



MyCare Ohio

Progress Report 2017

The Ohio Department of Medicaid

John R. Kasich, Governor Barbara R. Sears, Director



Department of Medicaid

John R. Kasich, Governor
Barbara R. Sears, Director

April 25, 2017

Governor of Ohio, John R. Kasich

Ohio House Speaker, the Honorable Cliff Rosenberger

Ohio Senate President, the Honorable Larry Obhof

Ohio House Minority Leader, the Honorable Fred Strahorn

Ohio Senate Minority Leader, the Honorable Kenny Yuko

Joint Medicaid Oversight Committee, Susan Ackerman, Executive Director

Legislative Service Commission Director, Mark Flanders

Re: MyCare Ohio Progress Report

As required by the 130th General Assembly Senate Bill 206, I am pleased to submit the third annual MyCare Ohio Progress Report.

Ohio Medicaid, in partnership with the Centers for Medicare & Medicaid Services (CMS), launched the MyCare Ohio Duals Demonstration in May 2014 to bring better health outcomes to dual-eligible individuals who have both Medicare and Medicaid benefits. Ohio was the third state in the nation to earn federal approval for its dual demonstration program, and is a national leader in its efforts.

In designing and implementing MyCare Ohio, Ohio Medicaid routinely engaged with stakeholders – providers, advocacy agencies and, most importantly, individuals served by Medicare and Medicaid – to learn from their first-hand experience. This exchange with stakeholders continues today and is fundamental in ongoing program decisions and improvements.

May 1, 2017 will mark three years for which MyCare Ohio has been operational. The attached report highlights the successes, as well as lessons learned, from MyCare Ohio over those three years.

Sincerely,

A handwritten signature in black ink that reads "Barbara R. Sears". The signature is written in a cursive, flowing style.

Barbara R. Sears

Director

2015 & 2016 Reports can be accessed at
medicaid.ohio.gov/resources/ReportsandResearch.aspx.

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INTRODUCTION

Ohio Medicaid, in partnership with the Centers for Medicare & Medicaid Services (CMS), launched the MyCare Ohio Duals Demonstration in May 2014 to bring better health outcomes to “dual-eligible” individuals who have both Medicare and Medicaid benefits. Medicare and Medicaid, historically, have operated as two very distinct and separate programs. Both are responsible for the delivery of health care of dual-eligible individuals, who often have the most complicated health care needs and are the most costly population to serve. Ohio was the third state in the nation to earn federal approval for its dual demonstration program, and is a national leader in its efforts.

MyCare Ohio has aimed to improve the lives of Ohioans and their health care delivery by:

- Utilizing managed care plans to improve continuity and coordination of care that is person centered;
- Providing a primary point of contact for beneficiaries;
- Focusing on individual choice and control of care delivery;
- Coordinating long-term care, behavioral health and physical health services;
- Encouraging and supporting an individual’s right to live independently; and
- Providing seamless transitions between settings of care and programs.

The five MyCare Ohio managed care plans coordinate both Medicare and Medicaid benefits – physical, behavioral and long-term care services – for the members they serve through a team approach to care management. The core team includes the member, the health plan’s care manager and the primary care practitioner, supplemented by the appropriate health care practitioners based on the member’s needs. Of note, Ohio Medicaid carved- in behavioral

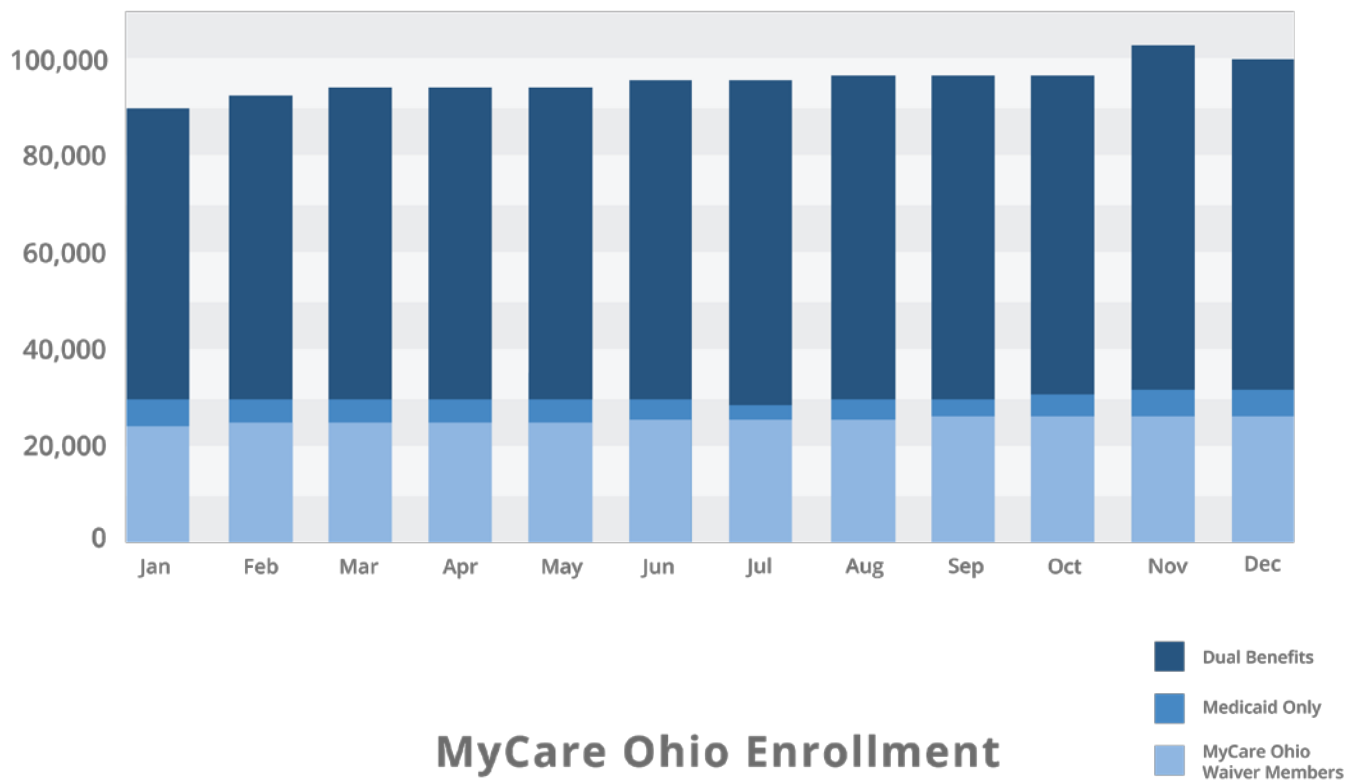
health and long-term services and supports into MyCare Ohio, the first time the state had extended managed care benefits to Ohioans in need of these Medicaid benefits. In designing and implementing MyCare Ohio, Ohio Medicaid routinely engaged with stakeholders – providers, advocacy agencies and, most importantly, individuals served by Medicare and Medicaid – to learn from their first-hand experience. This exchange with stakeholders continues today and is fundamental in ongoing program decisions and improvements.

■ Enrollment

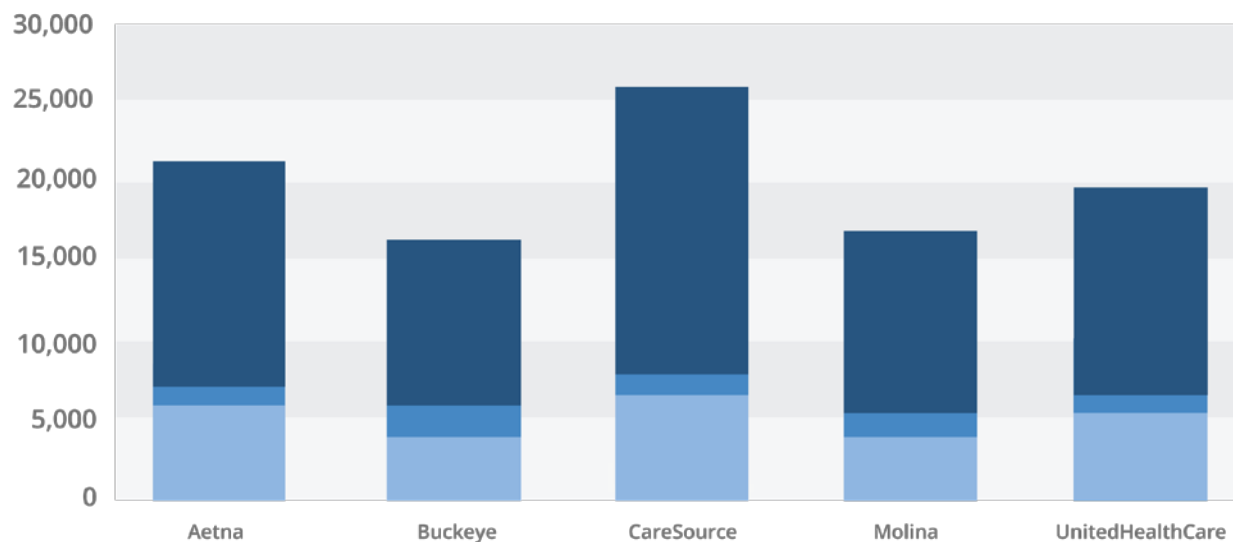
MyCare Ohio operates in seven regions covering 29 counties, including the major metropolitan areas of the state. Individuals who are 18 years of age and older and qualify for both Medicare and Medicaid in these regions are eligible for MyCare Ohio. Participation is mandatory for eligible individuals to receive their Medicaid benefits. Due to federal rules, eligible individuals must have the option as to whether their MyCare Ohio plan also provides their Medicare benefits. They may select traditional Medicare or a Medicare Advantage plan. To date, there are nearly 107,000 beneficiaries enrolled in MyCare Ohio, making our state’s duals demonstration the second largest in the country with the highest percentage of participation.

Nearly 70 percent of members have elected for their MyCare plan to coordinate both their Medicare and Medicaid benefits. This rate is often referred to as the “opt-in rate,” and Ohio leads the country in this measure among duals programs.

MyCare Ohio Enrollment Trend Calendar Year 2016

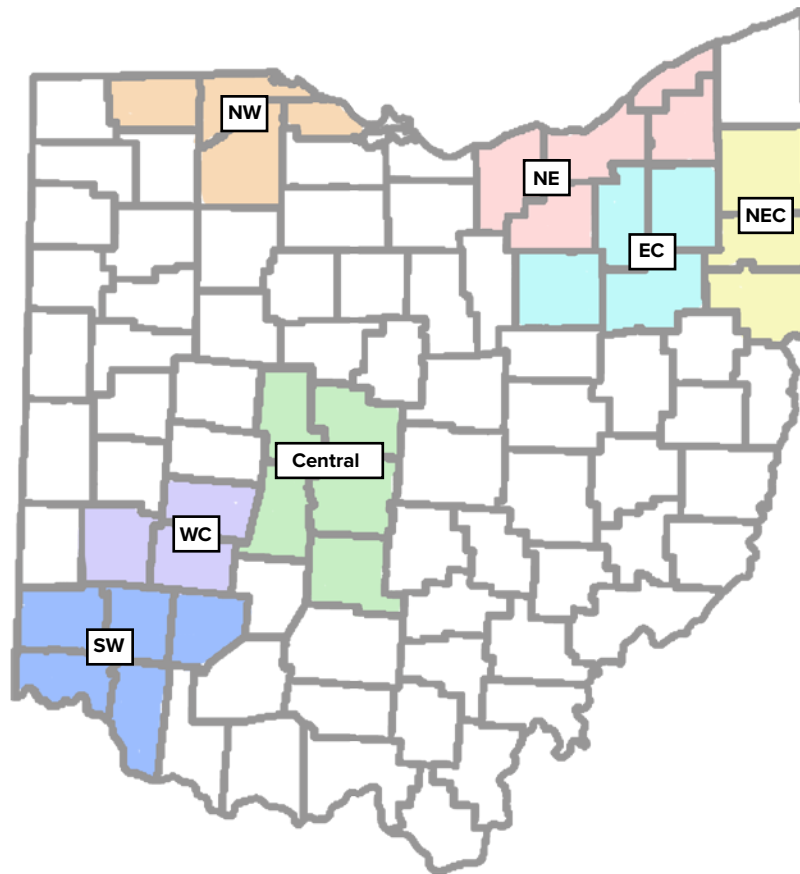


MyCare Ohio Enrollment by Plan for Dec. 2016



As of April 2017, MyCare Ohio has reached its highest enrollment to date at nearly 107,000.

■ MyCare Ohio Regions



Demonstration Region	Managed Care Plans Available
Northwest	Aetna, Buckeye
Southwest	Aetna, Molina
West Central	Buckeye, Molina
Central	Aetna, Molina
East Central	CareSource, UnitedHealthCare
Northeast Central	CareSource, UnitedHealthCare
Northeast	Buckeye, CareSource, UnitedHealthCare

CARE MANAGEMENT

The Ohio Department of Medicaid seeks to improve the health of the individuals enrolled in MyCare Ohio by taking a population health approach. Data are used to risk stratify members and group them into the following population streams: healthy adults, chronic conditions, and behavioral health. Strategies specific to risk levels and population streams are developed to improve quality of care, patient experience, and reduce costs of care. Care management is a critical component of population health management and the cornerstone of the MyCare Ohio program. Care management supports can keep people living in the community, increase individuals' independence, improve the delivery of quality care, and reduce unnecessary admissions, emergency room visits, and nursing facility stays. Care management services are available to all MyCare Ohio members to comprehensively coordinate the full set of Medicare and Medicaid benefits across the continuum of care including medical, behavioral, and long term services and supports needs.

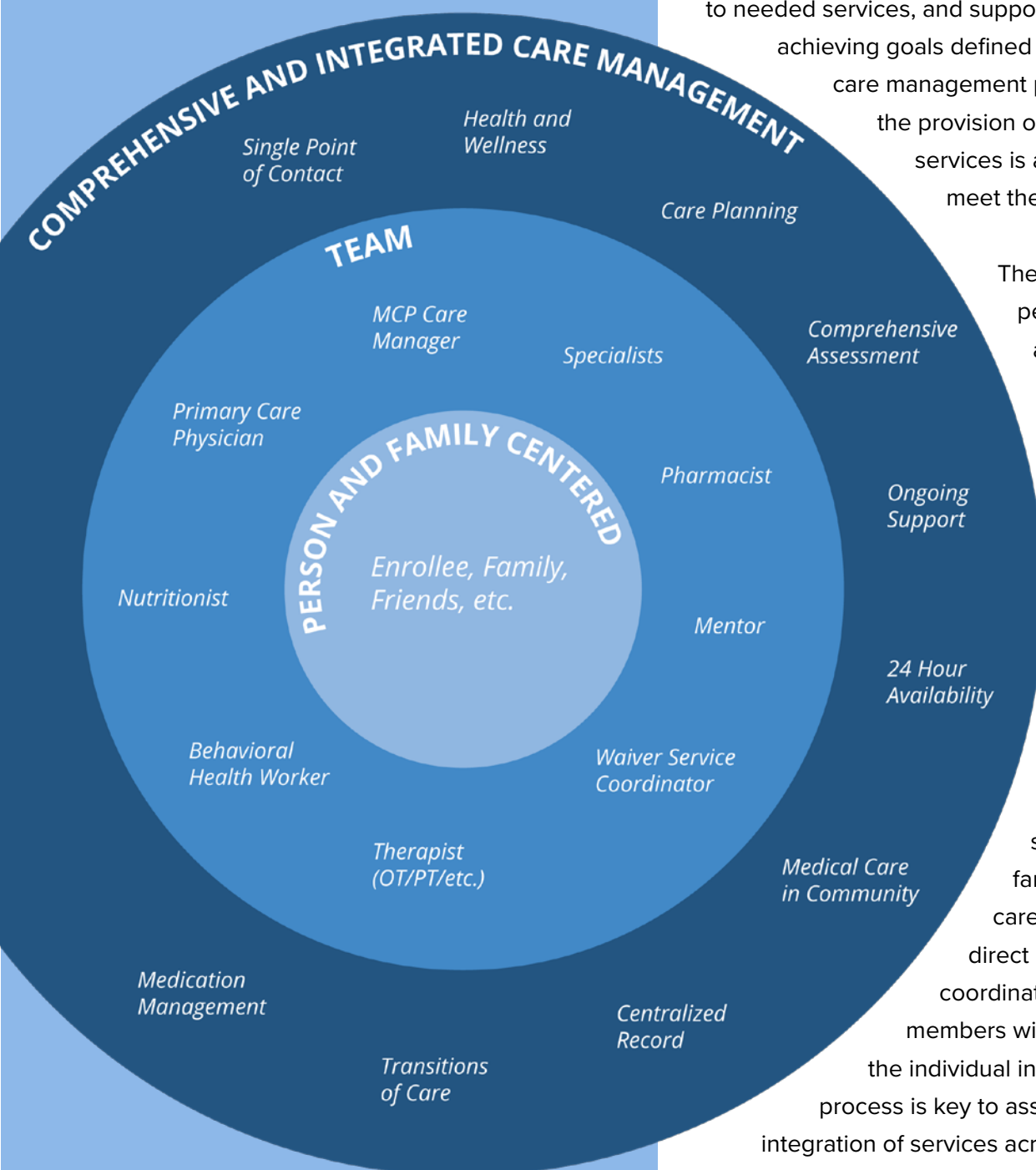
The Ohio Department of Medicaid expects the MyCare Ohio plans' care management approach to emulate the following attributes of a high performing care management system:

- Person and family centeredness;
- Alignment and support of primary managing clinicians;
- Timely, proactive planned communication and action;
- Assurance of health, safety and welfare;
- Promotion of self-care and independence;
- Emphasis of cross continuum collaboration and relationships; and
- Comprehensive consideration of physical, behavioral, and social determinants of health.



Because of MyCare Ohio...

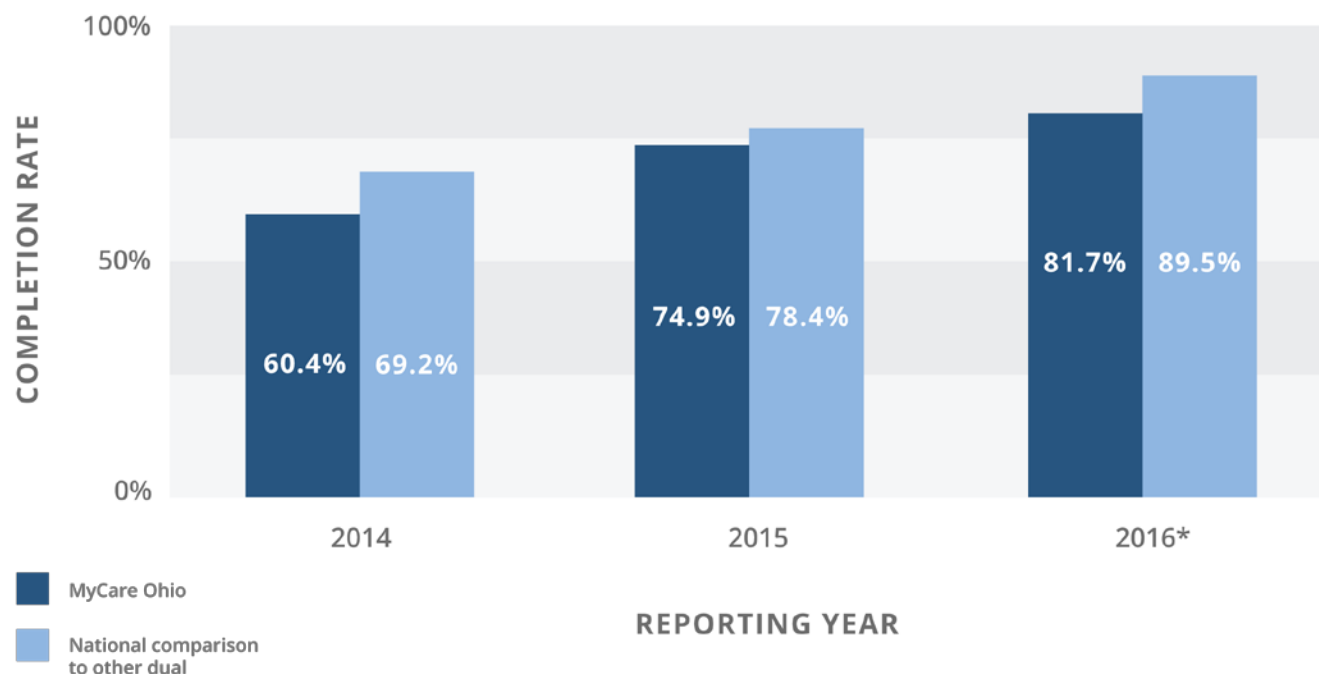
A member that was living in unsafe conditions is now receiving waiver services so she can safely stay home. The care manager had visited the 74 year old member's home to evaluate her status after she had insisted on returning home from a nursing facility, where she had been admitted after a hospital discharge for a fractured heel. The care manager discovered there was minimal food in the home, the member had not changed her clothing and was sleeping on her couch because she was unable to go upstairs to her bedroom. The member had also refused to go to her doctor's appointment because she was afraid to go alone – she suffered from anxiety and auditory hallucinations. The care manager was able to discuss options with the member, and she agreed to temporarily return to the skilled nursing facility where she could receive better care at that time. The care manager made a waiver referral and within two weeks the member was happy to return home with the appropriate home-based services. These included meal delivery, in-home psychiatric services, weekly nursing visits and home modifications.



Care management includes assessing an individual's medical, behavioral, and social support needs, developing an individualized care plan based on the assessment, monitoring the care plan to identify gaps in care and assisting the individual to obtain access to needed services, and supporting the individual in achieving goals defined in the care plan. The care management process is fluid and the provision of care management services is adjusted in order to meet the individual's needs.

These activities are performed as part of a trans-disciplinary care team approach that includes the individual, the primary care provider, the MyCare Ohio plan care manager, the waiver service coordinator, as applicable, and other members the individual chooses, such as specialists, family members, and caregivers. Facilitating direct communication and coordination between team members with involvement of the individual in the decision-making process is key to assure the comprehensive integration of services across the continuum of care. The figure to the left illustrates the person-centered, team-based approach and the MyCare Ohio plans' supports and resources in the outer ring that are vital components of a comprehensive and integrated care management model.

Health Risk Assessment



Measure: Percent of members who were reached, were willing to participate and had an HRA completed with 90 days.

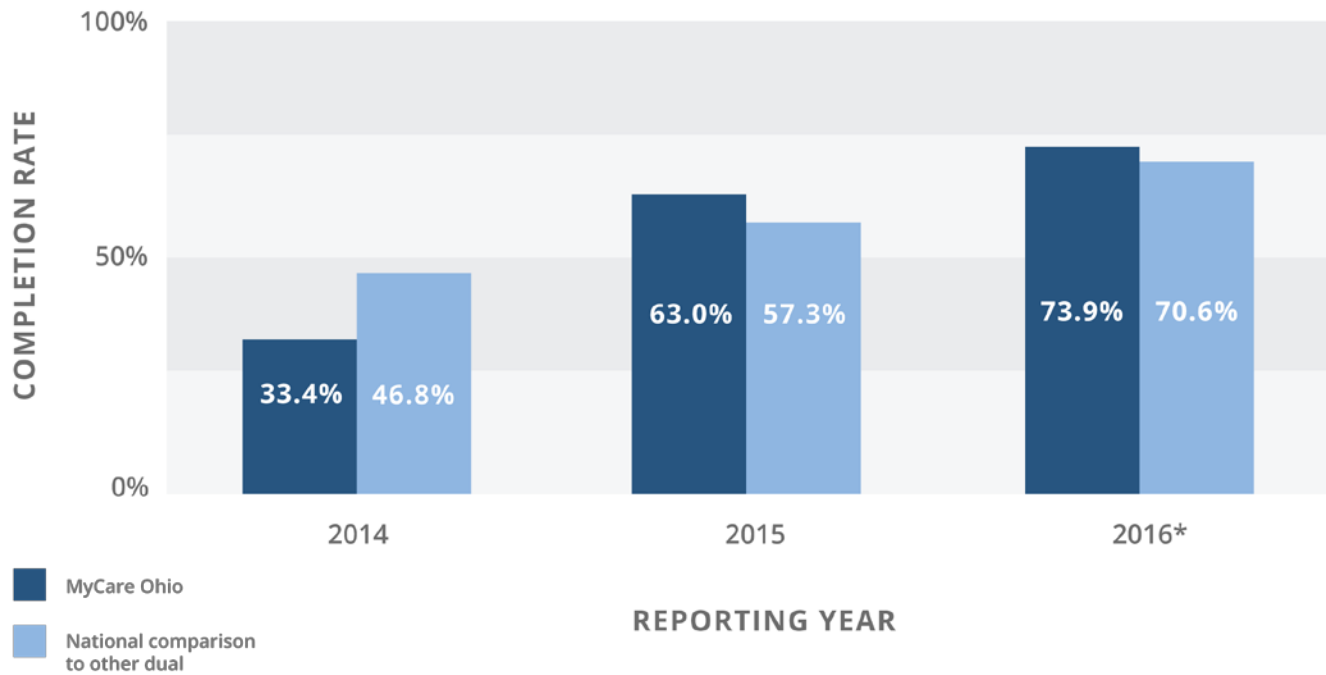
Source: Core Measure 2.1 as of Q4 2016 As reported by the MyCare Ohio Plans in accordance with Medicare-Medicaid capitated financial alignment model reporting requirements available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2016CoreReportingRequirements081016.pdf>

In Ohio, MyCare Plans are required to complete comprehensive assessments of a member's medical, behavioral, long term services and supports, and environmental needs with input from the individual, family, caregivers, and providers. Timeframes for completing assessments are dependent upon the member's assigned risk level: within 15 days of enrollment for the highest risk to within 75 days of enrollment for the lowest risk. Ohio's timeframes for completion of assessments were shorter than some of the other states participating in CMS' Financial Alignment Initiative (FAI) demonstration. For example, California required assessments to be completed within 45 days for those in the highest risk and 90 days for all others.¹ Overall, MyCare Ohio plans

completed assessments for members within 90 days at a rate that only slightly lagged behind the national rates, representative of all FAI demonstration states, from 2014 – 2016. Rates continued to consistently increase for Ohio and the FAI demonstration states from 2014 – 2016. In 2014, approximately 61% of MyCare Ohio members had an assessment completed within 90 days with an increase to 75% in 2015, and 82% in 2016. In 2014, approximately 61% of MyCare Ohio members had an assessment completed within 90 days with an increase to 75% in 2015, and 82% in 2016.

¹ Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative. (March 2017) <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf>. Accessed on April 14, 2017.

Care Plan Completion Rates



Measure: Percent of members who were reached, were willing to participate, and had a care plan completed within the required number of days. Source: State Specific Care Plan Measure Data reported as Q4 2016 As reported by the MyCare Ohio Plans in accordance with Medicare-Medicaid capitated financial alignment model reporting requirements available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2015CoreReportingRequirementsOH032116.pdf>.

While MyCare Ohio plans are relatively successful with completing initial assessments and reassessments within required timeframes, the plans are also proficient at updating assessments when there are changes in the beneficiary's health status or needs, when a significant change has occurred (such as hospital admission), or when requested by the beneficiary or provider. In addition, MyCare Ohio plans evaluated beneficiaries in their primary care setting which is critical for assuring that beneficiaries are safe by identifying and addressing environmental risks.² Information from assessments are merged with claims, medical records, and input from members of the trans-disciplinary care team in order to assure a

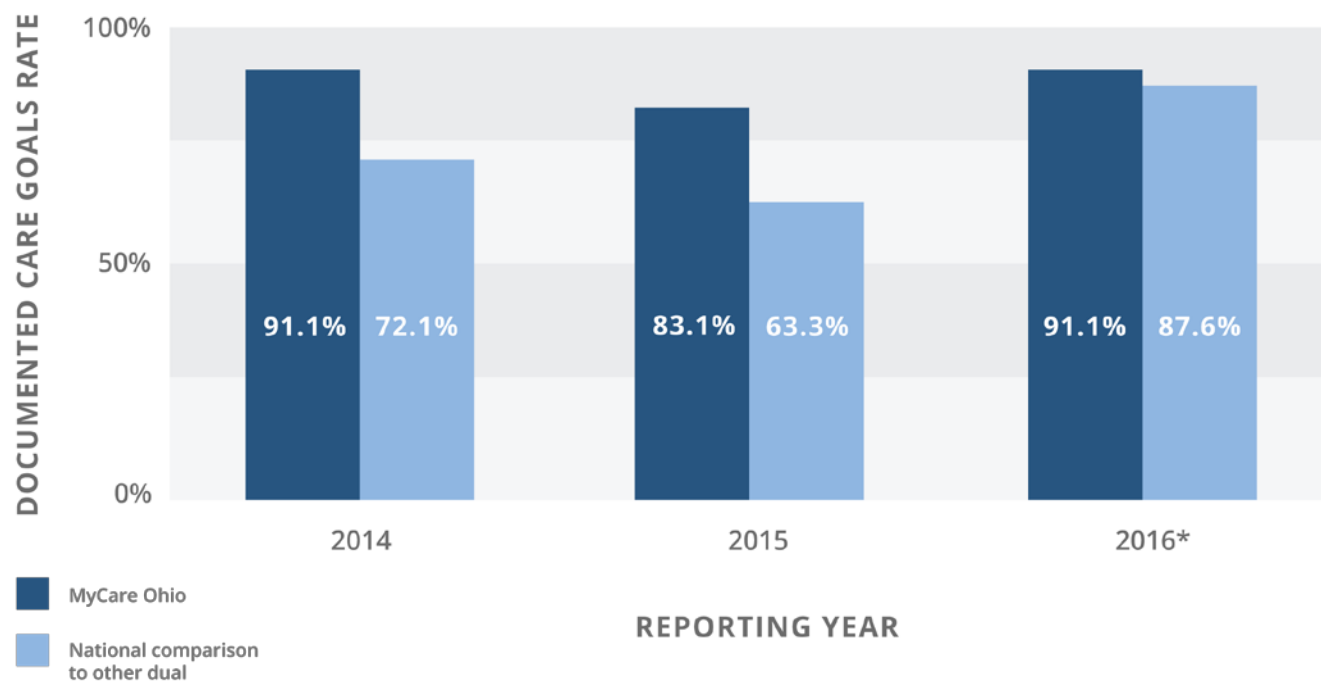
complete picture of the beneficiary's needs and to develop the individualized care plan.

The individualized care plan, the road map for guiding the beneficiary to optimal health, safety, and welfare, is informed by the assessment and includes goals, interventions and outcomes that are person-centered and consider the beneficiary's concerns, strengths, and preferences for care (such as cultural considerations). MyCare Ohio plans are required to complete individualized care plans within 15 days of assessments, which varies significantly from other FAI demonstration states. Michigan and Illinois, for example, require individualized care plans to be completed within 90 days of enrollment.³ Efforts by

² CY 2016 Aggregate Performance MyCare Waiver Record Reviews, Health Services Advisory Group, April 5, 2017

³ Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative. (March 2017) <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf>. Accessed on April 14, 2017.

Documented Care Plan Goals



Measure: Percent of initial care plans that included at least one documented discussion of care goals.

Source: State Specific Care Measure Data reported as of Q4 2016 in accordance with Medicare-Medicaid capitated financial alignment model reporting requirements: Ohio-specific reporting requirements Medicare-Medicaid capitated financial alignment model reporting requirements available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2015CoreReportingRequirementsOH032116.pdf>.

the MyCare Ohio plans to develop individualized care plans within required timeframes has markedly improved from 2014 to 2016, by an increase of approximately 40 percentage points from 33.4% to 73.9%. In 2015 and 2016, the MyCare Ohio rates surpassed the national rates by approximately 5 and 3 percentage points, respectively (see graph on page 7.)

In the MyCare Ohio program, the focus of care management exceeds the usual integration of medical and behavioral health systems by encompassing the needs of the entire individual, which often falls outside of the medical model and includes community based services and supports. Included in a person centered approach to care management is the view that the individual (and family/caregivers) is an equal partner in the initial care plan development and evolving care planning activities. The MyCare

Ohio plans demonstrated a commitment to person-centered care planning processes. In the first year of the program, MyCare Ohio plans had at least one documented discussion of care goals for 91% of initial care plans that were developed, exceeding the national rate by approximately 20 percentage points for two consecutive years. MyCare Ohio plans have consistently performed above the national rate for all three annual reporting periods.

Despite early challenges with contacting beneficiaries, the results for both care plan metrics indicate that once plans completed assessments there was successful continued engagement of beneficiaries in the care management process, and at rates higher than the national average.

All MyCare Ohio members have access to a trans-disciplinary care team led by their plan's care manager which also includes the member, the primary care provider, specialists, the waiver service coordinator, as appropriate, long-term services and supports providers, and other individuals selected by the member. The care team is designed to effectively manage and coordinate the individual's services by avoiding fragmentation, gaps, and duplication of care. MyCare Ohio beneficiaries who participated in CMS focus groups reported that their "care teams were helping them to achieve goals such as increasing mobility, independence and overall functioning."⁴ Furthermore, a 2016 evaluation of the MyCare Ohio plans' care management programs completed by Ohio Medicaid's contracted external quality review organization⁵ confirmed that 100% of the randomly sampled cases had an assigned care manager and 98% had a trans-disciplinary care team formed in conjunction with the beneficiary that was based on his or her needs and preferences.

For individuals who receive home and community based services, the coordination and integration of these services is extremely important to keeping an individual in the community. Ohio recognizes the right for the individual to choose his or her waiver service coordinator. The individual's selected waiver service coordinator works very closely with the assigned care manager to assure the comprehensive needs of the individual are being met. MyCare Ohio plans capitalized on the existing waiver service coordination infrastructure available through the Area Agencies on Aging for members over the age of 60. This partnership has been key to the successful integration and coordination of long-term services and supports with medical and behavioral needs. Several of the plans even maximized this partnership by delegating the full scope of comprehensive care management to

the Area Agencies on Aging as a means to achieve a single point of accountability for the member.

Another critical component of the MyCare Ohio care management service delivery is to assure effective transitions of care between settings (such as admissions and discharges between hospitals, skilled nursing facilities, and long term facilities) in an effort to avoid future unnecessary hospitalizations and emergency department visits. This includes responsibilities to participate in appropriate and safe discharges by conducting timely follow up and arranging for adequate services and supports. One of the key post discharge activities is to connect the beneficiary with a primary care provider as directed in the discharge plan, which usually occurs within 2-4 weeks of discharge. MyCare Ohio plans have demonstrated marked improvement from 2014 to 2016 in the percent of hospital discharges that had ambulatory care follow up visits within 30 days of discharge. In both 2015 and 2016, the MyCare Ohio plans' results were slightly higher than national rates.



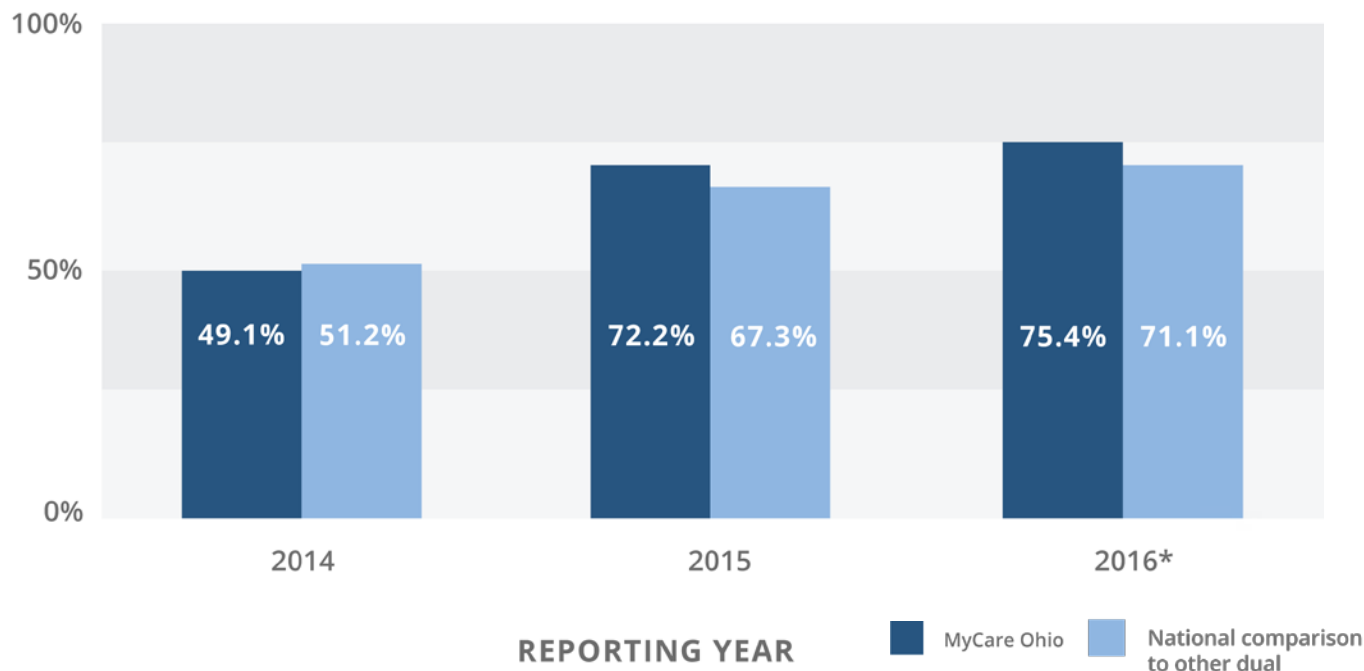
Because of MyCare Ohio...

A member was able to avoid eviction from her home. The care manager received a phone call from the member, who reported she was being evicted. The care manager connected the member with community supports, including United Way 211 to provide her with funds to avoid eviction and Legal Aid to help her negotiate an agreement with her landlord that allowed her to stay in her home.

⁴ Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative. (March 2017) <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf>. Accessed on April 14, 2017.

⁵ CY 2016 Aggregate Performance MyCare Waiver Record Reviews, Health Services Advisory Group, April 5, 2017.

Annual Rate of Follow-Up Care Visits



Measure: Percent of discharges with ambulatory care follow up visits within 30 days after discharge

Source: State specific follow up care measure data as of Q3 2016 in accordance with Medicare-Medicaid capitated financial alignment model reporting requirements: Ohio-specific reporting requirements Medicare-Medicaid capitated financial alignment model reporting requirements available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination/FinancialAlignmentInitiative/Downloads/FinalCY2015CoreReportingRequirementsOH032116.pdf>.



Because of MyCare Ohio...

A member with schizoaffective disorder and substance abuse was able to access the mental health treatment he needed and overcome chronic homelessness. During a hospitalization, two care managers, a behavioral health clinical liaison and a hospital social worker met with the member and worked together to gain his trust and convince him to take steps towards stabilizing his life, eventually moving him to a longer term hospitalization at a state hospital as acute stays were not having an impact. Ultimately, the member was discharged to a step-down transition residential program and the care managers worked with him and the provider to create a stable long-term discharge plan. Two months later he was still drug free and learning proactive skills for managing mood and anger and addiction triggers.

Care management remains to be one of the essential components of the MyCare Ohio program. There were documented early implementation challenges with care management, but there were also significant accomplishments. MyCare Ohio plans invested significant resources to successfully integrate care across systems which did not previously exist for dual beneficiaries in Ohio's fee for service delivery system. Within a compressed timeframe, MyCare Ohio plans hired and trained additional care managers, completed thousands of comprehensive assessments and individualized care plans, enhanced information systems to support care management, and developed new relationships with providers and partners to enhance care management service delivery.

Keeping Ohioans Safe – Closing Poor-Performing Nursing Homes

Governor Kasich's administration has been committed to improving nursing home quality, which provide care to some of our state's most vulnerable residents. An interagency team monitors poor-performing nursing homes, and if a facility does not improve and closure is necessary, the team will mobilize to safely and quickly move residents to new nursing homes. The MyCare Ohio managed care plans have become an integral part of this team.

Since 2015, the plans have been involved in the closure of 7 homes, moving about 325 residents.

The plans work closely with members to make referrals to other nursing homes or community settings based on members' needs and choices, and are present and actively involved throughout these transitions. The plans have even brought staff to closing nursing homes to pack members' belongings

in boxes supplied at the plans' expense, which allow for a more dignified move for residents who would otherwise be provided with garbage bags from the nursing homes.

The MyCare Ohio plans have played a key role in transitioning individuals out of institutions and back into home and community-based settings.

From 2014 – 2015, MyCare Ohio plans reduced the number of nursing facility days for residents by 4%.⁶

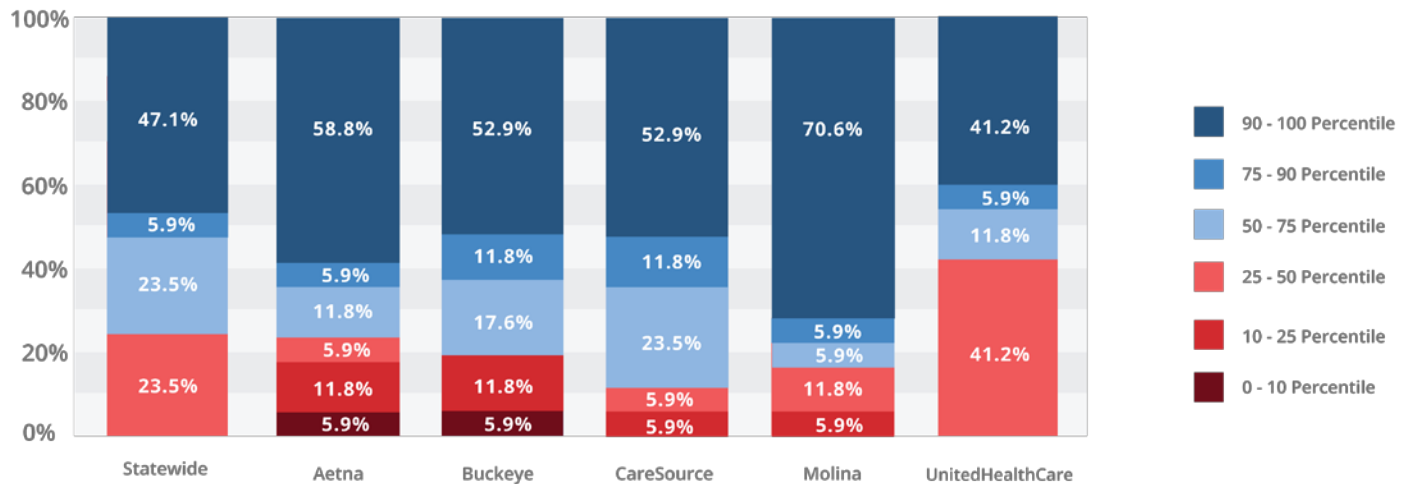


*Because of
MyCare Ohio...*

Over 100 residents were quickly and safely evacuated from a nursing facility in August that had no air conditioning and other violations. This was a difficult process that involved contacting guardians and power of attorneys, finding providers that could accept individuals that had severe and persistent mental illness, and arranging transportation to the new facilities. But the care managers successfully moved all residents to appropriate, air conditioned facilities within five days, as required by the state. The state simply would not have had the resources to move this many residents in a short time period. The MyCare Ohio plans have played a key role in transitioning individuals out of institutions and back into home and community-based settings.

⁶ Data compiled from MyCare Ohio plans.

HEDIS Measures Ranked by National Medicaid Percentile



QUALITY MEASURES – HEDIS AND CAHPS

The design of the MyCare Ohio Program includes a robust program evaluation and monitoring strategy. Performance assessment includes a comprehensive and independent program evaluation, routine data collection and reporting requirements, the use of quality measures and standards, and annual member surveys. These quality measures and member surveys are nationally recognized evaluation instruments and widely used throughout the health care industry.

MyCare Ohio – 2016 Quality Measure Results

Source: NCQA/HEDIS 2016: Medicare-Medicaid Plan Compliance Audited Data

The Ohio Department of Medicaid has established quality measures and standards to evaluate MyCare Ohio plan performance in key program areas, which include Health Effectiveness Data and Information Sets (HEDIS) measures issued by the National Committee for Quality Assurance (NCQA). HEDIS measures are reported to NCQA annually by managed care plans, and this is a CMS requirement for Medicare-Medicaid plans. Organizations reporting

HEDIS measures must meet audit requirements to ensure the validity and integrity of HEDIS data. HEDIS rates are calculated for MyCare Ohio members receiving both their Medicare and Medicaid benefits from a single managed care plan, and reported annually.

The HEDIS 2016 measures (based on calendar year 2015) are the first set of annual rates reported for the MyCare Ohio managed care plans. Certain measures require one or more years of historical data. Because the MyCare Ohio program's first full year of implementation was 2015, these specific measures could not be calculated and reported due to the unavailability of data for prior measurement years.

Measures reported for My Care Ohio for 2015 include those related to primary care and screenings, chronic conditions (such as diabetes and hypertension), behavioral health and medication management. Rates for the MyCare Ohio plans compare favorably to national Medicaid benchmarks. **Approximately 53% of the reported rates exceeded the national 75th percentile benchmarks; for the statewide average over 45% of the rates exceeded the national 90th percentile benchmark.**

Statewide rates exceeding the 90th percentile include adults' access to preventive/ambulatory health services, antidepressant medication management, and beta-blocker treatment after a heart attack.

Rates exceeding the 75th percentile include diabetes HbA1c testing, initiation of alcohol & drug dependence treatment, drug therapy for rheumatoid arthritis, follow-up after hospitalization for mental illness and pharmacotherapy management of COPD exacerbations.

In general, MyCare Ohio plan rates for the HEDIS clinical performance measures across the Ohio Medicaid focus population streams (healthy adults, behavioral health and chronic conditions) are evidence of access to care and appropriate management of chronic and behavioral health conditions. These performance measures indicate successful implementation of managed care processes, including the establishment of provider networks and adequate access to care. Over the next several years, it is expected that improvement in

HEDIS measure rates will show improved outcomes as a result of successful implementation of effective intervention and care coordination activities.

MyCare Ohio – 2016 Member Survey Results

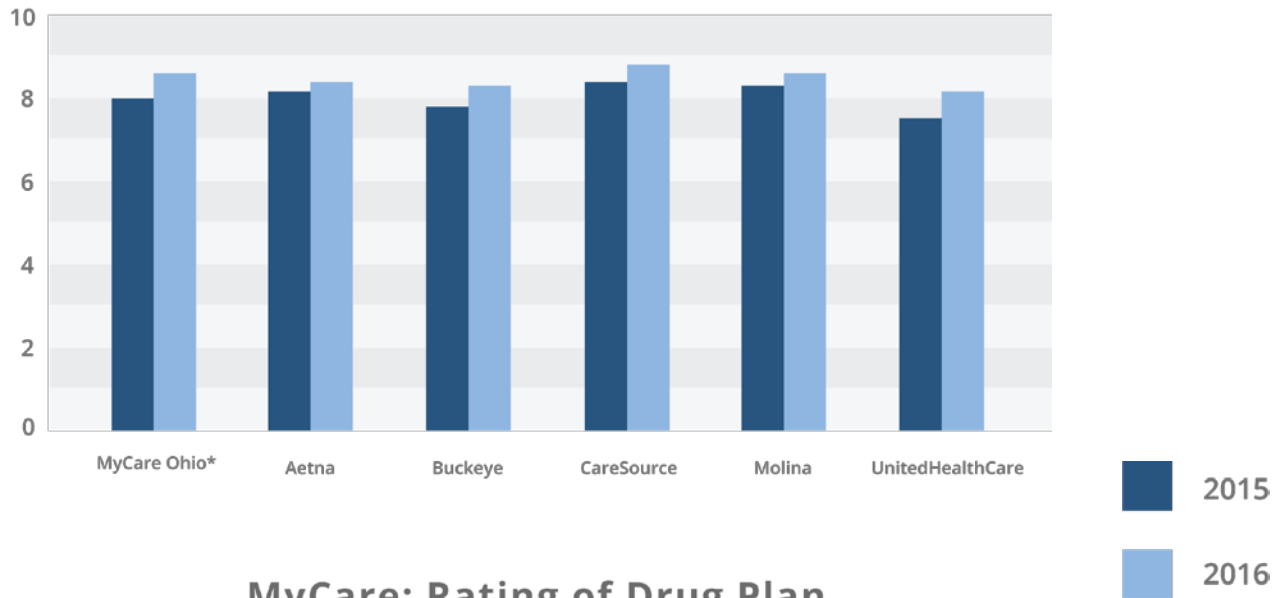
Source: 2016 Medicare-Medicaid Plan CAHPS Results (plan specific reports), Issued October 2016 by CMS

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instruments and protocols for data collection, analysis, and reporting are standardized to allow for comparisons across users and trending data over time. The Medicare CAHPS survey assesses topics such as quality of care, access to care, the communication skills of providers and administrative staff, and overall satisfaction with health and drug plans and providers.

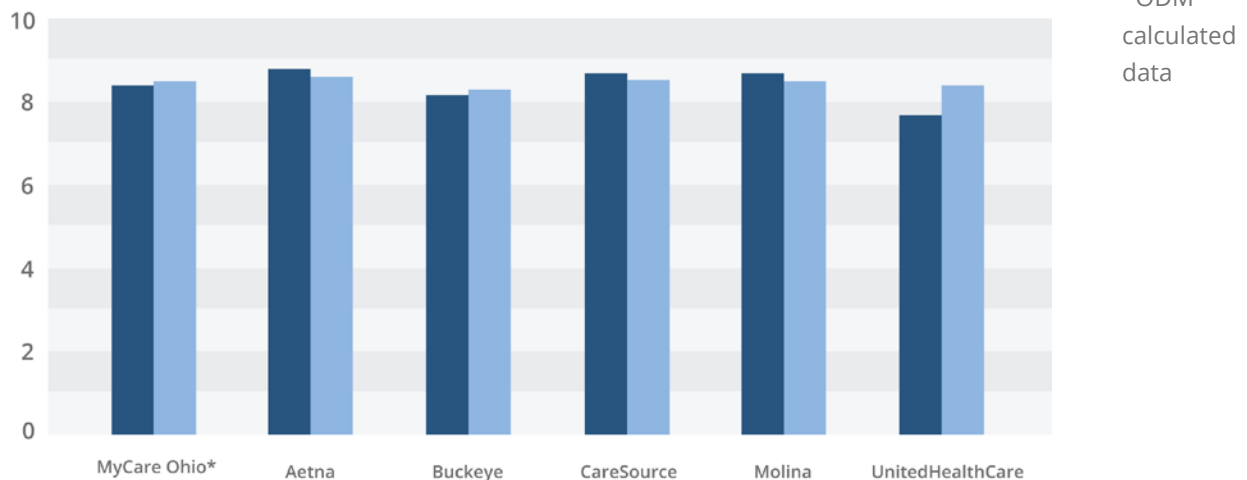
MyCare Ohio plans are required by CMS to contract with a CMS-approved survey vendor to administer

HEDIS 2016 (CY 2015 Measurement Year) - Selected Clinical Performance Measures	MyCare Ohio compared to National NCQA Benchmark	Population Stream
Adults' Access to Preventive/Ambulatory Health Services	>90 Percentile	Healthy Adults
Controlling High Blood Pressure	25 to 50 Percentile	Chronic Conditions
Persistence of Beta Blocker Treatment After a Heart Attack	>90 Percentile	
Comprehensive Diabetes Care: HbA1c Testing	50 to 75 Percentile	
Comprehensive Diabetes Care: Eye Exam	50 to 75 Percentile	
Comprehensive Diabetes Care: Attention for Nephropathy	>90 Percentile	
Annual Monitoring for Patients of Persistent Medications (ACE Inhibitors/ARBs, Digoxin, Diuretics)	>90 Percentile	
Initiation and Engagement of Alcohol/Other Drug Dependence Treatment - Initiation	50 to 75 Percentile	Behavioral Health
Antidepressant Medication Management - Effective Acute Phase Treatment	>90 Percentile	
Antidepressant Medication Management - Effective Continuation Phase Treatment	>90 Percentile	

MyCare: Rating of Health Plan



MyCare: Rating of Drug Plan



the Medicare CAHPS survey to a random sample of members and submit their survey data to CMS on an annual basis. CMS analyzes the data and prepares reports of findings. Users of CAHPS data include consumers, providers, health plans, public and private purchasers, regulators, and researchers. Results are used to evaluate and compare healthcare providers and improve the quality of the healthcare system.

Overall, the 2016 CAHPS results show improvement compared to 2015 on a program-wide basis. Eight

of ten core questions were comparable between 2015 and 2016. Seven of these eight core questions improved in 2016. Questions related to access to care, such as getting needed care, getting appointments and care quickly, and getting needed prescription drugs, all improved. Other questions related to plan performance, such as rating of health plan and rating of drug plan, also improved in 2016.

The plan-to-plan comparison for the rating of health plan measure shows some variation across the five

MyCare Ohio plans but as a collective, they are improving. Results for rating of drug plan showed much less variation, with all plans' results within 2%. Overall, these high plan ratings demonstrate MyCare Ohio is viewed favorably by members and this view is improving over time.

OPERATIONS AND ADDITIONAL PARTNERSHIPS

■ Prior Authorization

MyCare Ohio plans must provide timely access to all medically necessary covered services. Additionally, plans may require prior authorization for services – with the exception of emergency, certain urgent care, family planning and out-of-area renal dialysis services. All MyCare Ohio plans allow members to initiate requests for services and provide:

- Written policies and procedures for processing prior authorization requests;
- Mechanisms to ensure consistent application of review criteria for prior authorization decisions; and
- Consultation with requesting providers when appropriate.

Review guidelines must be consistent with Medicare standards for acute services and prescription drugs and must also be consistent with Medicaid standards for Medicaid services not covered by Medicare. Guidelines for integrated services must provide for review, authorization and payment using both Medicare and Medicaid criteria in that order.

Plans must make prior authorization decisions within the required time frames and must offer appeal rights to members for denied requests.

For pharmacy prior authorization requests, the plans must make a decision within 72 hours. The managed

care plans operate well within that requirement. In fact, the average turn-around-time for October through December 2016 was 13.2 hours.

For non-pharmacy prior authorization requests, the plans must make a decision within 14 calendar days. The managed care plans are also well within that requirement, with an average turn-around time of 4.3 days for October through December 2016.

The managed care plans have approved more than 90 percent of prior authorization requests received from providers for services during the first three years of MyCare Ohio.

Timeframe: Total number of prior authorization requests received by MyCare Ohio Plans

Jan. 1 2016 - Dec. 31, 2016

Total prior authorization requests

324,078

Total prior authorization requests per 1000 member months

286,635

Approval percentage

91.20%

Denial Percentage

8.80%

Calculation based on ODM member month data: Total Prior Authorization Requests per 1000 Member Months = Total Prior Authorization Requests x 1000 divided by member months.

■ Appeal Process

When a denial, reduction, suspension, termination or limited authorization for a service is issued by a MyCare Ohio plan, members have the opportunity to submit an appeal to that managed care plan.

Appeal processes vary at the state and federal levels among Medicare and Medicaid. As a result, significant negotiation occurred between Ohio Medicaid and CMS during the development of MyCare Ohio to agree on an appeals process that aligns with state and federal requirements, while also satisfying the expectations of various advocates and stakeholders. While Ohio Medicaid and CMS established the parameters associated with the appeal process, the MyCare Ohio plans are primarily responsible for executing the appeals process. Current Ohio Department of Job and Family Services Bureau of State Hearings processes are maintained.

Number of appeals received by the MyCare Ohio plans

Jan. 1 2016 - Dec. 31, 2016

Total number of appeals:

884

Number of appeals per 1,000 members months*

0.815

Number of appeals sustained**

312

Number of appeals overruled***

572

*Calculation based on ODM member month data: Total Appeal Requests per 1000 Member Months = Total Appeal Requests x 1000 divided by member months.

**Appeal Sustained - means the *MyCare Ohio* plan's action is overturned and the Plan must reverse their original decision.

*** Appeal Overruled - means the *MyCare Ohio* plan's action is upheld or stands.

In most cases, when a MyCare Ohio plan makes a decision on appeal to sustain or overturn their original determination, is is due to the receipt of additional supporting medical documentation submitted by the requesting physician or provider.

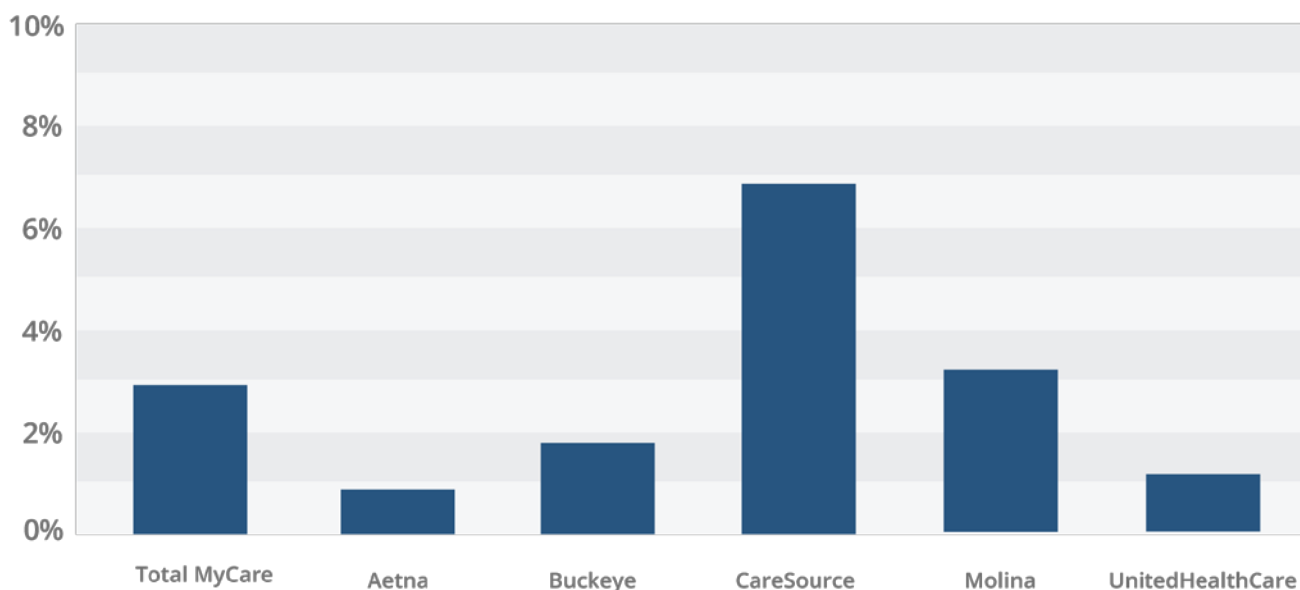


Because of MyCare Ohio...

A member was able to lose over 100 pounds, alleviating the obesity that was a key driver for many other health conditions including congestive heart failure, hypertension, diabetes, coronary artery disease, chronic obstructive pulmonary disease, chronic kidney disease, asthma and depression. The 49 year old member was able to move to a safer environment after gastric bypass surgery, and her case manager helped her get a personal care aide, home delivered meals and an emergency response system. The member is no longer experiencing symptoms of or taking medication for congestive heart failure, and has also been able to decrease several of her other medications. The member expressed that she is committed to taking care of herself and maintaining this better life, and that she would not have been able to make this transition without the care management support throughout the evaluation, surgical process and follow up care.

MyCare Ohio Grievances

Oct. through Dec. 2016



Data Source: MyCare Ohio Plans and ODM Enrollment Files

Grievances

As defined by Ohio Administrative Code (OAC) 5160-26-08.4(A)(3), a grievance is an expression of dissatisfaction with any aspect of the plan's or provider's operation, provision of health care services, activities, or behaviors, other than a request for review of a plan's "action" as defined in OAC 5160-26-08.4(A)(1). Plans are required to resolve access to care grievances within two working days. They submit all grievance records and an aggregate count for specified problem categories to the Ohio Department of Medicaid on a monthly basis, and the agency:

- Reviews grievances;
- Track and report on trends identified; and
- Monitors plans for compliance in regards to the grievance submission process and grievance coding.

The top 3 reasons that members submit a grievance with their MyCare Ohio plan are billing, administrative issues, and dissatisfaction with a provider.



*Because of
MyCare Ohio...*

A women with a former heroin addiction and other physical health conditions was able to obtain treatment and other supports from her plan that allowed for her to secure part-time employment. Her needs for treatment declined over time as she learned how to better manage her medical, addiction, and psychiatric issues from the treatment she received and using the skills she had learned. She is no longer a member of MyCare Ohio as she's now receiving health insurance from her employer.

Member Assistance Available

The Office of the Long-Term Care Ombudsman is available to help MyCare Ohio members who have a complaint against their MyCare Ohio plan and/or provider, or need assistance in understanding how MyCare Ohio impacts them. Ohio Medicaid has a strong partnership with the ombudsman office, and regular contact allows Ohio Medicaid to learn of any issues MyCare Ohio members are experiencing and address them with the plans as necessary. The ombudsman office is a recent recipient of a grant at the federal level that will allow them to make MyCare Ohio members more aware of their services. In this grant, they are also partnering with the Ohio Senior Health Insurance Information Program to provide education and counseling related to a member's opt in/out status of their Medicare benefits.

“Awareness of demonstration Ombudsman programs was low among focus group participants in most States, with Ohio being the notable exception where participants were more knowledgeable about the program.”

Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative, CMS March 2017

Provider Panel Requirements

Since MyCare Ohio is a Medicare-Medicaid integrated program, the Medicare panel requirements are commonly used for most provider types throughout the demonstration. Medicaid provider types include dentists, nursing facilities and waiver services providers. A common misconception of managed care is that members may have access to fewer providers than they do in fee for service Medicaid. In reality, plans must meet panel requirements as specified by both CMS and Ohio Medicaid for specified provider types. In managed care, plans are required to ensure members have access to every provider type and, when necessary, may incentivize a provider to join their network by paying them a higher rate. In fee for service, Ohio Medicaid does not have the flexibility to do this.

Holding Plans Accountable

Ohio Medicaid has a team of staff dedicated to ensuring the managed care plans meet contractual requirements. When a plan fails to meet these requirements, the agency may impose sanctions and remedial actions that include, but are not limited to, corrective action plans, financial sanctions, points, enrollment freezes, and contract termination.

The contract between the Ohio Department of Medicaid and the managed care plans is updated at least annually. When issues and challenges are identified with the plans, Ohio Medicaid makes changes to the contract to ensure plans are meeting standards and requirements and improve member experiences. For example, the transportation services provided by plans to assist members traveling to and from medical appointments was unacceptable during the implementation phase of MyCare Ohio. Members were often late to appointments due to untimely pickups, or the plans failed to properly plan and sent providers that did not meet members' individual needs (such as sending a non-wheelchair equipped

transportation provider to pick up a member who uses a wheelchair). Ohio Medicaid immediately took action and updated the contract with plans to reflect the following:

- Plans must identify and accommodate the special transportation assistance needs of members and communicate these to the transportation vendor, such as door-to-door assistance, attendant support and member specific timeliness requirements.
- Plans must meet prescribed pick-up time parameters to and from appointments. The plans must ensure transportation pick-up is completed not more than 15 minutes before or 15 minutes after the pre-scheduled pick-up time to ensure members are on time for their appointment. Following a scheduled appointment, pick-up must be completed no more than 30 minutes after a request for pick-up.
- Plans should contract with providers that have experience transporting members with long-term services and supports needs and can effectively manage special circumstances, such as securing a wheelchair and safely assisting the member to and from the vehicle.
- Ohio Medicaid will impose a fine if a plan fails to comply with transportation requirements or if the plan fails to transport a member to a pre-scheduled appointment on time, and that lateness results in a missed appointment.

Transportation complaints to the Ohio's Office of the State Long-term Care Ombudsman have substantially decreased since the contract was updated with these requirements.

■ Timely Payment to Providers

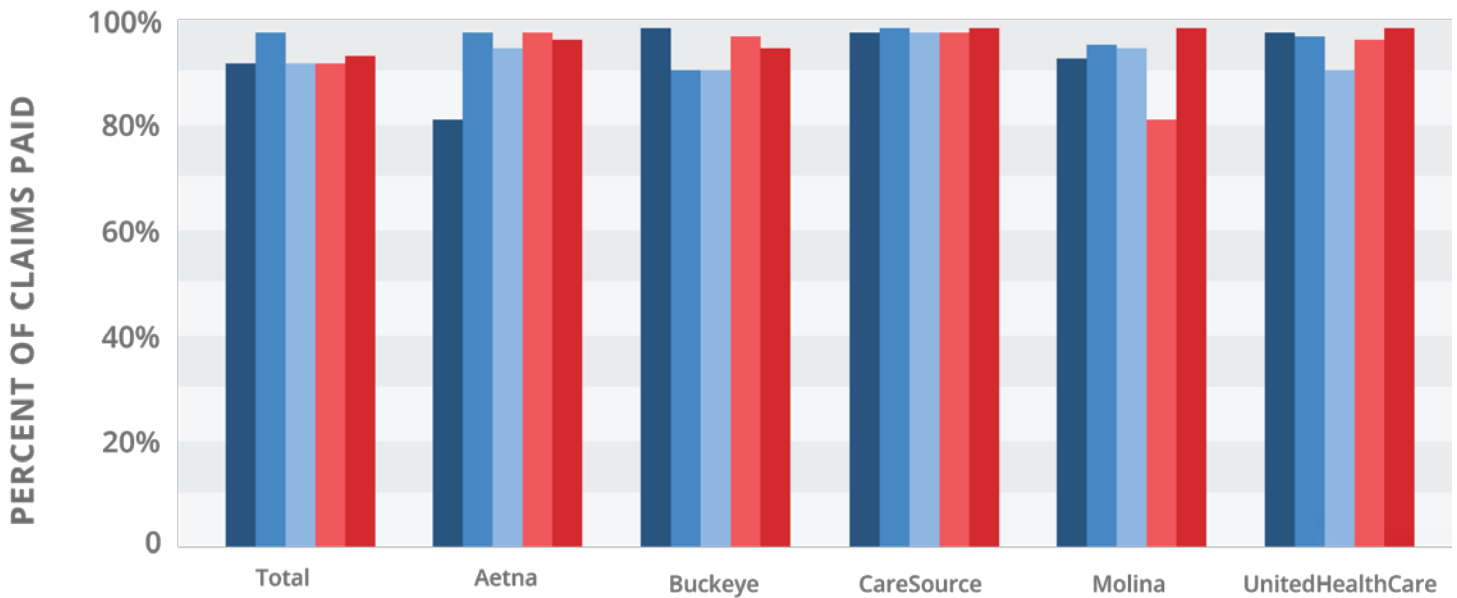
Ohio Medicaid recognizes the importance of providers being paid by plans in a timely manner. The Department monitors this practice and takes compliance on plans as necessary. At the inception of MyCare Ohio, plans had challenges meeting the need of some types of providers for prompt payments. Over time, through Ohio Medicaid's monitoring and contract changes, the plans have made improvements. The charts on the following page indicate that on the aggregate level our plans meet our timely payment requirements per state and federal requirements. Ohio Medicaid continues to adjust this policy to better serve providers based on the feedback received. Since January 1st, 2017, plans are required to submit timely payment information by category of service, which allows Ohio Medicaid to track prompt payments by provider type and identify any areas of concern that needs to be addressed.



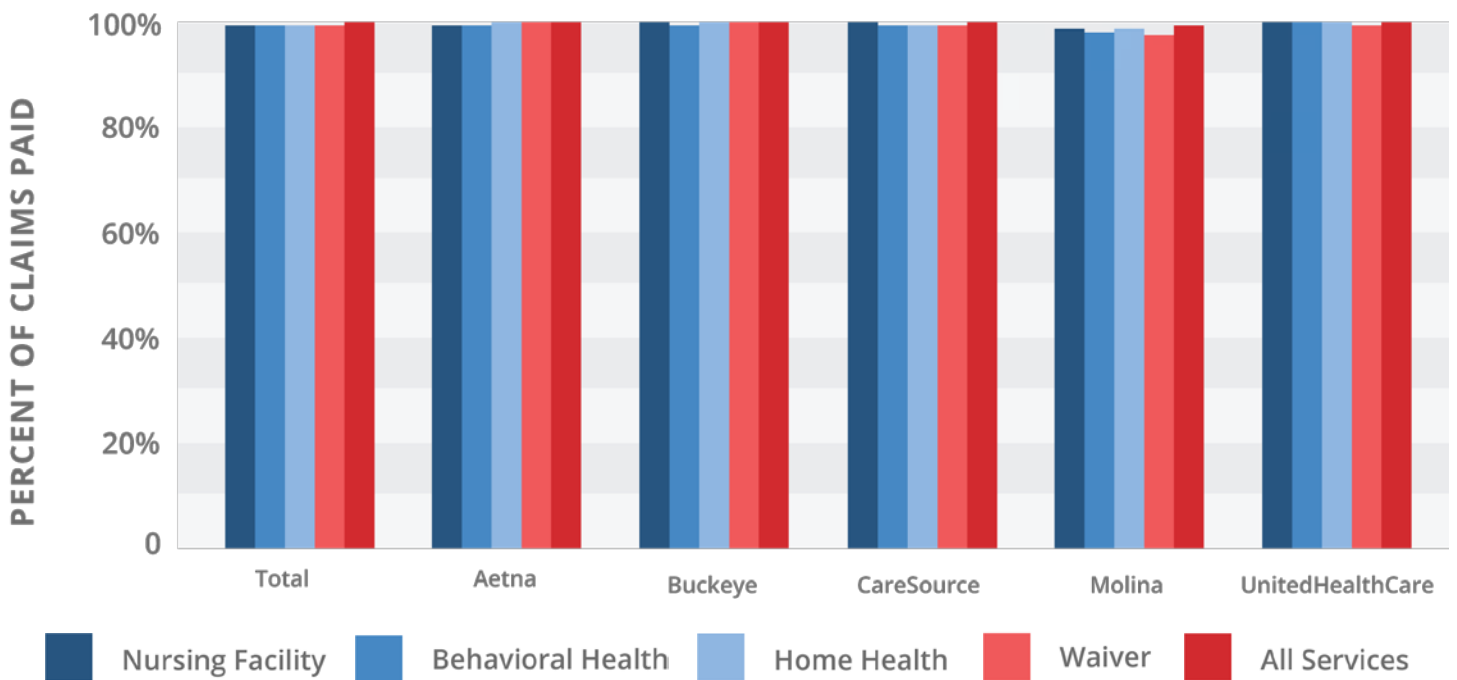
*Because of
MyCare Ohio...*

A member now has a primary care doctor, after more than 50 years of using the emergency room for routine care. Because this member had no coordination of care, he was unaware of any medical diagnosis. He also had not regularly seen a physician and was not taking any prescription medications. The care manager explained the importance of having an established primary care provider, located one in the community and scheduled a new patient appointment on the member's behalf. The member is now actively involved in his care and engages regularly with his care manager.

MyCare Ohio Clean Claims Paid Within 30 Days



MyCare Ohio Clean Claims Paid Within 90 Days



Data Source: MyCare Ohio Plans

FISCAL IMPACTS

■ Enrollment Rebalancing

Rebalancing is the proactive effort to shift enrolled individuals from a high cost care setting to a more cost-effective care setting. In the context of MyCare Ohio, this is the incentivized effort for MyCare Ohio plans to divert individuals from a nursing facility setting to a home and community based setting.

For each individual receiving long-term services and supports (LTSS)⁷ who moves from a nursing facility setting to a waiver setting, the average cost savings per member per month (PMPM) is approximately \$2,800.⁸ Based on an estimated 2% incremental rebalancing achieved by the MCOPs, there is an

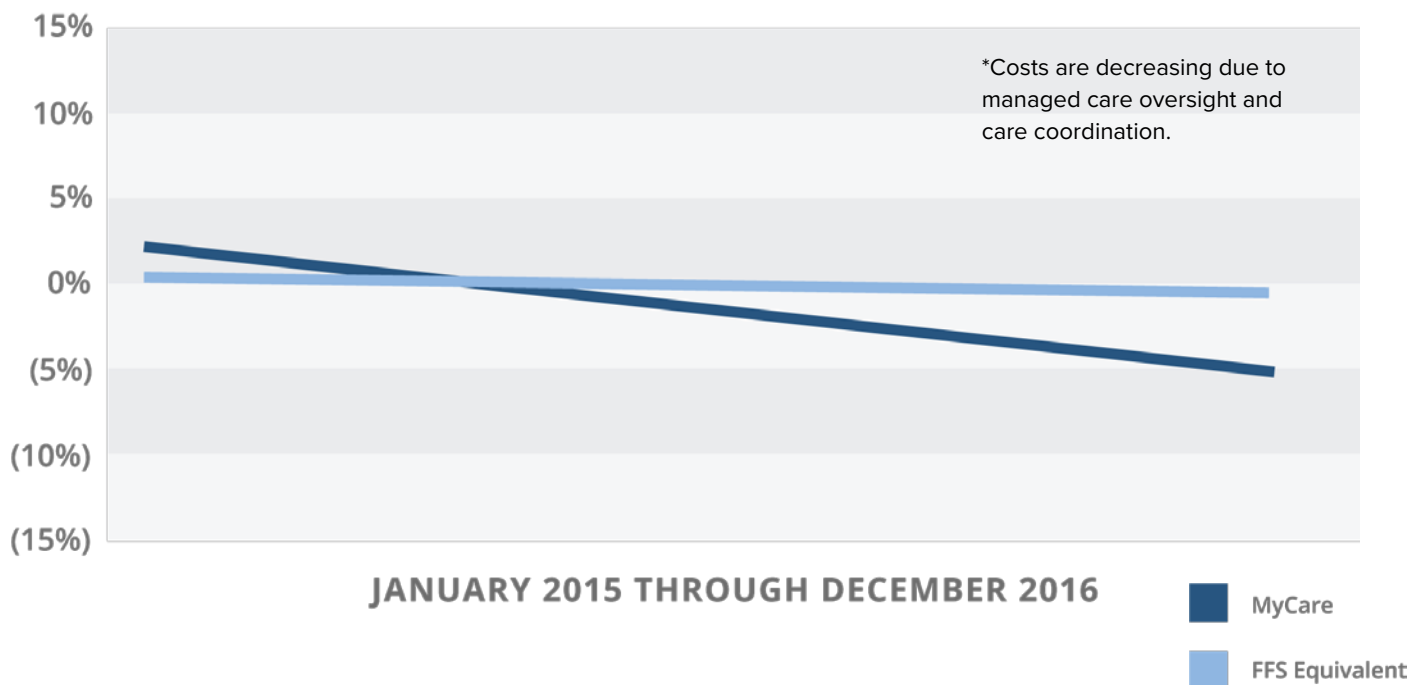
estimated monthly savings of approximately \$2.4 million above what would have been achieved under the traditional Medicaid fee-for-service program.

■ Cost Trend

Over the course of calendar year 2015 and 2016, average MyCare Ohio capitation rates PMPM have experienced a general downward trend while the average claim cost PMPM for the traditional Medicaid fee-for-service equivalent population experienced little to no cost changes. As further illustrated in the table below, the MyCare Ohio capitation rates at the end of calendar 2016 were 6.8% less than the MyCare Ohio capitation rates at January 2015.

As MyCare Ohio plans continue efforts to manage care, there is the potential for MyCare Ohio capitation rates to further reflect such cost efficiencies.

MyCare Ohio Total Medicaid Cost Trend Cumulative Trend of Medicaid Costs Per Member Per Month



Data Source: Milliman

⁷ Includes members in a nursing facility and those receiving waiver services.

⁸ Per July 2016 Effective MyCare Capitation Rates and Assumed Enrollment Mix.

MYCARE OHIO LESSONS LEARNED

Ohio continues its effort to extend the benefits of care coordination to all remaining fee for service populations. Ohio Medicaid has identified lessons learned from the implementation of MyCare Ohio that will support a smooth transition for Managed Long Term Services and Supports (MLTSS). Lessons learned represent processes that have worked well, which Ohio Medicaid intends to replicate, as well as challenges, which Ohio Medicaid will implement and operationalize differently with MLTSS.

In general, MyCare Ohio plans' rates for the HEDIS clinical performance measures across the ODM focus population streams (healthy adults, behavioral health and chronic conditions) are evidence of access to care and appropriate management of chronic and behavioral health conditions. Approximately 53% of the reported rates exceeded the national 75th percentile benchmarks; for the Statewide average over 45% of the rates exceeded the national 90th percentile benchmark.

In general, members are pleased with MyCare Ohio as represented with improved CAHPS data results and the fact that nearly 70% of all MyCare Ohio enrollees choose to receive both their Medicare and Medicaid services from one of the five MyCare Ohio plans.

Ohio Medicaid is working with its enrollment hotline to better train staff to be able to fully educate the member on the benefits for allowing their MyCare

plan to coordinate both their Medicare and Medicaid benefits.

The coordination of Medicare and Medicaid, two very complex systems of care, has been successful. Every member enrolled in a MyCare Ohio plan has access to care management, a valuable service that they would not otherwise receive.

Members are getting the care that they need, as evidenced by the approval of more than 90% of all provider-submitted prior authorization requests by the managed care plans since the implementation of MyCare Ohio. For prescribed periods of time during their new enrollment in MyCare Ohio, members benefit from protections that allow them to continue receiving the same level of services and accessing the same providers so that both the plan and member are able to adjust accordingly. Ohio Medicaid has received national accolades for this element of MyCare Ohio, formally known as transitions of care requirements.

Along with the MyCare Ohio accomplishments, Ohio Medicaid also recognizes opportunities for improvement. The majority of challenges experienced in the MyCare Ohio program have been related to operational issues. These include challenges with the process of rolling out MyCare Ohio over a short three month period, lack of integration of key Medicare and Medicaid systems, timeliness of provider payments and a lack of understanding of managed care plan processes and procedures. While CMS has been a great partner for MyCare Ohio, the nature of the demonstration does not provide Ohio with the flexibility to implement some of the fixes that Ohio believes are necessary. The following chart highlights some of the key challenges identified in MyCare Ohio that Ohio Medicaid plans to improve with the implementation of MLTSS. As the program is developed, Ohio Medicaid will continue to work with stakeholders to ensure a smooth and successful transition.

MyCare Ohio Area of Challenge	MLTSS Initial Design Ideas*
Member transition	<ul style="list-style-type: none"> • 90 day notification to members prior to member’s enrollment. • Phased in approach with transitions occurring every 60 days to permit care coordination/service authorization and other pre-enrollment activities between fee-for-service entity and managed care plan. • 90 day period after initial enrollment in MLTSS program for member to decide if their current managed care plan meets their need, or if a different plan would better serve them. • Annual open enrollment period for members after initial 90 day period.
Systems integration	<ul style="list-style-type: none"> • Ohio Medicaid has positioned itself to avoid some of the initial roll-out systems issues that were faced with MyCare Ohio. • Ohio Medicaid will not have interface with the CMS system which will alleviate some of the upfront enrollment challenges experienced with MyCare Ohio.
Managed care plan readiness	<ul style="list-style-type: none"> • Plans must have appropriate contracts in place prior to a member’s enrollment effective date, such as case management and independent provider contracts and contracts with a member’s current providers, and must be prepared to pay those providers • Plans must have services that the member is currently receiving appropriately loaded in the system to ensure service authorizations prior to member’s enrollment.
Comprehensive assessments	<ul style="list-style-type: none"> • Standardize comprehensive waiver assessment across all avenues.
Waiver services	<ul style="list-style-type: none"> • Streamline waiver services – one waiver for all members and all ages. • Package of services and supports to promote independence in the community that align waiver service definitions and provider qualifications. • Streamline waiver code set to allow for ease of billing for providers and payments by managed care plans.

* The information provided in this column are initial ideas. Ohio Medicaid intends to continue its work with stakeholders to ensure a smooth implementation of MLTSS.

MyCare Ohio Area of Challenge	MLTSS Initial Design Ideas*
Provider reimbursement	<ul style="list-style-type: none"> • Examination of prompt pay requirements to clarify state expectations for timely payment of provider claims. Penalties by provider type.
Patient liability	<ul style="list-style-type: none"> • Streamline client liability to utilize one process. • Dedicated work team to improve patient liability.
Value-based contracting	<ul style="list-style-type: none"> • Reward higher performing providers (i.e. nursing facility providers) and set standards around value based contracts. • Require MCPs to enter into value based contracts with specific provider types, including nursing facilities and provider quality incentive payments.
Network adequacy	<ul style="list-style-type: none"> • Expand Medicaid standards around access for providers.
Provider and member education	<ul style="list-style-type: none"> • Engage with relevant stakeholders. • Design program with stakeholders based on feedback of what did and did not work well with MyCare Ohio.

* The information provided in this column are initial ideas. Ohio Medicaid intends to continue its work with stakeholders to ensure a smooth implementation of MLTSS.

CONCLUSION

In the three years MyCare Ohio has been operational, Ohioans receiving Medicaid benefits have experienced better coordination among their primary, behavioral and long-term services and supports care; providers are getting more timely payments; and MyCare Ohio care capitation rates to managed care plans are trending lower, an experience that is not true for our fee for service costs. Ohio Medicaid and the MyCare Ohio plans continue to make improvements to better the program for members and providers. Although we have experienced a number of operational challenges with the implementation of MyCare Ohio, many of which have improved over the last three years, the main focus of our program has remained consistent. We have coordinated care for some of the most vulnerable Ohioans, have provided access to needed services, and, in many cases, have improved the quality of life for the people we serve.

Now is the time for us to shift our focus from a fee for service model that is focused on providers to a model of care in which vulnerable Ohioans come first. The experiences we have had in MyCare Ohio – both the successes and challenges – will allow us to design a Managed Long-Term Services and Supports program that will best meet the needs of Ohioans we serve. The success stories in this report demonstrate that individuals receiving Medicaid can benefit greatly from managed care. Thousands of other Ohioans currently in the fee for service Medicaid system could experience similar success once they too have access to the benefits of care coordination.

To learn more about Ohio's Managed Long-Term Services and Supports program or to be involved in the design or implementation of the program, please visit medicaid.ohio.gov/MLTSS.