

The MyCare Ohio Demonstration: Early Successes and Stakeholder Insights on Integrating Care for Dually Eligible Beneficiaries

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Executive Summary

To provide more integrated, coordinated care for its residents who are dually eligible for Medicare and Medicaid, Ohio is partnering with the Centers for Medicare & Medicaid Services (CMS) to test a capitated model demonstration, MyCare Ohio, under the Financial Alignment Initiative. MyCare Ohio aims to: (1) improve quality of care; (2) improve health and functional outcomes; (3) increase enrollee independence; (4) keep enrollees living in the community; (5) reduce health disparities; (6) improve transitions between care settings; and (7) reduce costs. This case study summarizes the demonstration's structure and results achieved to date, and provides stakeholder insights on lessons and promising practices from the demonstration's design and implementation.

- **Demonstration Structure:** Five health plans participate in three-way contracts with CMS and the state of Ohio to deliver all covered Medicare and Medicaid benefits to demonstration enrollees as well as comprehensive care coordination and management. While dually eligible individuals may opt out of receiving Medicare services through the demonstration, those residing in demonstration counties must still enroll with a MyCare Ohio plan to receive Medicaid-covered services including long-term services and supports (LTSS). The state requires health plans to contract with Area Agencies on Aging (AAAs) to coordinate home- and community-based services (HCBS) provided under Medicaid waivers for enrollees age 60 and over.
- **Results to Date:** An external evaluation by RTI International analyzed demonstration implementation between May 1, 2014 and December 31, 2016 and found high levels of enrollee satisfaction with their health plans and care coordination services. In addition, the demonstration resulted in significant reductions in service use, including: 21.3 percent fewer inpatient admissions and 15.3 percent fewer skilled nursing facility admissions. However, early results showed an increase in preventable emergency department visits. This early analysis found no statistically significant Medicare savings or losses; however, future reports will also include Medicaid cost data, which was not available for the first analysis, and will likely present a more complete understanding of potential savings. An internal evaluation by the Ohio Department of Medicaid (ODM) estimated annual savings of \$30 million compared to the Medicaid fee-for-service program, the result of a reduction in the percentage of enrollees living in nursing facilities and increased community placements.
- **Insights on Demonstration Design and Implementation:** Staff from ODM, MyCare Ohio plans, an AAA, the demonstration Ombudsman office, and a trade association representing non-profit LTSS providers shared insights on the demonstration's design and implementation including:
 - » **Design-phase decisions have important downstream effects.** ODM's decision to require dually eligible individuals to enroll with MyCare Ohio plans for their Medicaid benefits appears to have encouraged

beneficiaries to also enroll in the demonstration. However, its decision to move forward with mandatory Medicaid-only enrollment before beginning passive enrollment for the full demonstration caused challenges.

- » **Beneficiaries provide valuable input into demonstration operations.** Beneficiary feedback on specific components of the demonstration, such as communications with care managers and experience with newly covered benefits, has informed program changes, including improving the timeliness of supplemental transportation.
- » **Care management flexibility offers room for innovation.** ODM's original requirements around care management were very prescriptive, causing plans to initially focus more on trying to achieve rigorous contract milestones than on addressing enrollees' needs. Subsequent changes to the requirements allow plans to leverage their clinical and care management expertise.
- » **Plans and community-based entities benefit from collaboration.** As noted above, MyCare Ohio plans are required to contract with AAAs to provide waiver service coordination for enrollees age 60 and over. However, MyCare Ohio plans also have the option to fully delegate care management to external organizations such as the AAAs or retain this function within the plan. Both approaches have advantages and challenges, but the demonstration has created an opportunity for both plans and AAAs to leverage their strengths and work together collaboratively.
- » **Engaging LTSS providers is a key component of integration efforts.** The MyCare Ohio Long-Term Care Collaborative became a forum for the provider associations to help educate the MyCare Ohio plans about long-term care and the needs of their provider members, and for the plans to help the associations and their members understand how to work with managed care plans.

While early evaluation results point to strengths of the MyCare Ohio model, stakeholders believe that its long-term effectiveness will depend on ongoing improvements to data sharing and quality measures and continued stakeholder engagement.

Introduction

People who are dually eligible for Medicare and Medicaid have a higher prevalence of chronic conditions, including diabetes, dementia, and mental illness than individuals eligible for only Medicare or Medicaid.² They also face challenges related to social risk factors (e.g., lower educational levels, housing instability) that put dually eligible individuals at higher risk for poor health outcomes.³ Moreover, a lack of coordination between Medicare and Medicaid makes it difficult for them to access needed care and increases program costs.

In 2011, the Centers for Medicare & Medicaid Services (CMS) announced the Financial Alignment Initiative, which allows states to test new payment and service delivery approaches that fully integrate care for dually eligible individuals.^{4,5} Through the Financial Alignment Initiative, CMS and the Ohio Department of Medicaid (ODM) are testing a capitated model, which is called MyCare Ohio. By fully integrating a comprehensive array of Medicare and Medicaid services, MyCare Ohio's goals are to: (1) improve quality of care; (2) improve health and functional outcomes; (3) increase enrollee independence; (4) keep enrollees living in the community; (5) reduce health disparities; (6) improve transitions between care settings; and (7) reduce costs.⁶

This case study provides an overview of the MyCare Ohio demonstration. It summarizes the results to date and provides stakeholder insights on lessons and promising practices from the demonstration's design and implementation. Case study insights may be helpful for state Medicaid agencies looking to integrate care for dually eligible beneficiaries in capitated delivery systems.

Background on Ohio’s Managed Care Experience

Ohio has a long history of providing Medicaid services through managed care programs, but dually eligible individuals and people enrolled in home- and community-based services (HCBS) waiver programs had always been excluded from these arrangements. Similarly, although Ohio had a relatively high Medicare Advantage penetration rate in 2011 — 36 percent — the majority of dually eligible beneficiaries in the state were receiving their Medicare benefits through fee-for-service arrangements.⁷ Therefore, the state’s decision to pursue a capitated model demonstration led to significant changes for dually eligible beneficiaries as well as for Medicaid providers, particularly providers of long-term services and supports (LTSS).

A key aspect of MyCare Ohio’s design is that while dually eligible individuals who reside in demonstration counties may opt out of the demonstration and elect to receive their Medicare benefits through Medicare fee-for-service or a Medicare Advantage plan, they must still enroll with a MyCare Ohio plan to receive their Medicaid-covered services including LTSS. (For more information see, **Eligibility and Enrollment** below.)

MyCare Ohio Demonstration Structure

This section describes the overall structure of the MyCare Ohio demonstration, including eligibility criteria, background on key entities, benefits provided, the care management model, and the payment model. It also discusses how stakeholders were engaged in demonstration design and ongoing implementation.

Eligibility and Enrollment

To be eligible for the demonstration, individuals must be 18 years or older, qualify for both Medicaid and Medicare, and live in one of seven regions covering 29 counties in the state where the demonstration operates (see blue shading in **Exhibit 1**).⁸

As described above, just prior to the demonstration’s launch, Ohio began to mandate that eligible individuals enroll in MyCare Ohio plans for their Medicaid services.⁹ Beginning in May 2014, dually eligible individuals could voluntarily opt-into the demonstration and select a MyCare Ohio plan for their Medicare and Medicaid services. Starting in January 2015, all dually eligible individuals who did not opt-in were passively enrolled into the demonstration.¹⁰ These individuals could choose to opt out of the demonstration or disenroll, but if they did so, they had to remain enrolled in a MyCare Ohio plan to receive their Medicaid benefits, including LTSS.

As of July 2019, the MyCare Ohio demonstration had 80,788 enrollees, representing the second largest enrollment among the nine other capitated model demonstrations currently operating under the Financial Alignment Initiative.¹¹ MyCare Ohio has the highest enrollment penetration of all the demonstrations nationally, with 70 percent of eligible individuals enrolled. Another 26,000 dually eligible beneficiaries in Ohio receive their Medicaid benefits only through MyCare Ohio plans after choosing not to enroll in the demonstration.¹²

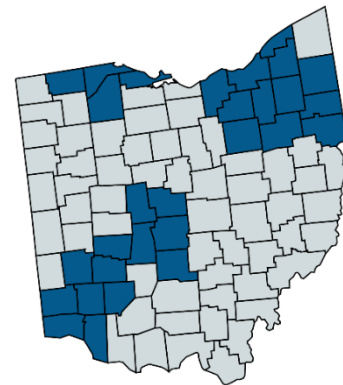


Exhibit 1. MyCare Ohio Demonstration Counties.

Covered Benefits

MyCare Ohio enrollees still receive all the Medicare and Medicaid benefits they had before the demonstration began, and also receive a new, more comprehensive level of care coordination and management along with new services and benefits. Enrollees also may receive an enhanced array of HCBS. Previously, individuals could only receive the HCBS provided by the specific waiver program in which they were enrolled. Now, all MyCare Ohio enrollees have access to the entire array of HCBS waiver services covered by the state. In addition, they may receive “value-added” benefits (e.g., enhanced dental benefits, additional transportation benefits) that vary by plan.

MyCare Ohio Plans and Area Agencies on Aging

The five competitively selected MyCare Ohio plans — Aetna, Buckeye (Centene), CareSource, Molina, and UnitedHealthcare — have three-way contracts with CMS and ODM for the demonstration and separate two-way contracts (also known as provider agreements) with ODM for the Medicaid-covered benefits that they provide to dually eligible individuals not in the demonstration.

In Ohio, the Area Agencies on Aging (AAAs) have been responsible for coordinating all HCBS waiver services for beneficiaries age 60 and older for more than 25 years. To maintain the AAAs’ long-standing relationships with beneficiaries and providers, the state required MyCare Ohio plans to contract with the AAAs to continue to provide waiver services coordination for demonstration enrollees age 60 and over.¹³ MyCare Ohio plans may also choose to fully delegate all care management for all demonstration enrollees to external organizations such as AAAs. Two of the five plans — Aetna and CareSource — have chosen to do so for specific populations.

Care Management Model

MyCare Ohio emphasizes the importance of person-centered care management and the ability of enrollees to live independently. The plans must coordinate all Medicare and Medicaid benefits and also meet the needs of certain sub-populations (e.g., those with behavioral health needs, chronic conditions, etc.) and at different levels of risk (e.g., monitoring, low, medium, high, and intensive).¹⁴

Using a variety of data, plans assign enrollees to a risk level and then conduct either a health risk assessment (for enrollees in the monitoring and low risk groups) or a comprehensive assessment (for individuals in the moderate, high, and intensive risk groups and any waiver consumer). All enrollees have a care manager who also leads the transdisciplinary care team that must include the enrollee, the AAA waiver service coordinator (if applicable),¹⁵ primary care provider, specialists, other providers as needed, and family members/caregivers as requested.¹⁶ The care team must complete assessments no later than 75 days after the individual’s effective date of enrollment. Initial care plans must be developed within 15 calendar days of the assessment completion date. Care managers must have in-person visits once every two months with individuals in the intensive risk category, and every three and six months for those at high and medium risk, respectively. Plans may set their own contact schedules, with ODM approval, for enrollees in the monitoring and low-risk categories.

Payment Model

MyCare Ohio plans receive prospective capitated payments that cover Medicare Parts A and B services, Medicare Part D services, and Medicaid services. As in all the capitated model demonstrations, the Medicare Parts A and B portion of the rate is risk-adjusted at the beneficiary level using the CMS Hierarchical Condition Category (HCC) and the CMS-HCC ESRD models.¹⁷ The Part D portion is risk-adjusted using the Part D national average monthly bid amount and a beneficiary's prescription drug HCC risk score. The Medicaid portion of the payment is risk-adjusted using a retrospective member-mix adjustment, which is designed to provide greater revenue to plans with high-risk beneficiaries.¹⁸

A portion of the plans' capitated rate is withheld to incentivize them to meet quality thresholds set by CMS and ODM.¹⁹ Based on performance compared to the quality thresholds,²⁰ plans can earn back all or part of the withheld amount. For MyCare Ohio, the quality withhold percentages started at 1 percent in Year 1 and increased to 3 percent as of Year 3.²¹ Starting in Year 6, a separate 1 percent quality withhold also applies to the Medicare Parts A and B amount.

Additionally, aggregate savings percentages are applied to the Medicare Parts A and B and Medicaid components of the capitated rate, starting at 1 percent in Year 1 and increasing to 4 percent as of Year 3.²²

Stakeholder Engagement

During the demonstration's design phase, ODM and the Ohio Department of Aging held regional forums for stakeholders including LTSS providers, the AAAs, home care providers, and others to share insights on the initial demonstration proposal and design.

The state also established a multi-stakeholder Enrollment Advisory Workgroup to inform its enrollment process. After enrollment began, Ohio restructured this group to become the MyCare Ohio Implementation Team, with a broader scope and membership (e.g., enrollees, MyCare Ohio plans, providers, AAAs, CMS, other state agencies, and the state's long-term care Ombudsman). The Implementation Team meets regularly to discuss demonstration updates, key findings, and other topics.²³

The three-way contract requires that MyCare Ohio plans collect beneficiary input through beneficiary advisory committees (BACs). Plans must have a committee in each of the demonstration regions in which they operate.

Results to Date

CMS contracted with RTI International to evaluate the impact of the MyCare Ohio demonstration on beneficiary experience, quality of care, service use, and cost of care. RTI's first evaluation report, released in November 2018, drew upon information from multiple sources to analyze demonstration implementation between May 1, 2014 and December 31, 2016.²⁴ In addition, ODM released its own evaluation of MyCare Ohio in June 2018 that included additional data from ODM enrollment files and plan-reported data through 2017.²⁵ Results from these two evaluations are summarized in **Exhibit 2**.

Exhibit 2. Summary of Evaluation Findings.

Domain	RTI Evaluation ²⁶	ODM Evaluation ²⁷
Beneficiary Experience and Access to Care	<p>Most enrollees responding to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey were very satisfied with their health plan, rating it as a 9 or 10 out of 10.</p> <p>Focus group participants’ satisfaction level often related to how their new coverage aligned with their needs, and those who encountered limits due to prior authorization requirements were less satisfied.</p> <p>For each plan, 73-100% of enrollees who used care coordination reported being very or somewhat satisfied with these services.</p> <p>Enrollee awareness of their care managers increased over time. CAHPS survey results by plan showed that a majority of enrollees found it to be “usually” or “always” easy to access behavioral health service, LTSS, or durable medical equipment when they needed it.</p>	<p>Improvement in CAHPS results from 2016 to 2017.</p> <p>2017 independent survey of enrollees found 70% were satisfied with their care manager.</p>
Care Coordination	<p>Use of care coordination services increased between 2015 and 2016 in four of five plans.</p> <p>In 2016, 26-43% of enrollees in each MyCare Ohio plan received help coordinating care from their health plan, doctor’s office, or clinic. Then, of those who received care coordination, 73-100% were somewhat or very satisfied with this help.</p>	<p>The rate of assessment completion within 90 days increased from 60% in 2014 to 84% in 2017.</p> <p>The percentage of enrollees with a documented care plan increased from 33% in 2014 to 77% in 2017.</p> <p>The percentage of hospital discharges with ambulatory care follow up visits within 30 days increased from 49% in 2014 to 79% in 2017.</p>
Quality of Care	<p>In 2015, plans had mixed performance on Healthcare Effectiveness Data and Information Set (HEDIS) measures. All or most MyCare Ohio plans reported rates better than the national Medicare Advantage plan mean on select HEDIS measures such as antidepressant medication management, outpatient visits per 1,000 members, annual monitoring for patients on persistent medications, initialization and engagement of alcohol and other drug dependence treatment, and follow-up after hospitalization for mental illness. However, the plans performed below the national Medicare Advantage plan means on six other measures, including plan all-cause readmissions, comprehensive diabetes care, blood pressure control, adults’ access to preventive/ambulatory health services, disease modifying anti-rheumatic drug therapy in rheumatoid arthritis, and emergency department visits.</p>	<p>In 2017, plan performance on HEDIS measures compared favorably to the national benchmarks.</p> <p>Nearly 60% of the reported MyCare Ohio plan 2017 HEDIS rates exceeded the 75th percentile of the national benchmarks.</p>
Service Use	<p>There was a significant reduction in service use between the two-year pre-demonstration period (May 2012-April 2014) and the first demonstration period (May 2014-December 2015) as measured against a comparison group.</p> <p>Service use reductions included 21% fewer inpatient admissions, 6% fewer physician evaluation and management visits, and 15% fewer skilled nursing facility admissions.</p> <p>However, there was a 10% increase in preventable emergency department (ED) visits, and no statistically significant effect on overall ED visits.</p>	<p>Not evaluated.</p>
Cost Savings	<p>No statistically significant Medicare savings or losses found over the first two demonstration periods (May 1, 2014 through December 31, 2016).</p> <p>Medicaid data was not available for this analysis, and future analyses that include both Medicare and Medicaid cost data will likely present a more complete understanding of potential savings.</p> <p>State officials reported cost savings resulted from reductions of hospital admissions and readmissions and lower use of skilled nursing facilities.</p>	<p>Estimated an annual savings of \$30 million compared to the Medicaid FFS program as a result of the incremental rebalancing achieved by MyCare Ohio plans.</p>

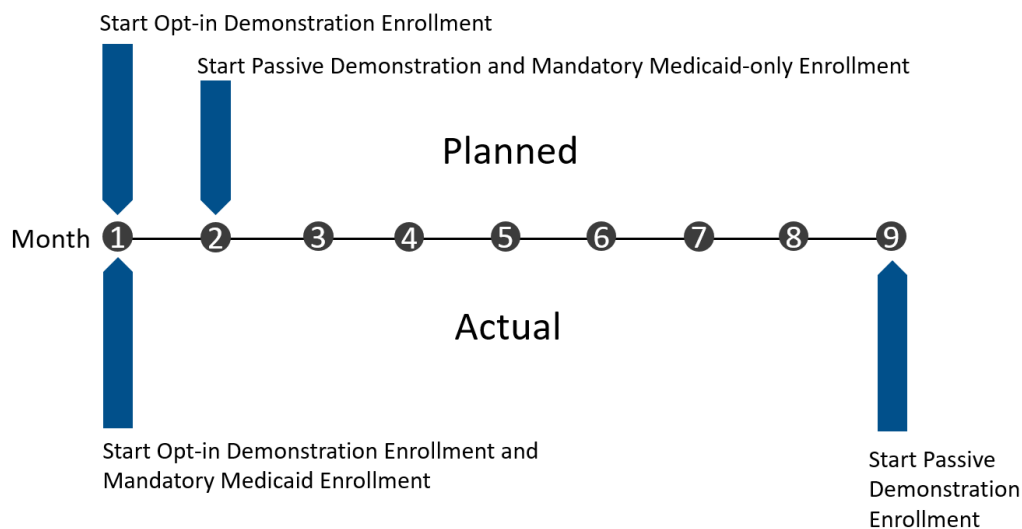
Insights on Demonstration Design and Implementation

To gain further insight into the design and implementation of the MyCare Ohio demonstration, ICRC interviewed staff from: (1) ODM; (2) two MyCare Ohio plans — CareSource and Molina; (3) an AAA — Direction Home Akron Canton; (4) the demonstration Ombudsman’s office; and (5) Leading Age, a trade association representing not-for-profit LTSS providers. Following are insights from those conversations:

Design-phase decisions have important downstream effects.

The state originally planned to launch MyCare Ohio with one month of opt-in enrollment, to be followed by the start of passive enrollment — for both Medicare and Medicaid benefits — in phases across the seven demonstration regions. However, due to complications, ODM could not begin passive enrollment on this schedule. Instead of delaying all enrollment until it could do passive enrollment for both Medicare and Medicaid benefits at the same time, ODM chose to begin opt-in enrollment into the demonstration in three phases across the seven regions. Simultaneously, it started passive enrollment into MyCare Ohio plans for Medicaid-only benefits (see **Exhibit 3** for a timeline).

Exhibit 3. Planned versus Actual Timeline for MyCare Ohio Enrollment.



Between May 1 and October 31, 2014, 100,341 dually eligible beneficiaries were enrolled in MyCare Ohio plans for Medicaid benefits only, and another 14,957 voluntarily enrolled in these plans under the demonstration and were receiving both Medicare and Medicaid benefits. Another 60,000 people were enrolled in the demonstration in January 2015 — the month that passive enrollment in the demonstration began in all seven regions at the same time.

Requiring mandatory enrollment for Medicaid benefits coupled with changes to the timing of passive enrollment had downstream effects. On one hand, the longer-than-anticipated ramp up to passive demonstration enrollment allowed the state, the MyCare Ohio plans, and AAAs to identify and address early issues related to eligibility determination, enrollment procedures, claims processing, and transportation. In addition, ODM’s decision to require dually eligible individuals to enroll with MyCare Ohio plans for their Medicaid benefits does appear to have encouraged them to also enroll in the demonstration over the longer term. About 70 percent of those eligible for the MyCare Ohio demonstration have enrolled — a higher penetration rate than any of the other capitated model

Financial Alignment Initiative demonstrations. This high penetration rate has been sustained throughout the demonstration by ODM's decision to conduct ongoing passive enrollment of newly dually eligible beneficiaries into MyCare Ohio plans.

On the other hand, these early design choices created other challenges:

- **Confusing beneficiary notices.** RTI's evaluation report noted that some of the MyCare Ohio plans it interviewed said that, during the opt-in period, beneficiaries were confused by the notices they received and unsure of what benefits MyCare Ohio covered. This confusion seems to be borne out by an increased volume of calls to the Ohio Senior Health Insurance Information Program, Ohio Medicaid Consumer Hotline, and the AAAs by beneficiaries asking for assistance.
- **Backlogs in locating and assessing new enrollees.** The large number of enrollees entering MyCare Ohio plans made it difficult for the plans and the AAAs to complete assessments within required timeframes. CareSource noted that the AAA to which it delegated all care management activities had more than 3,000 assessments to complete within 90 days.
- **Staff turnover.** To cope with enrollee volume, plans and AAAs had to quickly hire additional care management staff. Even so, RTI reported that the pressure of needing to complete so many assessments contributed to a high turnover rate among care managers. Also, as plans staffed up, there was considerable shifting of member caseloads from one care manager to the other.

Several of the stakeholders that ICRC interviewed hoped that the state would consider a more phased enrollment approach for any future endeavors.

Beneficiaries provide valuable input into demonstration operations.

Beneficiary feedback on specific components of the MyCare Ohio demonstration, including communications with care managers and experience with newly covered benefits, has informed specific program changes to improve enrollee satisfaction. ICRC's interviews with MyCare Ohio stakeholders identified the importance of creating opportunities for enrollees to provide feedback on issues that plan leadership cannot learn from survey results or other formal activities alone. For example, CareSource enrollees reported to the plan that they were unsure where to go for care in different situations, so the plan made refrigerator magnets listing guidelines on when to go to different care settings.

MyCare Ohio plans must establish at least one beneficiary advisory committee (BAC) in each demonstration region in which they operate to obtain enrollee and community input on program management.²⁸ Plans set up and manage BACs in different ways, with some specifically seeking enrollee input on policies and benefits and others serving more as a vehicle to provide enrollees with information on how to access services and other topics.

Plans cite the importance of using innovative strategies to recruit and train BAC members as well as structure BAC projects. Recruiting a representative group of enrollees to participate in BACs can be a challenge. Instead of using a large recruitment mailing, CareSource sent invitations to an upcoming BAC meeting just to enrollees living with a limited radius of the meeting location, and found not only that these enrollees attended, but that they returned to participate in additional meetings. CareSource also partnered with Ohio Consumer Voices for Integrated Care to train enrollees on how to effectively participate in BACs, which helped to establish expectations and foster a productive BAC experience.

To foster more robust engagement across all plans' BACs, the Office of the State Long-Term Care Ombudsman offered recommendations to plans on effective ways to engage enrollees. For example, plans could highlight participating enrollees in their newsletters, as one plan has done, and share meeting minutes with the full membership to ensure plan accountability to all enrollees. Additionally, the Ombudsman recommended that the

state address the low representation of nursing and assisted living facility residents in BAC activities across the plans, to ensure that these committees reflect the diversity of the membership. For more information on the Ombudsman's role, see the call out box **Demonstration Ombudsman Performs an Important Oversight Function**.

Finally, although there was agreement on the value of the BACs to gather enrollee input on ongoing plan operations, the long-term care Ombudsman noted that the demonstration could have benefited from more robust beneficiary engagement both in the design and early implementation phases, as well as greater opportunities for beneficiaries to communicate with ODM. Beneficiaries did not generally participate in the Enrollment Advisory Workgroup or the Implementation Team. The Ombudsman hoped that beneficiaries would have the opportunity to provide input on any future demonstration changes.

Demonstration Ombudsman Performs an Important Oversight Function

The MyCare Ohio Ombudsman, part of the Office of the State Long-Term Care Ombudsman, is tasked with advocating for a better enrollee experience in the demonstration. The Ombudsman performs multiple functions, including:

- Conducting outreach to beneficiaries to explain the demonstration and answer questions;
- Advocating for beneficiary interests at both the state and plan levels;
- Participating in plans' beneficiary advisory committee meetings;
- Receiving complaints and assisting enrollees with grievances and appeals processes;
- Working with ODM and MyCare Ohio plans to resolve issues identified by beneficiaries.²⁹

The ombudsman believed that its early meetings with MyCare Ohio plans, prior to the demonstration's launch, were an excellent opportunity to convey its expectations around quality and how it could partner with plans to ensure that enrollees would receive needed services. As an example of its response to specific areas of beneficiary complaint, the Ombudsman cited its work to engage ODM and plans to modify the three-way contract to improve the timeliness of supplemental transportation.³⁰ In its focus groups, RTI found that enrollees were very familiar with the Ombudsman program, which contributed to its effectiveness.³¹

Care management flexibility offers room for innovation.

The MyCare Ohio care management model, as defined in the original three-way contract for the demonstration, included very prescriptive requirements around timelines for completion of assessment and care plans as well as the frequency of care manager contacts with enrollees. Soon after the demonstration's launch, the joint CMS-state Contract Management Team (CMT) recognized that MyCare Ohio plans were not consistently completing assessments or care plans within the required timeframes. Key reasons for these issues include: (1) the difficulty of locating enrollees; (2) lack of willingness of enrollees to participate; and (3) the volume of assessments and care plans to be completed. The CMT established performance improvement requirements in November 2014, and plans worked to comply by devoting additional staff resources to locating enrollees.

Although all plans achieved 80 percent compliance with the assessment timeframe requirements by October 2016, several plans experienced ongoing challenges, and ODM staff described how care management requirements still encouraged plans to focus on compliance rather than on meeting enrollees' needs.³²

A 2017 contract revision promoted a population health approach and created new flexibilities for plans to conduct assessments based on enrollee needs and to reduce the frequency of care managers' in-person visits in some situations.³³ ODM characterized these changes as a way to encourage plans to build the necessary capacity to

improve care management and focus resources where plans identified the greatest needs. In ICRC's interviews with CareSource and Molina, plan representatives welcomed the new requirements as an opportunity to allow care managers to use their clinical expertise in working with enrollees.

MyCare Ohio plans have had to think creatively about their care management models, which they have restructured to meet the goals and timelines of the demonstration. Representatives from CareSource described how it has adapted its care management model (see the call out box **CareSource's Care Management Model Supports LTSS Rebalancing Efforts.**)

CareSource's Care Management Model Supports LTSS Rebalancing Efforts

For the MyCare Ohio demonstration, CareSource restructured its care management model to support LTSS rebalancing.³⁴ It seeks to identify individuals in nursing facilities who are ready to transition to the community and to ensure community supports are in place to keep them safely at home. This effort included:

- **Restructuring and redeploying its care manager work force.** CareSource geographically redistributed its care managers so that they work with fewer nursing facilities. In addition, it redesigned workflows so that care managers can devote more time to high-need members and communicate more effectively with other care team members. CareSource also assigned a select team of care managers to focus only on coordinating services for members who are transitioning from nursing facilities to the community.
- **Using a discharge readiness planning tool.** To help care managers identify individuals who no longer need skilled care, CareSource uses a discharge readiness tool, the Activity Measure for Post Acute Care (AM-PAC™) tool, which has questions about mobility, individuals' readiness and willingness to return home, and potential barriers with leaving the facility. Care managers use the tool to ensure the member has sufficient HCBS waiver services in place to support their transition home.
- **Improving coordination with nursing facilities.** CareSource's partner, University Hospital, hired 15 Advanced Practice Nurses (APNs) to work in its post-acute care facilities. The APNs coordinate with CareSource's care managers on discharge planning for individuals identified through AM-PAC™ who are ready to transition home. APNs also provide clinical services to "treat in place" facility residents who develop conditions that might otherwise require a hospital admission.

Plans and community-based entities benefit from collaboration.

To leverage the AAA's expertise in coordinating LTSS and serving older adults, MyCare Ohio plans must contract with AAAs to provide HCBS waiver service coordination for all enrollees age 60 and older. For all other care management, plans may choose to delegate that function or retain it within the plan. Each approach has advantages and challenges, but both have the potential to foster greater collaboration between MyCare Ohio plans and the community-based AAAs.

Two plans — CareSource and Aetna — chose to fully delegate care management to AAAs for all or a portion of their membership. ODM believes that the biggest advantage of this approach is that enrollees have a single point of contact to coordinate their medical, behavioral health, and LTSS needs. CareSource contracts with three AAAs — Western Reserve, Direction Home Akron Canton, and Direction Home of Eastern Ohio. In ICRC's interviews with CareSource and Direction Home Akron Canton, both organizations reported that the biggest challenge of the fully delegation approach is that the AAA's care management staff needed plan-specific training to customize their skills in disease management and patient navigation. Optimizing this model requires plans and AAAs to invest in training and build trusting relationships. CareSource and Direction Home described AAAs as needing to make a cultural shift from

a strictly social model of care to one that also incorporates physical and behavioral health. To facilitate this transition, CareSource has invested in ongoing trainings with the Institute for Healthcare Improvement’s 4M Age-Friendly Care Model,³⁵ a dynamic staff training curriculum. Direction Home noted that plans and AAAs need to acknowledge each other’s strengths. AAAs, which have long worked in communities with MyCare Ohio members, brought key skills to the demonstration’s care management model (see the call out box **Direction Home’s Collaboration with Health Plan Partners**).

The three other MyCare Ohio plans — Buckeye (Centene), Molina, and UnitedHealthcare — contract with AAAs to coordinate waiver services only for enrollees age 60 and older. ODM staff had previously suggested that, in this partial delegation approach to care management, enrollees may be confused about when to communicate with their plan care manager versus their AAA waiver service coordinator.³⁶ To help eliminate confusion, Molina developed clear workflows that ensure waiver service coordinators and care managers efficiently collaborate on care management across the plan and AAA staff. Staff from Molina believed that this approach best leveraged their expertise in managing medical services as well as the historical expertise of AAAs in coordinating LTSS.

Both the fully delegated and waiver service coordination approaches require plans and AAAs to collaborate. They have developed new information-sharing protocols and data capabilities to optimize the flow of information between partners. To share member data with AAAs, some MyCare Ohio plans provide the AAAs with direct access to their plan electronic health record system, while others create separate dashboards for AAA staff. Molina recently partnered with AAAs to synthesize members’ medical information, and it developed a quick reference tool to train AAA staff. Both CareSource and Molina support the participation of health systems and other stakeholders in future initiatives to redesign clinical information-sharing for MyCare Ohio to help ensure a “one-member view” of key information for AAA staff.

Direction Home’s Collaboration with Health Plan Partners

Direction Home Akron Canton Area Agency on Aging & Disabilities (Direction Home) has a 40 year history as an Aging and Disability Resources Center, managing all of Ohio’s HCBS waiver programs and providing case management services through the Older American Act.

Representatives from Direction Home believed that two key strengths make them valuable partners to MyCare Ohio plans. First, Direction Home embeds its nurses in hospitals, which allows it to know when a “hard-to-locate” individual is admitted and also quickly identify plan members who are hospitalized so that transition planning can begin right away. Second, Direction Home understands social determinants of health. Its care managers know the intimate details of enrollees’ lives (e.g., their daughter’s name and phone number, which neighbor can look in on the enrollee, they have a pet that needs to be cared for if the enrollee is hospitalized).

While Direction Home acknowledges that it can be challenging to work in a managed care environment and learn about new billing and information systems unique to each health plan, it believes that it has forged successful partnerships with MyCare Ohio plans. Direction Home has implemented a pay-for-performance model with CareSource that advances quality initiatives for demonstration enrollees. This pay-for-performance model aligns with federal and state quality initiatives and drives improved health outcomes for the enrollees.

Engaging LTSS providers is a key component of integration efforts.

The MyCare Ohio demonstration was the first time in Ohio that Medicaid LTSS had been covered through a managed care arrangement. Facility-based long-term care providers and HCBS providers had no experience working in a managed care environment. Similarly, none of the five MyCare Ohio plans had prior experience managing Medicaid benefits for dually eligible populations in Ohio.³⁷

The state and the MyCare Ohio plans undertook several initiatives to engage LTSS providers in the demonstration and improve nursing facility quality. To obtain input from LTSS providers on the demonstration's design, ODM convened an Enrollment Advisory Workgroup consisting of: the AAAs; the long-term care Ombudsman; and representatives from the Centers for Independent Living, the three nursing facility provider associations (LeadingAge Ohio, the Ohio Health Care Association, and the Academy of Senior Health Sciences, Inc.), and the Ohio Council for Home Care & Hospice. After the demonstration's start, ODM rebranded this group as the MyCare Ohio Implementation Team, adding representatives from other organizations (e.g., the MyCare Ohio plans, providers, additional state agencies, and CMS) and expanding the scope of its activities. The state used this group to provide stakeholders with implementation updates, discuss special topics, and present key research findings.

The Implementation Team's meetings were not intended as a forum to resolve implementation challenges affecting enrollees and providers broadly. Instead, state officials addressed these issues through collaborative workgroups on long-term care and behavioral health (see the call out box **LeadingAge Ohio: Finding Value in Collaboration**). For example, the MyCare Ohio Long-Term Care Collaborative became a forum for the provider associations to help educate the MyCare Ohio plans about long-term care and the needs of their provider members, and for the plans to help the associations and their members understand how to work with managed care plans. Representatives from both LeadingAge and Molina commented on the value of the Collaborative in building engagement.

LeadingAge Ohio: Finding Value in Collaboration

The MyCare Ohio Long-Term Care Collaborative formed in 2014. The membership of this group included LeadingAge Ohio, the association of non-profit nursing facilities and hospices, as well as the other two long-term care associations and the five MyCare Ohio health plans. The group was mainly focused on resolving billing issues to ensure that nursing facilities could be paid.

Representatives from LeadingAge noted that the health plan staff attending the Collaborative's meetings had a higher-level policy focus, and often needed to follow up with their operational staff regarding questions that came up during meetings. Eventually, a sub-group formed that included operations staff from the plans.

LeadingAge reported that this subgroup helped to develop workable processes for nursing facility providers that the associations were then able to disseminate to their members. In addition, through their participation in the sub-group, nursing facility providers were able to educate the MyCare Ohio plans about processes for billing nursing facility stays. The Collaborative disbanded in 2016 after initial implementation challenges were largely resolved. LeadingAge staff reported that they continue to communicate directly with the MyCare Ohio plans and viewed the Collaborative as very helpful in helping them to establish these relationships.

Improving the quality of nursing facility care was another area of opportunity for ODM and the MyCare Ohio plans to engage providers. In its demonstration proposal, the state described its efforts to increase the value of health care by using payment reform to reward the delivery of high-quality, person-centered care.³⁸ As envisioned, the demonstration would build on previously enacted reforms to nursing facility reimbursement that better linked Medicaid payment to direct care for residents and quality.

All of the MyCare Ohio plans have established value-based payment (VBP) programs with nursing facility providers. For example, Molina currently has one VBP model in place, the Quality Living Program, which provides financial incentives, resident and community integration activities, and facility supports to 106 qualifying facilities in two networks (see the call out box **Molina’s Quality Living Program** for additional details). Molina reports improvements in the quality of care for residents of these facilities, and it is finalizing plans to implement another VBP model focused on post-acute care. Staff from LeadingAge commented that they believe there is opportunity for refinement of the demonstration’s VBP criteria so that they provide better incentives to providers to think creatively and proactively engage in the care of facility residents to improve outcomes.

Molina’s Quality Living Program³⁹

Molina rewards nursing facilities that meet or exceed specific performance criteria. It developed the Quality Living Program in 2017 as a pilot in 13 counties. Molina invites facilities to participate at three different levels — Platinum, Gold, or Silver — based on the facility’s Star Ratings and the number of facility residents who are Molina members. Facilities are eligible to receive an additional payment per resident per month for meeting or exceeding quality and performance measure thresholds in various categories. Facilities also receive additional benefits, including monthly plan-supported activities for residents, money to purchase equipment to benefit all facility residents, value-added services for members (e.g., a blanket, socks, and tote bag), and a dedicated provider services representative.

The Molina Quality Living Program covers approximately 700 MyCare Ohio members and has resulted in a 25 percent facility improvement rate across five key quality measures.

Summary

The MyCare Ohio demonstration seeks to: (1) improve quality of care; (2) improve health and functional outcomes; (3) increase enrollee independence; (4) keep enrollees living in the community; (5) reduce health disparities; (6) improve transitions between care settings; and (7) reduce costs. Early evaluation results suggest that the demonstration is achieving many of these goals. In addition, its design has successfully encouraged dually eligible beneficiaries to enroll.

Some early enrollment-related challenges were overcome, and the demonstration’s care management model has evolved to allow participating health plans more flexibility to design approaches that meet the needs of their enrollees. MyCare Ohio plans and their community-based partners are working to improve quality through value-based payment arrangements. The state and other stakeholders have learned to work collaboratively and have built mechanisms to support ongoing communication and problem solving. While early evaluation results point to strengths of this model, its long-term effectiveness will depend on continued stakeholder engagement and ongoing improvements to data sharing and quality measures.

The information in this case study may be helpful to state Medicaid agencies, particularly those looking to integrate care for dually eligible beneficiaries in capitated delivery systems.

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ABOUT THE INTEGRATED CARE RESOURCE CENTER

The *Integrated Care Resource Center* is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by [Mathematica](#) and the [Center for Health Care Strategies](#). For more information, visit www.integratedcareresourcecenter.com.

ENDNOTES

¹ Ms. Rava was formerly a program associate at the Center for Health Care Strategies.

² Centers for Medicare & Medicaid Services (CMS). Medicare-Medicaid Coordination Office. "Medicare-Medicaid Coordination Office Fiscal Year 2022 Report to the Congress." 2023. Available at: <https://www.cms.gov/files/document/mmco-report-congress.pdf-0>

³ Assistant Secretary for Planning and Evaluation. "Report to Congress: Social Risk Factors and Performance under Medicare's Value-Based Purchasing Programs." December 2016. Available at: <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>

⁴ Ten states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Texas, Rhode Island, South Carolina, and Virginia) used the capitated model in which the state and CMS enter into three-way contracts with health plans to cover all Medicare and Medicaid services in return for a blended prospective payment. Virginia ended its demonstration as of December 31, 2017. New York State has two capitated demonstrations: Fully Integrated Duals Advantage (FIDA); and FIDA I/DD, which enrolls dually eligible beneficiaries with intellectual and developmental disabilities. For more information on the demonstrations, see: Centers for Medicare & Medicaid Services. "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees." SMDL 11-008. July 2011. Available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

⁵ A demonstration in Minnesota is testing an alternative integration model that is separate from the capitated or MFFS models being tested in the other Financial Alignment Initiative demonstrations.

⁶ State of Ohio. "State Demonstration to Integrate Care for Medicare-Medicaid Enrollees. Proposal to the Center for Medicare and Medicaid Innovation." April 2012. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioProposal.pdf>

⁷ Kaiser Family Foundation. "Medicare Advantage 2012 Data Spotlight: Enrollment Market Update." May 2012. Available at: <http://kff.org/health-costs/report/medicare-advantage-2012-enrollment-market-update>

⁸ Populations not eligible for the demonstration include individuals who: (1) have intellectual or development disabilities (I/DD) and are served through an I/DD 1915(c) home and community-based services (HCBS) waiver or intermediate care facility for individuals with I/DD (ICF-I/DD); (2) are dually eligible but have third-party creditable health care coverage; (3) are dually eligible but are on a delayed Medicaid spend-down whose Medicaid coverage is not continuous; or (4) are enrolled in the Program of All-Inclusive Care for the Elderly (PACE).

⁹ In the capitated model demonstrations under the Financial Alignment Initiative, participating health plans are referred to as "Medicare-Medicaid Plans" (MMPs). In Ohio, plans provide both Medicare and Medicaid benefits to some members and Medicaid-only benefits to others, so this case study will refer to them as MyCare Ohio plans.

¹⁰ Passive enrollment is an enrollment process through which an eligible individual is enrolled into a Medicare-Medicaid Plan following a minimum 60-day advance notification from the enrollment effective date that includes the plan selection and the opportunity to cancel the passive enrollment into the demonstration prior to the effective date. The individual may opt-out of passive enrollment at any time.

¹¹ “Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, July 2018 to July 2019.” Integrated Care Resource Center, February 2019. Not available online.

¹² CMS. “Medicaid Managed Care Enrollment and Program Characteristics, 2017.” Winter 2019. Available at: <https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf>

¹³ CMS and the State of Ohio. “Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with The State of Ohio Department of Medicaid.” Effective October 1, 2017. Not available online.

¹⁴ CMS and the State of Ohio, 2017, op. cit.

¹⁵ Individuals receiving HCBS waiver services also have a waiver services coordinator from an AAA.

¹⁶ CMS and the State of Ohio, 2017, op. cit.

¹⁷ RTI International. “Financial Alignment Initiative MyCare Ohio: First Evaluation Report.” November 15, 2018. Available at: <https://innovation.cms.gov/Files/reports/fai-oh-firstevalrpt.pdf>

¹⁸ CMS and the State of Ohio, 2017, op. cit.

¹⁹ RTI International, 2018, op cit.

²⁰ CMS. “Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes (DY 2-5): Ohio-Specific Measures.” Effective as of January 1, 2016; Issued March 16, 2018. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPIInformationandGuidance/Downloads/OHQualityWithholdGuidanceDY2-5_03162018.pdf

²¹ CMS and the State of Ohio, 2017, op. cit.

²² CMS and the State of Ohio, 2017, op. cit.

²³ RTI International, 2018, op cit.

²⁴ Data sources include: (1) key informant interviews and conversations with CMS and ODM officials; (2) beneficiary focus groups; (3) beneficiary surveys using the Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) instrument with core Medicare CAHPS questions as well as 10 supplemental questions added by the RTI evaluation team; (4) demonstration data reported through the State Data Reporting System and data on quality measures reported by MyCare Ohio plans; (5) demonstration-related materials; (6) complaints and appeals data; and (7) service utilization data including Medicare data on demonstration and comparison group members. Medicaid data on service utilization was not available for this evaluation; however, CMS administrative data identified beneficiaries who used Medicaid-reimbursed LTSS to understand their Medicare service use.

²⁵ Ohio Department of Medicaid. MyCare Ohio Evaluation 2018.” June 2018. Available at: http://www.jmoc.state.oh.us/Assets/documents/reports/MyCare_Ohio_Evaluation_2018.pdf

²⁶ RTI International, 2018, op cit.

²⁷ Ohio Department of Medicaid, 2018, op. cit.

²⁸ CMS and the State of Ohio, 2017, op. cit.

²⁹ CMS and the State of Ohio, 2017, op. cit.

³⁰ RTI International, 2018, op cit.

³¹ RTI International, 2018, op cit.

³² RTI International, 2018, op cit.

³³ CMS. “MyCare Ohio Demonstration: Summary of Contract Changes.” October 2017. Not available online.

³⁴ Center for Health Care Strategies. “PRIDE Plan Profile: CareSource.” August 2018. Available at: <https://www.chcs.org/media/CareSource-PRIDE-Profile-081018.pdf>

³⁵ Pelton, L., Fulmer, T., Hendrich, A., and Mate, K. “Creating Age-Friendly Health Systems: How to Meet the Needs of a Growing Population of Older Adults.” *Healthcare Executive*. 2017 Nov;32(6):62-63.

³⁶ RTI International, 2018, op cit.

³⁷ Weiser, R. and Gold, M. “Demonstrations to Improve the Coordination of Medicare and Medicaid for Dually Eligible Beneficiaries: What Prior Experience Did Health Plans and States Have with Capitated Arrangements?” Kaiser Family Foundation, April 2015. Available at: <https://www.kff.org/report-section/demonstrations-to-improve-the-coordination-of-medicare-and-medicaid-for-dually-eligible-beneficiaries-conclusion/>

³⁸ Ohio Department of Job and Family Services, Office of Ohio Health Plans. "State Demonstration to Integrate Care for Medicare-Medicaid Enrollees: Proposal to the Center for Medicare and Medicaid Innovation." April 2012. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioProposal.pdf>

³⁹ Molina Healthcare. "The Molina Quality Living Program." Available at: <https://www.molinahealthcare.com/providers/tx/medicaid/resource/Pages/quality-living-program.aspx>