In 2015, Urban conducted case studies examining health care stewardship in five states: Colorado, Minnesota, Ohio, Oregon, and Vermont. Stewardship demands active pursuit by governments of systemwide improvements, beyond typical public health and purchasing roles. This means developing a strategic framework for a health policy that reaches all citizens, building support among stakeholders, regulating and monitoring health care systems, and using data to improve. Through a series of on-the-ground interviews, we examined the unique ways states have leveraged their authority to improve the quality and efficiency of health care systems. To learn more or read the other case studies, visit http://www.urban.org/policy-centers/health-policy-center/projects/health-care-stewardship-case-studies.

Overview

Ohio has not historically been viewed as a leader in health policy innovation among states. This has changed since the election of Republican Governor John Kasich in 2010. As part of an overall priority to improve the state’s economy and respond to the state’s dramatic loss of more than 400,000 jobs in the 2007–08 recession (Connaughten and Madsen 2012), Governor Kasich entered office with an agenda that included improving the health of the workforce and making Ohio a more attractive place for business.

Ohio’s approach is largely driven by Governor Kasich’s administration, which aims to move state health care purchasing toward value rather than volume. The most visible element of this plan is adoption of an episode-based payment model, with rewards and penalties for those with costs below or above a normal range. The model, developed and promoted by McKinsey & Company, is also in use in
Arkansas and Tennessee (Latkovic 2013). The payment model does not disrupt the core fee-for-service payment system. Instead, it assigns an “accountable provider” associated with major care episodes, such as a knee replacement or a coronary artery bypass graft. Each episode is defined with precision, stripping away outliers and confounding factors. All costs associated with the episode are attributed to the responsible provider, who is then rewarded or penalized financially if those costs are below or above certain levels.1 Another important element of the state’s approach is the statewide expansion of the use of patient-centered medical homes (PCMH). State political leaders intend to implement these initiatives in the Medicaid program with some private carrier participation, and stakeholders hope that the efforts will spill over into the private sector.

In 2013, Ohio was awarded $3 million to design its model under the State Innovation Models (SIM) program of the Center for Medicare and Medicaid Innovation (CMMI). In December 2014 the state received an award of $75 million to implement its plan.

Although the current administration has embraced stewardship as a means to improve population health and the state’s economy, the future of the state’s efforts remains uncertain. With a second-term governor as the driving force behind system change in a state that has not historically engaged in such efforts, it is unclear if reforms will be sustained. The Medicaid program has the legal authority to move forward with episode based payments, but without continued strong leadership from the executive branch, retaining private-sector engagement may be difficult.

Political and Policy Context

Ohio currently has a Republican governor and a Republican-controlled legislature.2 With the exception of one four-year term, Ohio has had Republican governors since 1991.3 The state did not establish its own health insurance exchange, but it did opt to retain its authority to regulate insurance within the exchange.4 Lieutenant Governor Mary Taylor (who is also the insurance commissioner) has been an outspoken critic of the Affordable Care Act (ACA), and Governor Kasich has publicly supported repealing some ACA provisions (Taylor 2013).5 Ohio did expand Medicaid, but through a unique approach that circumvented significant legislative opposition.

The state’s Medicaid program has grown almost 26 percent compared with its size before the ACA’s enactment, and now more than one-quarter of the state’s population is enrolled in either Medicaid or CHIP.6 Although the state has managed to slow average Medicaid spending growth to around 3 percent, the state still ranks in the top third of highest spending per enrollee.7

Ohio has a relatively competitive insurance market; the largest insurer has a market share of 35 percent, and three insurance plans have at least 5 percent market share.8 Sixteen insurers offer qualified health plans in the state, and the Cleveland area has some of the lowest insurance premiums in the country (Kaiser Family Foundation 2014).9 No single carrier dominates the market, and insurers are continually competing for Medicaid contracts.
Ohio lags behind in public health measures. The state ranks 40th in population health measures and has higher-than-average rates of diabetes and obesity. It also ranks among the worst in the nation for infant mortality rate.\textsuperscript{10} As of mid-2014, the uninsurance rate in Ohio was 11.5 percent, down from 13.9 percent in 2013.\textsuperscript{11}

Also relevant to the state context are Ohio’s legislative term limits. Ohio is one of 15 states that limit the amount of time state legislators can serve. This limit is eight consecutive years each in the House and Senate, although each body allows a return after a four-year hiatus.\textsuperscript{12} These term limits mean that members have a relatively short time to develop expertise before they are placed in leadership positions.

### State Goals

The Kasich administration has three primary health goals. First, officials view a more efficient health care sector as essential to creating an attractive business climate. Second, the administration seems determined to tackle growing Medicaid costs more strategically than by cutting payment rates or benefits; such strategy differs from the primary methods used by previous administrations. Third, poor health indicators (interviewees frequently mentioned infant mortality) are seen as a deterrent to business in Ohio because of those indicators’ implications for the labor force and the burden they place on the public treasury. Ohio leaders articulate health improvement goals almost entirely in the context of a broader need to improve the business climate and restore lost jobs.

### View of the State’s Role

The recent and current political environments in Ohio do not lend themselves to strong action by the state to shape the private sector. But when the goals are to be efficient and build a more attractive business climate to increase jobs in the state, a credible leader such as Governor Kasich is viewed as an appropriate messenger. Thus, the state’s role in improving the functioning and efficiency of the health care system is viewed as appropriate primarily through signaling, affecting direct purchasing behavior, and leading the multipayer coordination, not by regulating the private sector.

### Leadership

The new focus on health system transformation is overwhelmingly attributed to the leadership of Governor Kasich and his administration. Although the state did participate in system improvement initiatives during previous administrations, such as the State Quality Improvement Institute, those programs did not catalyze system change to the degree occurring now.\textsuperscript{13} Participants noted that previous initiatives created a base of policies and support for the current administration to draw from, but those initiatives did not drive significant improvements to the state’s health system. Interviewees widely agreed that Governor Kasich has been direct about his intentions to change the state’s health
system and his expectation of results, specifically results in cost containment and health system improvement. Respondents also noted that Governor Kasich developed much of his plan for health system improvement before he entered office.

Interviewees identified the legislature as a source of leadership in advancing specific population health objectives but not an overall agenda of health system improvement. This might change with the newly created Joint Medicaid Oversight Committee (JMOC), which will be discussed in more detail below.

The fragmented and competitive health insurance market limits private sector leadership at the level of payment policy. Large provider systems have significant clout within their markets, but the separation of the three major markets in the state (Cleveland, Cincinnati, and Columbus) limits alignment across those markets. Almost every interviewee mentioned the differences among the three major markets and that they function fairly autonomously in the absence of a history of strong state leadership.

Authority

Formal authority for achieving health system change, particularly in payment models, is quite limited. As in every state, the Ohio Medicaid agency can define the terms of its purchasing and has done so in a manner that aligns with the state’s overarching goals. The state’s Medicaid statute is quite general, giving significant latitude to the Medicaid agency in the requirements it places on contracting health plans.

The legislature has historically deferred heavily to the executive branch on health policy. In 2013, the legislature created the JMOC with a mission to review Medicaid’s effect on public and private coverage, assess reforms proposed by the Medicaid director, and recommend policies and improvements to the program. The JMOC arose in part in response to Governor Kasich’s decision to circumvent the legislature and instead go to the state’s Controlling Board to obtain approval of the Medicaid expansion. As its name implies, the JMOC focuses on Medicaid and the Medicaid budget, not the overall health care system. The committee’s oversight is designed to encourage longer-term conversations about Medicaid’s direction. Although it is possible the JMOC will emerge as a home for deeper discussion of health policy, it is too early to know if that will happen, and its status as an oversight committee means it does not refer legislation to the state House or Senate.

Ohio has taken advantage of some of the new authorities created by the ACA. Although Ohio did not create its own health insurance exchange, the state did expand Medicaid and is participating in programs through CMMI. The Cincinnati-Dayton region is one of seven national markets participating in the multipayer Comprehensive Primary Care Initiative, and the state has received two grants through the SIM initiative, described in more detail below. These CMMI initiatives bring significant federal resources and help rally private sector interest around specific policies.
Leverage

The state is mainly leveraging the executive branch to achieve its goals. Through contracts with carriers and purchasing power, the Medicaid program is able to pursue its desired agenda. Funding for the SIM program supports the state’s effort to attract private stakeholders, such as carriers and providers, to participate in delivery system initiatives.

Additional leverage stems from two informal sources. The first is credibility. According to several interviewees outside state government, Greg Moody, hired to run the Office of Health Transformation, and John McCarthy, the Medicaid Director, are both respected and widely viewed as substantive experts. These hires sent a strong message of competence and engagement with the substance of health policy. Governor Kasich himself is described as committed and passionate; his willingness to go out on a limb to achieve the Medicaid expansion was described by many as a major source of credibility that he will succeed when he establishes an agenda.

The second informal source is stakeholders’ desire to maintain good relationships with Governor Kasich. The state is making full use of this desire to secure voluntary participation from the private sector. Participants routinely commented on the importance of staying on the good side of the governor. One frequently mentioned anecdote was a public appearance in which Governor Kasich informed attendees that they could either “get on the bus or get run over by the bus.” The specific causes or consequences of getting run over do not seem to have been made explicit, but everyone understood that it was an undesirable result.

Federal Role

Opportunities from the federal government have facilitated many of Ohio’s initiatives. Although the state’s planning for delivery system reform predates the SIM program, the funding and support provided by the program have enhanced the state’s efforts. Ohio also opted to expand Medicaid, a decision that increases the program’s size and leverage in terms of purchasing power; as mentioned previously, however, the state has not fully embraced the ACA. Leadership in the state still largely supports partial or full repeal of the law.

Role of Medicaid

Medicaid has been one of the primary drivers of Ohio’s delivery system reform agenda. The Medicaid agency has strong rulemaking and contracting authority and has used contract stipulations to drive insurers toward value-based payment. As a large payer, the Medicaid program has purchasing power and influence with insurance plans in the state. Commercial plans are often competing for Medicaid contracts, giving them an incentive to work with the state even if they don’t currently participate in Medicaid.
Medicaid is also the springboard for the SIM project with implementation of episode-based payments and PCMHs. The SIM project’s ultimate goal is for 80 to 90 percent of medical spending in the state to be value-based within five years, building off of the Medicaid payment model of episode payments. The state also plans to scale the PCMH model statewide within the next five years using the strategies described below, covering a majority of the population. The state’s SIM proposal states that “Ohio Medicaid will lead by example, implementing PCMH for its fee-for-service business and requiring managed care organization (MCO) partners to participate with their Medicaid business” and “implement episode-based models, and where it has influence, encourage other payers to move meaningful spend to value-based payments” (Governor’s Office of Health Transformation 2013, 33).

Structure and Processes

Almost immediately upon taking office, Governor Kasich created the Office of Health Transformation (OHT). OHT is an executive-level office with strategic planning and budget authority over Ohio’s health and human services agencies. Although the agency heads do not report to OHT, they are directed to comply with all requests and directives it issues. Rather than an agency, OHT is designed as a coordinating entity to help departments that work on health issues work together more effectively. OHT, along with the Medicaid agency, is a large driver of ideas and policies related to delivery system change in the state. As first designed, the office was only supposed to last 18 months as a temporary force for organizing and focusing on critical issues, but it is now entering its fourth year. It remains temporary in theory, having only a handful of staff and a budget that is largely administrative.

The state relies heavily upon small meetings with individual stakeholders essential to the success of its efforts. Governor Kasich met personally with the leaders of the state’s health plans to secure their commitment to his value-purchasing agenda and the SIM project. The stakeholders most often mentioned were health plans, hospitals and other providers; consumer groups were mentioned little. There was not much use of terms such as “consensus” when describing the approach to garnering support. Describing the process, one participant’s said that “there isn’t any strong arming, but there is a disconnect between stakeholders and what the state chooses to pursue.”

The state also engages stakeholders in workgroups. These are described as addressing more technical issues—the “how to” of payment reforms, rather than the general approach. According to participants, the agenda and approach is largely determined by the administration before the convenings. In the case of episode-based payments, stakeholders were asked to give input on specific details, such as episode definitions, but not on the state’s decision to use the episode payment method.

Strategy for System Change

Although interviewees generally agreed on the state’s goals for system change, accounts differed on how this change would spread from the Medicaid program into the private sector. As discussed previously, the majority of the state’s health system agenda is based on its efforts through the SIM
initiative. The state plans to lead by example by implementing episode-based payment and PCMH in the Medicaid program. The episode-based payment model, also used by Arkansas and Tennessee, involves defining specific “episodes of care,” such as a joint replacement or a heart attack. Each episode has a start and end point, an accountable provider, exclusions, and risk adjustment. Episodic data is extracted from claims and physician performance is measured based on an average across providers. The model can be built on fee-for-service claims and does not require significant physician investment in infrastructure. The first sharing of episode-based payment data occurred recently, but actual payments have not yet changed, and the episode-based methodology has only been applied to six conditions.

One key insight from our interviews was that the administration largely determined the outline and direction for the SIM project, including the use of episode payments and PCMH. This early embrace of episode-based payments as the cornerstone of the agenda to promote value in health care gave clear direction to the state’s early efforts. It enabled Governor Kasich to make a very specific request of key stakeholders, particularly health plans. It gave clear guidance to the Medicaid agency in its approach to payment and health plan contracting. Although stakeholder advisory groups convened, participants indicated that their input was largely sought on implementation details and that the overall approach appeared to be a foregone conclusion. Some participants believed that the administration would modify its approach if stakeholders expressed serious substantive concerns with the approach and could offer an alternative, but that view was not universally held.

The general impression from a range of private sector participants is that among stakeholders there is (1) broad consensus on the need to move toward value payment; (2) openness to the episode payment model as the means for doing so; and (3) broad understanding that such an endeavor needs to be carried out uniformly across payers if it is to have the intended effect.

But what happens next is very unclear, and it is difficult to discern the depth of support for the governor’s approach. Stakeholders appear to be solidly on board in concept and confident that their technical concerns will be heard, but they seem to be holding back on full endorsement of the model until it takes more shape. Some payers and some providers are interested in different payment models that embrace “value” but are carried out differently than the episode model advocated by the administration. Some payers and providers are uncertain what the effects of the episode model will be and whether they will continue to view it as the best approach once it is more broadly applied. No one interviewed could say what will happen in these circumstances. Respondents expressed a general sense that the governor is more interested in seeing action than in the precise method, but they were unsure how the administration would react to a proliferation of “value” models. The state’s limited historical strides combined with few efforts to incorporate stakeholder views in defining the state’s overall approach may yield conflict in the future if stakeholders begin to question the model or Governor Kasich leaves office.
Progress to Date

For reporting and measuring progress, the state has set goals and measures that are largely process-based rather than quantitative. Although one goal is financial savings and economic improvement, the only related measure appears to be limiting Medicaid spending growth. Progress concerning the SIM project largely consists of spreading the initiatives to a wider population and increasing the percentage of value-based payments rather than meeting quality or cost targets.

The major system goals for the state’s SIM initiative include rolling out 50 episode bundles, converting 80 percent of state health spending to value-based payment, including 80 to 90 percent of the population in some value-based payment model, and having a majority of the state’s residents receiving care in a PCMH. As mentioned, the majority of the state’s large carriers and the Medicaid program have agreed to move toward episode-based payment. Although it will be straightforward to measure if the state has succeeded at these efforts in the next five years, these process goals do not automatically yield the overarching goals established by the governor: controlling overall costs, improving the health of the population, or restraining growth in the Medicaid budget.

At the time of interviews, several participants mentioned expecting performance reports for the first six episodes. OHT has since released preliminary slides that illustrate the variation in episode costs and sample provider performance reports (Governor’s Office of Health Transformation 2015). Medicaid, health plans contracting with Medicaid, and participating commercial insurers will each release their own report on claims for the selected episodes. Reporting begins quarterly in 2015 but is not tied to payment until 2016. As stakeholders gain perspective on whether or not the process goals are translating into real savings and improvements, their views about the governor’s agenda, and their willingness to support it, may change.

Sustainability

Governor Kasich and his administration are largely responsible for the state’s agenda and much of the success so far at achieving this agenda. However, much of this success has come from informal authority, especially the governor’s persuasive and charismatic nature and the credibility of some of his policy experts. The governor’s vision increases the state’s role in health care beyond what it has historically been. OHT meets the needs of this administration, but may not meet the needs of future governors, and it could easily be disbanded because it lacks statutory grounding or programmatic authority.

The SIM initiative is the crystallizing and uniting force behind the state’s system improvement agenda. This singular approach provides both a focus for stakeholders around specific policies and considerable federal funding. The state is able to articulate and frame a clear vision for its agenda and define goals related to the program. However, such a singular approach puts the agenda at risk if the initiative is not successful. If episode-based payment does not achieve the goals the state has set, it will
be a considerable setback because most payers and providers will have focused efforts to make their models compatible with that payment method.

The SIM grant will end about the same time as the Kasich administration. With eight years in office, Governor Kasich may be able to institutionalize the changes he has launched, but how they will survive in a new administration is unclear. Continuing this agenda would require that system changes take hold in both the public and private sector, generating momentum that goes beyond the political sphere and state agencies. When asked about sustainability, most participants said they hoped efforts at system improvement would last beyond Governor Kasich’s term, but they were not certain how it would happen. One participant said, “This thing isn’t assured, that it’s going to happen, but there is enough money to throw at it at this point that something is going to get traction.”

Conclusions

The Kasich administration has embraced an agenda of improving the state’s health care system, controlling health care costs, and improving the health of the population. This broad vision appears to be a departure from a narrower set of ambitions that describe previous administrations. The executive branch drives this agenda, although many in the private sector support it. The administration has largely used informal authority to target key stakeholders critical to the success of their efforts. As Ohio lacks a strong history of stewardship and health system reform, it remains to be seen if the current initiatives will outlast the administration leading them.

Notes


References


**About the Authors**

**Alan Weil** became the editor-in-chief of *Health Affairs* on June 1, 2014. For the previous decade he was the executive director of the National Academy for State Health Policy, an independent, nonpartisan, nonprofit research and policy organization. Previously, he directed the Urban Institute’s Assessing the New Federalism project; held a cabinet position as executive director of the Colorado Department of Health Care Policy and Financing; and was assistant general counsel in the Massachusetts Department of Medical Security. He earned his bachelor’s degree from the University of California at Berkeley, a master’s degree from Harvard’s Kennedy School of Government, and a JD from Harvard Law School.

**Rachel Dolan** is the special assistant to the editor-in-chief at *Health Affairs*. Before joining *Health Affairs*, Rachel worked at Families USA on implementation of eligibility policy and the application process, as well as on support for programs that train in-person assisters. Previously, she spent four years at the National Academy for State Health Policy working with states on health reform implementation, particularly on issues related to marketplaces and consumer assistance. Rachel has an MPP from the McCourt School at Georgetown University and graduated summa cum laude from the University of Georgia with a BA.

**Emily Hayes** joined Urban as a research assistant in 2014 soon after graduating from Pomona College, where she majored in public policy analysis with a concentration in politics. She was drawn to Urban’s Health Policy Center as a way to apply her academic experience to her passion for improving health care, which she explored in her senior thesis on children’s access to mental health care. Hayes’s first experience with health policy was during the summer of 2013, when she received an independent research grant to do a qualitative study of coordinated care organizations in Deschutes County, Oregon, where she was born and raised.
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