylvania

2014 Technology & Informatics Institute
November 5–6, 2014 – Washington, D.C.
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