PROCESS EVALUATION OF MYCARE OHIO

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EXECUTIVE SUMMARY

BACKGROUND

There are 253,000 Ohioans who receive coverage from both the federal Medicare and the state and federal Medicaid programs. Medicare benefits emphasize acute medical services, while Medicaid covers acute and long-term services and also includes a cost-sharing element that supports the co-pays and deductibles typically charged to Medicare beneficiaries. Individuals who are dual eligible often have chronic illnesses and a sizeable proportion have a need for long-term services and supports (LTSS). Nationally, individuals who are dual eligible comprise about one-fifth of all Medicare enrollees and 15% of the Medicaid population, yet they account for more than 35% of Medicare and Medicaid expenditures. Concerns have been raised that the Medicare and Medicaid programs are not well coordinated, resulting in an array of negative outcomes for individuals and the system of care. As part of a national demonstration called the Financial Alignment Initiative (FAI), ten states entered into a partnership with the Centers for Medicare and Medicaid Services (CMS) to better align Medicare and Medicaid services. The demonstration was rooted in a belief that enrolling individuals who are dually eligible into a managed care plan that included both Medicare and Medicaid could improve the quality of both acute and long-term services and lower costs for the states and federal government.

In May 2014, Ohio began implementation of its FAI, which is called the MyCare Ohio program. The MyCare program uses a three-way contract between the state, CMS, and five participating managed care health plans called MyCare Ohio Plans (MCOPs) where the health plan receives a prospective blended payment to provide comprehensive and coordinated care. The MCOPs are required to contract with the Area Agency on Aging (AAA) within each region to provide coordination of home- and community-based (HCBS) waiver services for beneficiaries age 60 and older. CMS contracted with a national evaluator, the Research Triangle Institute (RTI), to evaluate the state FAI initiatives. The initial evaluation report for Ohio was released in November of 2018 and, on average, results were positive for the demonstration overall, but mixed for the population enrolled in the long-term services component of the demonstration. Unfortunately, the evaluation did not include Medicaid costs, an issue of paramount importance to state policy makers.

With no other evaluation data available for the MyCare program, the Ohio Department of Medicaid (ODM) funded the Scripps Gerontology Center at Miami University (Scripps) and the Ohio Colleges of Medicine Government Resource Center at the Ohio State University (GRC) to conduct an independent evaluation of the demonstration. The study includes both this process evaluation and an impact evaluation. The goals of this report are to describe the implementation of MyCare, identify administrative issues for

ODM consideration, and provide context for better understanding impact evaluation findings.

Process Evaluation Research Questions and Methodology

This process evaluation examines *how* the MyCare program is being implemented. Demonstrations such as MyCare consist of complex chains of action. A determination of how critical components of the program are being implemented is essential in understanding program outcomes. The process study relied on (1) interviews and focus groups with key stakeholders at the state and regional levels and (2) a review of MyCare descriptive data available through the ODM dashboard and demonstration agreements. To better understand day-to-day program implementation of MyCare and to identify differences in care management structures and processes for both AAAs and the MCOPs, the process evaluation focused on four of the seven MyCare Ohio regions.

To gain a broad understanding of the benefits and challenges associated with MyCare implementation and care management, the research team initially conducted 29 telephone interviews with state-level stakeholders including representatives from the Ohio Department of Medicaid, Ohio Department of Aging (ODA), four AAAs, the five MCOPs, professional associations representing LTSS and acute care providers, and consumer advocacy groups. To understand the administration and day-to-day implementation of care management within MyCare Ohio, the research team conducted 76 regional interviews/focus groups with a total of 331 respondents. These respondents were comprised of personnel from four AAAs and all five MCOPs. The team also conducted interviews and focus groups with 87 service provider respondents representing 36 different provider organizations. Additionally, interviews were conducted with 40 MyCare members, with three family members serving as proxies.

Program Description

The MyCare Ohio demonstration was created to provide Ohioans who are eligible for both Medicare and Medicaid access to coordinated care for their medical, behavioral health, social, long-term services and supports, pharmacy, and specialty needs. Goals of the demonstration include: lowering avoidable hospital and nursing home admissions and unnecessary emergency room (ER) visits, improving access to primary care providers and other needed services, providing behavioral health services, and identifying and improving social determinants of health and barriers to well-being. Additionally, the demonstration seeks to improve transitions between care settings, increase beneficiaries' engagement in their medical care, and develop care coordination that improves access to affordable care and services.

MyCare Ohio Plans—The five MCOPs—Buckeye Health Plan (Buckeye), CareSource, Molina Healthcare of Ohio (Molina), Aetna Better Health of Ohio (Aetna),

and UnitedHealthcare (United)—provide integrated primary, acute care, behavioral health, and Medicare and Medicaid LTSS services across 29 counties grouped into seven regions which were centered around the main urban areas of the state. Each region is served by two MCOPs, except for the Northeast region, which is served by three MCOPs.

Enrollment—Individuals who are dually eligible, over 18 years of age, and live in one of the covered geographic regions must enroll into MyCare. Some individuals with dual eligibility were excluded from the demonstration including individuals with developmental disabilities, those with access to private insurance, and those who receive Medicaid program support for co-pays and premiums, but are not fully eligible for Medicaid. All eligible individuals have the option to voluntarily enroll in any of the MCOPs available in their region. If they do not choose, they are automatically enrolled by ODM into a MCOP for both their Medicaid and Medicare benefits. Beneficiaries can select to have the MCOP continue to coordinate both their Medicaid and Medicare benefits (called “opt-in”) or they may choose to “opt-out” from the Medicare portion of the demonstration and choose either fee-for-service Medicare or pick from an array of Medicare Advantage plans. Beneficiaries who opt-in have the right to opt-out at any time after enrollment and return to fee-for-service or enroll in a different Medicare Advantage plan for Medicare services.

Care management—Under the rules of the demonstration, MCOPs must provide care management services to all enrolled members that promotes their ability to live independently and that coordinates the full set of Medicare and Medicaid benefits across the continuum of care. Additionally, the MCOPs are required to contract with the AAA within each region to provide coordination of HCBS waiver services for members age 60 and older. For those members under the age of 60, the MCOP or another qualified entity may provide coordination of HCBS waiver services. Primary care physicians and other providers are included in the transdisciplinary care teams to assist in development of service plans, communicate with members about their care, and work with the care manager or waiver service coordinator on updates with significant changes to the member’s health or services.

The MCOPs were given considerable flexibility in designing their care management models. Two distinct models of LTSS waiver care management were implemented: waiver service coordination and fully-delegated waiver care management. Three of the MCOPs (Buckeye, Molina, and United) chose to operate within a model where waiver service coordinators employed by the AAAs coordinate services for LTSS members who are age 60 and older in such areas as personal care, home delivered meals, durable medical equipment, and transportation. A MCOP care manager assigned to each member is responsible for creating and implementing a care plan for the member with input from the AAA waiver service coordinator. The AAA waiver service coordinator

is responsible for conducting the required monitoring visits and providing the information necessary to inform the care plan. Two MCOPs (Aetna and CareSource) elected to operate within a fully-delegated model in which care managers employed at the AAAs are responsible for care management of all members age 18+ and coordinate their HCBS waiver services, medical, and behavioral health needs.

Member categories—MyCare beneficiaries are assigned to two primary categories, Community Well and nursing facility level of care (NFLOC), referenced in this report as "LTSS", which has significance in how the MCOPs and AAAs have structured their care management and waiver service coordination personnel and processes. The LTSS group includes individuals who are in need of long-term care and are enrolled in the MyCare Ohio waiver, or are a long-term resident in a nursing facility. Within MyCare, the Community Well population represents individuals who do not need long-term services and supports, and therefore do not receive HCBS waiver services.

MyCare members are assigned a risk stratification level (monitoring, low, medium, high, intensive) by their MCOP within the first month of their enrollment, which is reviewed and adjusted based on assessment of the member's needs. The risk stratification levels dictate the frequency of contact required within care management.

Description of MyCare Members

As of November 2021, total MyCare enrollment was 144,000, which covered 57% of dual eligible individuals in the state. Enrollment varies slightly across the five plans, with CareSource having the highest proportion of members (23%). While the majority of plan members (52%) were over the age of 65, a sizeable proportion (48%) were under age 65, including more than one in five individuals under age 45. Four in ten MyCare members were reported to be classified as Black, Indigenous, or other person of color and six in ten were women. Overall, forty percent of members were opted-out of the Medicare portion of MyCare. The current opt-in/opt-out data show variation by MCOP with United recording an opt-out rate of 46%, in contrast to 37% for CareSource. Community Well members have a 39% opt-out rate compared to 46% for waiver and 51% for long-stay nursing facility residents.

MyCare Implementation

Process findings have been grouped into three analysis categories: care management at the core, program design, and program operations.

Care Management at the Core

Comprehensive care management—Care management is the core element of MyCare. Although care management has been historically widely used for individuals on

a Medicaid waiver program, in the MyCare demonstration this was expanded to include all members. Nearly all interview respondents agreed that this total care management requirement is a strength of the demonstration and particularly beneficial for the Community Well population. Respondents described serving as advocates for members and encouraging them to engage with their health providers and others. Interviewees shared that even prior to the COVID-19 pandemic, care management provided important opportunities for socialization and connection for isolated Community Well members. MCOP respondents also reported that the total care management component of MyCare and their engagement with the Community Well population has increased access to LTSS that can help beneficiaries avoid institutionalization or return them to less-restrictive environments through repatriation efforts.

Effective care management with the Community Well population hinges upon engagement with the care team and one of the most-frequently discussed challenges reported by MCOP staff who work with Community Well members was the inability to reach members. The three-way contract requires the MCOP to attempt to reach beneficiaries at least three times during the first 75 days of enrollment. MCOP respondents reported repeated frustration with receiving incomplete and incorrect contact information for new members at the time of enrollment. They also cited members running out of cell phone minutes and frequently changing phone numbers as barriers. The in-person visit restrictions imposed by COVID-19 have exacerbated this challenge.

Care management models—Three of the four focus AAAs were engaged in both fully-delegated care management and waiver service coordination and were able to provide perspectives on their experiences with operating both models within the same organization. AAAs reported that full-delegation provides them access to more and better data than they receive in their waiver service coordination programs, which is a benefit to the whole organization. The MCOPs engaged in the full-delegation model also expressed their belief that it reduces confusion for members to have a single point of contact for all their needs. In addition, they spoke of the mutual benefits of partnering with community-based organizations.

A consistent challenge shared by the AAA respondents within the fully-delegated model was “scope creep”, referring to increasing numbers of “asks” requested of the AAA fully-delegated care managers with no real ability on AAA leadership’s part to decrease caseload sizes due to stagnant rates from the MCOPs. MCOP respondents also expressed challenges with the fully-delegated model and being ultimately responsible for the member’s well-being and health outcomes, but not having direct supervision over fully-delegated care managers to address issues as they arise.

Reported benefits of the waiver service coordination model included effective teamwork between MCOP care managers and waiver service coordinators which allowed them to "divide and conquer" to address the needs of members. The ability to draw upon each other's expertise was another reported benefit of this model. The MCOP care managers have a good understanding of medical/acute care issues and have access to more information about claims. AAA waiver service coordinators have more knowledge of waiver rules and have long-standing relationships with local providers and close community connections.

One of the challenges reported within the waiver service coordination model included members' lack of understanding and their comprehension of the different roles of the care manager and waiver service coordinator. Respondents reported that despite attempts to educate members, some call waiver service coordinators for assistance with medical issues and non-waiver equipment or call MCOP care managers with questions regarding waiver services.

Both MCOP care managers and AAA waiver service coordinators reported some strain regarding division of labor and communication. AAA waiver service coordinators expressed frustration with MCOP care managers' limited understanding of waiver services and rules. They also perceived a reduced professional status and lack of empowerment to work directly with local service providers and address and resolve issues for members within the MyCare system.

MyCare Design

Education about MyCare—It was very clear from both the state-level and regional interviews that there continues to be significant confusion about what MyCare is and how it works. This is not altogether surprising, considering that the majority of persons in the U.S. do not understand the difference between Medicare and Medicaid and know very little about managed care. Nearly all of the respondents reported that MyCare members are often surprised that they have been enrolled in MyCare. Even though the written information provided to beneficiaries focuses on their ability to choose, respondents felt that the majority of beneficiaries do not make a choice (often because they are not aware that they should or can) and are surprised when they are automatically enrolled. Many respondents felt that notification letters are insufficient in helping beneficiaries understand MyCare enrollment and that more contact needs to be made with beneficiaries to educate them *before* they are auto-enrolled into a plan. They felt that someone needs to personally connect with beneficiaries to explain MyCare and go over their list of providers so they can make an informed choice about which MCOP to select.

Opt-in and Opt-out in MyCare—In addition to the general lack of understanding about the MyCare model, respondents also reported a significant lack of understanding among members related to opt-in/opt-out status. As previously stated, members have the right to opt-out of the Medicare portion of the demonstration at any time after enrollment. Respondents understood and respected beneficiaries' right to and desire for choice, but also felt that the majority of members are not making informed decisions and often do not realize the implications of opting out of the fully-integrated component of MyCare. Both AAA and MCOP care management respondents frequently cited opt-in/opt-out status of members as a major barrier to fully realizing the integrated care goals of the demonstration. Opt-out members are entitled to all the same care management benefits as those who opt-in, but respondents likened coordinating care and services for opt-out members to *"trying to work with one hand tied behind your back."*

Program rules and regulation challenges—While respondents recognized that the combining of multiple waivers into one offers additional benefits and flexibility to MyCare beneficiaries, they discussed that MyCare rules often refer back to PASSPORT and Ohio Home Care Waiver rules and that it can be confusing as to which rules should be applied. They expressed that further alignment of rules and regulations to be specific to MyCare would help reduce confusion. Several respondents longed for the development of a "universal MyCare playbook" with a set of rules that are consistently applied across plans and settings.

Program Operations

Enrollment issues—The availability and accuracy of eligibility and enrollment information was frequently mentioned by respondents as creating operational challenges and barriers. In fact, these issues occur so frequently that the MCOPs and AAAs reported engaging in regular meetings specifically to discuss and troubleshoot enrollment and eligibility issues. MCOP respondents reported that they face barriers with being able to access information even if a member transfers from another MyCare region.

Assessment issues— Conversations with AAA MyCare assessors revealed that the demonstration's requirement that level of care (LOC) assessments and re-assessments must be conducted by the AAA "front door" can be confusing to members. They reported that members will often not speak with them, because they do not understand the assessor role and do not know them. In some cases, they may have recently had a routine care management assessment with their MyCare care manager or waiver service coordinator and do not see the need for another session.

Assessor team members reported lags between when they identify an individual as eligible for waiver services and when the individual actually ends up getting services put in place. They shared that individuals who were assessed a month prior have contacted them and asked "Where are my services?" and they have to explain that they don't make the final waiver determination and that there is nothing they can do to speed up that process. The assessor team respondents also described frustration around wanting to be good collaborators and notify MCOP care managers of issues they become aware of during LOC re-assessments, but not having a way to communicate more than basic information with them. MCOP care management staff also expressed a desire for better communication when members transition from other waivers into MyCare.

Transitions of care—Despite significant efforts by MCOPs and AAAs around addressing transitions of care and significant change events, many respondents spoke about room for improvement around transitions for both opt-in and opt-out members. Primarily, challenges come from "hefty" demonstration requirements. In particular, the contact and follow-up requirements were mentioned as posing major challenges for care management personnel because the timeframes allowed for contact and follow-up are extremely short and can disrupt the flow of an already full schedule of required routine activities.

Poor communication during transitions between settings poses serious barriers to ensuring that those transitions are smooth and that members have needed services and equipment in place in a timely manner. Care managers and waiver service coordinators reported that they are often not made aware when a member is discharged, even if they have been successful in making contact with hospital and NF staff while the member is inpatient. An inability to secure discharge summaries from hospitals and NF facilities, despite multiple attempts, was a universal complaint and source of great frustration to both MCOP and AAA care management personnel. Respondents felt that the busyness of hospital and NF staff and a general misunderstanding of MyCare and the care manager role were contributing factors.

Information access and communication— Many non-MCOP respondents expressed disappointment that the MyCare demonstration has not resulted in better access to information and information sharing between the MCOPs, AAAs, and providers. Respondents offered suggestions to achieve greater access to member information, electronic medical records, and health histories to provide better services.

MCOP respondents shared steps they have taken to work with providers and to establish points of contact to facilitate communication. Two MCOPs shared that they have created "post-acute" positions specifically dedicated to working with NF and hospice providers to serve as a single point of contact; addressing questions about authorizations, coordination of care, claims, and assisting to streamline those

processes. The MCOPs recognized the competing goals that exist in the long-term care space. The MCOPs are focused on diversion and rebalancing, while providers continue to be paid largely on a fee-for-service model. They saw these post-acute positions as important to building better relationships with providers and exploring how to move to value-oriented payment models.

Interactions with providers—In their interviews, regional provider respondents were focused on inadequate rates and reimbursement, difficulty working with MCOPs to resolve billing issues, and service delays caused by added authorization requirements. Provider respondents repeatedly reported a desire for a streamlined billing process across the MCOPs and discussed many administrative burdens associated with working in multiple billing systems. Several providers related that they had to hire additional staff to manage the increased workload. Numerous providers mentioned that billing under PASSPORT is easier and faster and felt that simplifying the billing and reimbursement processes within MyCare would lead to more provider options for members.

Care management personnel consistently identified a shortage of in-home personal care providers (and *quality* providers) as one of their biggest challenges in working with members and providing effective care management. Home care providers also discussed challenges with recruiting and retaining personal care staff. While COVID-19 has exacerbated home care staffing challenges, respondents pointed out that this issue was significant prior to the pandemic. Some respondents felt that this challenge is exacerbated by the cumbersome certification requirements independent providers must meet.

Issues with transportation availability and reliability were the most frequently-mentioned service provision challenge by care managers and waiver service coordinators after personal care staff shortages. Lack of available transportation and problems with scheduled transportation were reported as major challenges and barriers to members being able to adequately address their health needs and contributing to issues related to social determinants such as securing food and engaging with social support. Respondents described numerous incidents where members were unable to access transportation in their needed timeframe (e.g., being able to accept a short-notice appointment with a physician) and experienced very long wait times for pick-up (or were never picked up).

Behavioral health—The fact that BH was included in MyCare from the beginning of the demonstration and that substance use disorder (SUD) residential benefits are covered by Medicaid was reported as a huge benefit. The challenges of providing care management and services for members with behavioral health (BH) came up frequently in interviews and focus groups. Respondents reported that housing issues and SUD are major factors within the BH population and there is much more homelessness and

unstable housing with these members. One MCOP estimated that over 50% of their membership has some sort of BH diagnosis in addition to chronic disease.

Issues for Future Consideration

The MyCare demonstration design allowed significant variation to occur across MCOPs. One of the questions as we enter the seventh year of the demonstration is, if the state continues MyCare, should it become more standardized? For example, three MCOPs use a waiver service coordination care management model and two plans use a fully-delegated care management model. We also see variation in other operational issues, such as caseload size, reimbursement rates for both the care management tasks and providers, and the type of information and communication practices between the plans, AAAs, and providers. Provider respondents reported a desire for a streamlined and transparent billing process across the MCOPs and discussed many administrative burdens associated with working with multiple billing systems. As programs move from a demonstration to ongoing phase, we typically see more standardization. To this point however, there is very limited information on the association between design decisions and member outcomes making it more difficult to standardize program design and operations.

An overall design issue that has a large impact on the demonstration is the opt-out rate. With four in ten members opting out, for a large number of members the benefits of Medicare and Medicaid coordination, which was a major goal of the demonstration, does not exist. While Medicaid participation is mandated by the state, federal rule prevents mandatory Medicare participation. A further complication is that the LTSS population has a higher opt-out rate than those members classified as Community Well. Because the LTSS group has higher rates of disability and, on average, use more services, the higher opt-out rate for this group further limits the strength of the intervention. To use the context of the COVID-19 vaccine, this means that about half of those individuals in greatest need are getting one “dose” of the MyCare intervention, rather than two.

The high rate of opt-out members also impacts day to day operations for MCOP and AAA care managers and waiver service coordinators. For example, communication with providers, particularly with hospitals and physicians, was a common challenge reported and for those members who opt-out, these challenges are heightened. These issues are compounded by data concerns, as less information is available for opt-out members, making it doubly-difficult to manage care for these individuals. The coordination goals of the demonstration are compromised when Medicare is excluded from the picture.

Study respondents were thoughtful and insightful about MyCare design and operations and identified practices that would be good candidates for quality improvement initiatives. However, because of ongoing and frequent changes by CMS, ODM, and the

MCOPs, many respondents felt that the demonstration had not yet achieved stability or a steady state. This means efforts to incorporate quality improvement strategies into day-to-day operations are limited. It also means that some of the impact and implementation findings will change when steady state can be achieved. If ODM continues to operate MyCare as currently configured, a plan to arrive at steady state and a plan to incorporate demonstration-wide quality improvement activities will be important steps forward.

INTRODUCTION

There are 253,000 Ohioans who receive coverage from both the federal Medicare and the state and federal Medicaid programs.[1] Medicare benefits emphasize acute medical services, while Medicaid covers acute and long-term services and also includes a cost-sharing element that supports the co-pays and deductibles typically charged to Medicare beneficiaries. Individuals who are dual eligible often have chronic illnesses and a sizeable proportion have a need for long-term services and supports (LTSS). Nationally, individuals who are dually eligible comprise about one-fifth of all Medicare enrollees and 15% of the Medicaid population, yet they account for more than 35% of Medicare and Medicaid expenditures.[2] Concerns have been raised that the Medicare and Medicaid programs are not well coordinated, resulting in an array of negative outcomes for individuals and the system of care. As part of a national demonstration called the Financial Alignment Initiative (FAI), ten states entered into a partnership with the Centers for Medicare and Medicaid Services (CMS) to better align Medicare and Medicaid services. The demonstration was rooted in a belief that enrolling individuals who are dually eligible into a managed care plan that included both Medicare and Medicaid could improve the quality of both acute and long-term services and lower costs for the states and federal government through a capitated model.

In May 2014, Ohio began implementation of its FAI, which is called the MyCare Ohio program. The MyCare program is a three-way contract between the Ohio Department of Medicaid (ODM), CMS, and five managed care health plans called MyCare Ohio Plans (MCOPs), where the MCOP receives a prospective blended payment to provide comprehensive and coordinated care. Additionally, the MCOPs are required to contract with the Area Agency on Aging (AAA) within each region to provide coordination of home- and community-based (HCBS) waiver services for beneficiaries age 60 and older. The MyCare Ohio demonstration was created to provide Ohioians who are eligible for both Medicare and Medicaid access to coordinated care for their medical, behavioral health, social, long-term services and supports, pharmacy, and specialty needs.

Goals of the demonstration include: lowering avoidable admissions and unnecessary emergency room (ER) visits, improving access to primary care providers and other needed services, providing behavioral health services, and identifying and improving social determinants of health and barriers to well-being. Additionally, the demonstration seeks to improve transitions between care settings, achieve cost savings for the state and federal government, increase

individual engagement in their medical care, and develop care coordination that improves access to affordable care and services.[3]

CMS contracted with a national evaluator, the Research Triangle Institute (RTI) to evaluate the state FAI initiatives. The initial evaluation report for Ohio was released in November of 2018 and, on average, results were positive for the demonstration overall, but mixed for the population enrolled in the long-term services component of the demonstration.[4] Unfortunately, the evaluation did not include Medicaid costs; an issue of paramount importance to state policy makers.

With no other evaluation data available for the MyCare program, ODM funded the Scripps Gerontology Center at Miami University (Scripps) and the Ohio Colleges of Medicine Government Resource Center at the Ohio State University (GRC) to conduct an independent evaluation of the demonstration. The study includes both this process evaluation and an impact evaluation (Bowblis et al., 2021). The goals of this report are to describe the implementation of MyCare, identify administrative issues for ODM consideration, and provide context for better understanding impact evaluation findings.

Process Evaluation Research Questions

MyCare was designed to better coordinate the benefits offered through the Medicaid and Medicare programs with the goals of improving the overall well-being of individuals while also improving health care quality and containing costs. Before we can assess outcomes of interest, we need to understand how the program is being implemented. Therefore, this process analysis explores how critical components of the program are carried out in order to provide context to consumer experiences and program outcomes. The process evaluation addresses the following questions regarding the implementation of the demonstration:

- What is the model of care coordination implemented in MyCare and how does it differ by MCOP?
- What is the role of the AAAs in program implementation?
- How does care management differ based on member setting (community-dwelling or long-term nursing facility)?
- How does implementation differ in regard to “opt-in” vs. “opt-out” members?
- What intentional steps are taken by the MCOPs to address coordination of care across settings?
- How do the MCOPs work with the provider community?
- How do the MCOPs innovate within the demonstration?

- Do MCOPs pay differently than the traditional Medicaid system?
- Do MCOPs emphasize the social determinants of health?

Background

The expansion of managed long-term services has generated considerable interest over the last decade. In addition to the capitated FAI programs, other states are testing or exploring some type of managed long-term services system. For example, Colorado and Washington are testing an integrated model using the fee-for-service system, while others have focused primarily on the Medicaid population with an opportunity to enroll members in a complementary Medicare Advantage plan, when possible.[5] States believe that better integration of Medicare and Medicaid services can lower costs and improve quality. There has been a long-standing criticism that the Medicare and Medicaid programs have not worked in concert with one another and that state and federal policy incentives have not been aligned. The increasing older population, the cost pressures from both Medicare and Medicaid, and health and long-term services quality concerns highlight the need for new models of service delivery. Additionally, a shift to a managed care strategy is attractive to states, to the extent that it can provide more predictability of expenditures from year to year.

The strong push to integrate Medicare and Medicaid services has been driven by the federal government, through CMS, and by the states themselves in response to two major system concerns: quality and cost. Professionals, researchers, and consumers are well aware of the lack of coordination between hospitals, nursing facilities, home health, and HCBS providers. The silos result in organizations typically being well-versed in their own part of the system, but less so for the other components. Negative outcomes, such as inappropriate hospital re-admissions, unnecessary nursing home placement, uncoordinated use of medications, and overlapping in-home providers visiting the consumer's home are the result of this fragmentation. In many instances the lack of integration translates into an inefficient and expensive delivery system. Because the dual eligible group is a large part of Medicaid expenditures and Medicaid is about one-quarter of most state budgets,[6] efforts to both control costs and make those costs predictable each year, are paramount to the states. A growing older adult population compounds these problems for today and tomorrow. For this reason, many of the states participating in the FAI are the most populated states in the nation including New York, California, Texas, Illinois, Michigan, and Ohio.[7,8]

An integrated care delivery system could have a positive impact on individuals in several ways. First, incentives that better coordinate care could help to create a more cost-effective system. Since the 1970's critics have argued that the long-

term care system has been out of balance, with Medicaid favoring more expensive institutional care over HCBS. Often, home- and community-based options have been restricted, while access to nursing facilities has not. While most states, including Ohio, have already made major changes that have altered the balance between nursing facilities and HCBS, an integrated care delivery system could enhance these efforts since the funding stream is more integrated.

The fragmentation and misaligned financial incentives that have existed between the Medicare and Medicaid funding sources have also been identified as a major contributor to poor quality and high costs of care. States have had strong incentives to shift costs to Medicare and away from Medicaid and this can result in inappropriate transfers of individuals across settings. One common example is the coordination between hospitals and nursing facilities, which has been heavily criticized, as Medicare's payment mechanisms incentivize hospitals to discharge patients earlier in their stay. Because Medicare and Medicaid have different funding approaches and reimbursement rates, the lack of coordination has also had an impact on provider behaviors across multiple settings. A well-implemented integrated care system could help to ensure that older individuals get the right care, in the right place, at the right time. While many of these issues have been the object of numerous strategic initiatives, system change has been slow and inconsistent across the nation. Proponents of integrated care argue that the demographic and cost challenges must be addressed as Americans age.

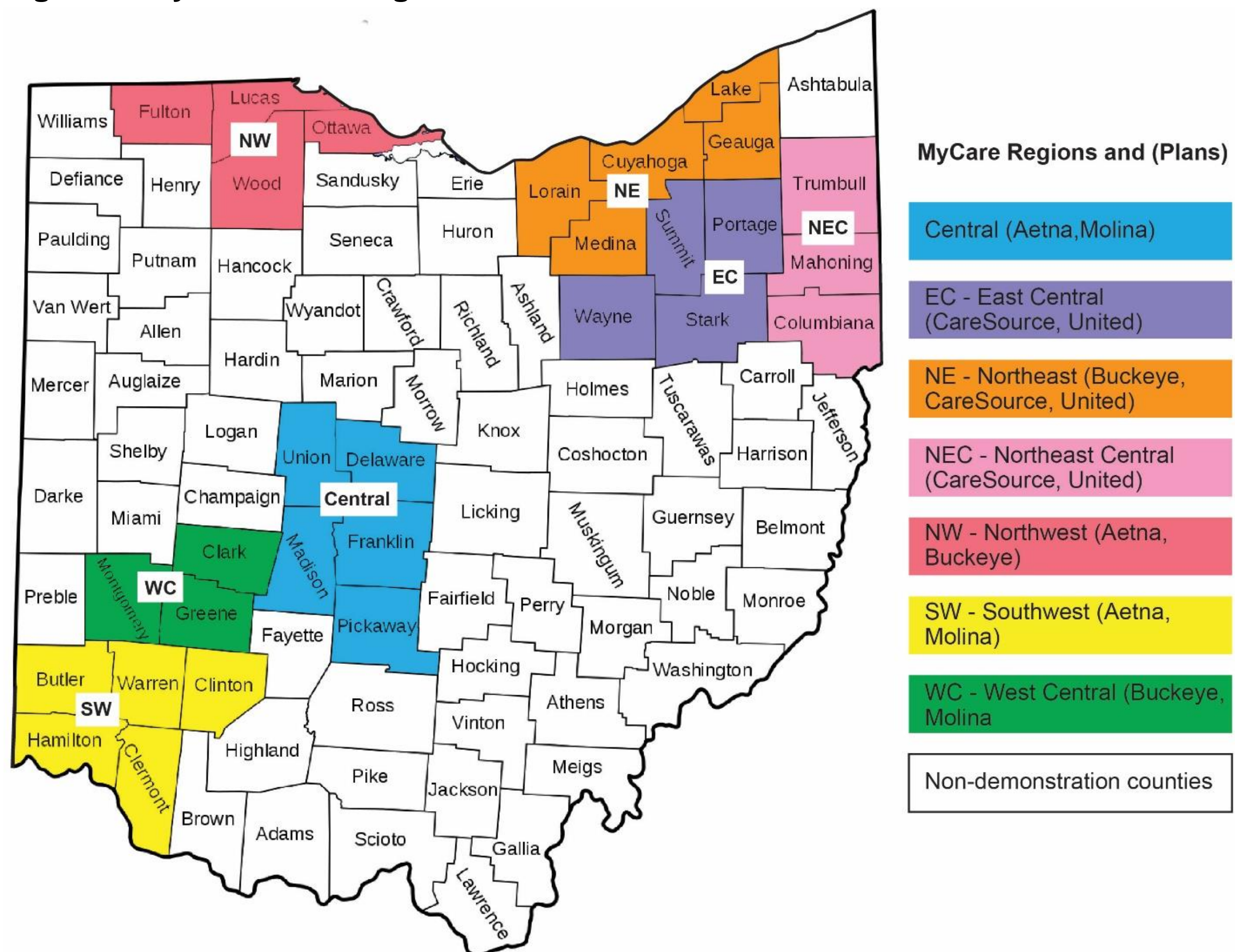
MyCare Ohio

The MyCare Ohio demonstration began in May 2014 and serves individuals who are dually eligible for Medicare and Medicaid, with the program covering 57% of those who are dually eligible in the state (144,000 Ohioans).[9] MyCare covers two distinct populations: (1) individuals who require long-term services and supports, which includes those with severe disabilities who reside in a home or apartment community setting, in an assisted living residence, or in a nursing facility (the nursing facility level of care (NFLOC), or long-term services and supports (LTSS), population); and (2) individuals who reside in the community and have some, little, or no disability (the Community Well population). The demonstration is regulated by a three-way contract between ODM, CMS, and five managed care health plans, called MyCare Ohio Plans (MCOPs). A two-way contract also exists with the Ohio Department of Medicaid and the MCOPs which is known as the provider agreement. This provider agreement is updated every six months by ODM. Amendments are made to the three-way contract as necessary.

The five MCOPs—Buckeye Health Plan (Buckeye), CareSource, Molina Healthcare of Ohio (Molina), Aetna Better Health of Ohio (Aetna), and

UnitedHealthcare (United)—provide integrated primary, acute care, behavioral health, and LTSS Medicare and Medicaid services across 29 counties grouped into seven regions and centered around main urban areas across the state.[10] Each region is served by two MCOPs, except for the Northeast region, which is served by three MCOPs.[11] Figure 1 shows the MyCare Ohio demonstration regions and the MCOPs serving each region.

Figure 1. MyCare Ohio Regions and Plans



Prior to MyCare, Medicaid recipients that required LTSS could receive home and community-based services through three separate Medicaid HCBS NFLOC waivers: PASSPORT (age 60 plus), the Assisted Living waiver (18 and older in assisted living), and the Ohio Home Care Waiver (below age 60). Under the MyCare demonstration, these three waivers were combined so that dually eligible Ohioans in demonstration regions receive LTSS services through the MCOPs in partnership with the AAAs. Dually eligible Ohioans in non-MyCare counties and those only on Medicaid still receive these services though PASSPORT, the AL Medicaid wavier, and the Ohio Home Care waiver.

MyCare Program Eligibility

Ohioans are eligible for the MyCare program if they are age eighteen years or older at the time of enrollment and are dually eligible (i.e., eligible for Medicare parts A, B and D and also eligible for the Medicaid program). Individuals must also reside in one of the 29 plan demonstration counties in Ohio.[12] Members have access to health services, medications, behavioral health, social services, and LTSS including nursing facility and HCBS. Under a MyCare Ohio plan, members who meet the Medicaid Nursing Facility Level of Care (NFLOC) criteria and/or an authorized representative on the member's behalf, have the ability to choose HCBS waiver services or nursing facility placement.[13]

The following groups are not eligible to enroll in the demonstration: individuals with intellectual disabilities and other developmental disabilities (IDD) who are served through an IDD 1915(c) HCBS waiver or intermediate care facilities for individuals with IDD (ICF-IDD); individuals with third-party creditable health care coverage; those on a delayed Medicaid spend-down, whose Medicaid coverage is not continuous; and individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE).[14]

MyCare Program Enrollment

Individuals who are dually eligible for Medicare and Medicaid, over 18 years of age, and live in the covered geographic area, except those previously mentioned, must enroll into the MyCare Ohio plan demonstration. They have the option to voluntarily enroll in any of the MCOPs available in their area. If they do not make a selection, they are automatically enrolled by ODM into an MCOP for both their Medicaid and Medicare benefits. Beneficiaries can choose to have the MCOP continue to coordinate both their Medicaid and Medicare benefits (called "opt-in") or they may choose to "opt-out" from the Medicare portion of the demonstration and choose either fee-for-service Medicare or pick from an array of Medicare Advantage plans. Beneficiaries who are opted-in have the right to opt-out at any time after enrollment and return to fee-for-service or a Medicare Advantage plan for Medicare services. Beneficiaries also have the right to change to a different MCOP available in their region at any time after enrollment with the change effective at the beginning of the following month.[15]

MyCare Ohio requires that MCOPs must provide care management services to all enrolled members through a person-centered approach that promotes the member's ability to live independently and that "comprehensively coordinates the full set of Medicare and Medicaid benefits across the continuum of care including medical, behavioral, LTSS, and social needs".[16] Additionally, the MCOPs are

required to contract with the AAA within each region to provide coordination of HCBS waiver services for beneficiaries age 60 and older.

Under MyCare Ohio, the following waiver services are covered for beneficiaries: adult day health, assisted living, Choices Home Care Attendant, community integration, community transition, enhanced community living, homemaker, home care attendant, home delivered meals, home maintenance and chore, home medical equipment and supplemental adaptive and assistive devices, home medication, nutrition consultation, out-of-home respite, personal care aide, personal emergency response, pest control, social work counseling, waiver nursing, and waiver transportation.[17]

Care managers or waiver service coordinators conduct routine assessments to evaluate member's medical, behavioral health, LTSS, and social needs to create a thorough, integrated, and personalized care plan to address the member's specific medical and behavioral health needs, identify their clinical and non-clinical goals, and implement suggested interventions.[18] The transdisciplinary care management team includes the member, their MyCare care manager (and waiver service coordinator, if applicable), the member's family/caregiver, primary care physician, specialists, and other providers to assist in development of service plans, communicate with members about their care, and work with the care manager or waiver service coordinator on updates with significant changes to the member's health or services.

Beneficiary Categorizations

MyCare beneficiaries are assigned to two primary categories, Community Well and LTSS (NFLOC), which has significance in how the MCOPs and AAAs have structured their care management and waiver service coordination personnel and processes.

Level of Care

The three-way contract outlines the two primary categories of beneficiaries that dictate the rates for the Medicaid component of MyCare. The LTSS population includes individuals who meet NFLOC and are enrolled in the MyCare Ohio waiver program, *or* are a long-term resident in a nursing facility.[19] The Community Well population includes individuals who do not meet NFLOC, and therefore do not receive HCBS waiver services.

All eligible MyCare beneficiaries in the waiver program are initially and annually assessed to determine whether they meet Intermediate Level of Care (ILOC), which is required to receive HCBS waiver services. To demonstrate ILOC, an

individual must have a need for at least one of the following: assistance with two activities of daily living (ADLs); assistance with one ADL and medication self-administration; one skilled nursing or skilled rehabilitation service; or 24-hour support in order to prevent harm due to a cognitive impairment.[20] Within MyCare Ohio, AAA “front door” personnel are responsible for conducting ILOC assessments. Individuals newly-eligible for MyCare are entered into the State of Ohio Healthcare Electronic Notification System (HENS), which is the system through which the AAAs communicate with MCOPs. Assessors at the AAAs conduct the assessment, determine whether the individual meets ILOC, enter the ILOC determination into the Ohio Integrated Eligibility System (Ohio Benefits), and then also communicate the determination to the MCOP through HENS.

Between annual ILOC assessments, the MCOP and AAA fully-delegated care managers are responsible for monitoring the status of members in their caseloads and identifying changes that may affect the member’s ILOC status. If a care manager believes that a member has had such a change, they can submit a request for an ILOC determination or re-determination.

Risk Stratification

MyCare members are assigned a risk stratification level (monitoring, low, medium, high, intensive) by their MCOP within the first month of their enrollment, which is reviewed and adjusted based on assessment of the member’s needs.[21] Members designated as monitoring or low risk are required to have a health risk assessment (HRA) and members receiving waiver services and those designated as medium, high, and intensive risk are required to have a comprehensive assessment. In lieu of an HRA, MCOPs can also choose to administer the comprehensive assessment for all members, regardless of risk level.[22]

The risk stratification levels dictate the frequency of contact required within care management. Minimum contact requirements for the medium, high, and intensive levels are dictated by the three-way contract. The MCOPs have the ability to establish minimum contact requirements for low and monitoring levels, which are approved by ODM. Members receiving HCBS waiver services are monitored according to the “high” minimum contact schedule. Table 1 shows the minimum contact requirements outlined in the three-way contract.

Table 1. Minimum Contact Requirements per Risk Stratification Level	
Risk stratification level	**Minimum contact schedule**
Intensive	One in-person visit every two months Maximum of 60 days between visits Telephonic contact as needed
High	One in-person visit every three months Maximum of 90 days between visits Telephonic contact as needed
Medium	One in-person visit every six months Maximum of 180 days between visits Telephonic contact as needed

Source: Centers for Medicare and Medicaid Services & Ohio Department of Medicaid. July 1, 2019. *Ohio demonstration three-way contract.* https://medicaid.ohio.gov/static/Providers/ProviderTypes/Managed+Care/ICDS/3-WayContract-072019.pdf

Note: Face-to-face interactions with members were suspended in March 2020 due to the COVID-19 pandemic and were still suspended at the time of regional interviews.

Care Management Status

Once enrolled in an MCOP, MyCare members are also categorized by their care management status. The provider agreement outlines these statuses as "outreach and coordination", "engaged", and "inactive".[23] These categories have implications for caseload size and, in some MCOP structures, which personnel within the care management team will be in most frequent contact with the member.

Population Stream

MyCare members are also categorized into one of ODM's four population streams dictated by the provider agreement (women's health, behavioral health, chronic condition, and healthy adults). MCOPs are required to submit data on these population streams in accordance with the MyCare Ohio Population Stream Data Submission Specifications.[24]

This study is designed to gain a better understanding of the MyCare program being implemented in Ohio. Because of the growing interest in Medicaid managed LTSS and the recent expansion legislation which now allows Medicare Advantage plans to incorporate an array of community-based services into its benefit package, it is critical for policy makers to have good information about the FAI in Ohio. The challenge is that, despite six years of demonstration experience, there is a lack of data about how MyCare is being implemented and the experiences of members and providers. In order to make evidence-informed

decisions on whether and how to continue MyCare, a comprehensive evaluation of the intervention is critical.

METHODS

The process evaluation data collection was conducted in two phases. The first phase occurred from March – December 2020 and included two main components: (1) interviews and focus groups with key stakeholders at state and regional levels and (2) a review of MyCare descriptive data. The second phase, between June 2021 and November 2021, involved interviews with MyCare members and interviews with additional nursing facility and assisted living facility providers.

To better understand day-to-day program implementation of MyCare Ohio and to identify differences in care management structures and processes for both AAAs and MCOPs, the process evaluation focused on four of the seven MyCare Ohio regions: Central (Columbus), East Central (Akron/Canton), Northeast (Cleveland), and West Central (Dayton). These regions were selected to ensure representation of each care management model (fully-delegated waiver care management and waiver service coordination) and each of the five MCOPs. Table 2 shows the evaluation focus regions, including the counties served and the MCOPs and AAAs operating in each region.

Table 2. Evaluation Focus Regions, Counties Served, MCOPs, and AAAs

Region	Counties	MyCare Plans	AAA
Central	Delaware, Franklin, Madison, Pickaway, Union	Aetna Molina	Central Ohio Area Agency on Aging (COAA)
East Central	Portage, Stark, Summit, Wayne	CareSource United	Direction Home Akron Canton (Direction Home)
Northeast	Cuyahoga, Geauga, Lake, Lorain, Medina	Buckeye CareSource United	Western Reserve Area Agency on Aging (Western Reserve)
West Central	Clark, Greene, Montgomery	Buckeye Molina	Area Agency on Aging (PSA2)

INTERVIEWS AND FOCUS GROUPS WITH KEY STAKEHOLDERS

The original evaluation design included site visits to each region to conduct in-person interviews and focus groups. However, due to the COVID-19 pandemic,

the research team was required to conduct all interviews and focus groups by telephone or video conference platform. The timing of the interviews and focus groups was also affected by the COVID-19 pandemic. State-level interviews were originally slated to begin in April 2020, however, nearly all identified stakeholders were service providers heavily engaged in responding to pandemic-related needs of older adults. Out of respect for the myriad of service delivery and administrative challenges caused by the pandemic, the research team delayed contact with stakeholders until June 2020.

State-level Stakeholders

To gain a broad understanding of the benefits and challenges associated with MyCare implementation and care management, the research team conducted 29 telephone interviews with state-level stakeholders between June 29 – September 8, 2020. These stakeholders included representatives from ODM, the Ohio Department of Aging (ODA), the four focus AAAs, the five MCOPs, professional associations representing LTSS and acute care providers, and consumer advocacy groups. These initial interviews assisted the research team in identifying areas for deeper exploration during regional interviews.

Care Management Stakeholders

To understand the administration and day-to-day implementation of care management with MyCare Ohio, the research team conducted 76 regional interviews/focus groups with a total of 331 respondents between September 1 – October 31, 2020. These respondents were comprised of personnel from the four focus AAAs and all five MCOPs including, AAA and MCOP leadership; care management supervisors; care managers; waiver service coordinators; AAA and MCOP care management support staff (clinical case aides, community health workers, Medicaid support specialists); AAA and MCOP personnel dedicated to transition of care; MCOP personnel dedicated to behavioral health; AAA assessment and intake personnel; MCOP waiver authorization personnel; and other AAA and MCOP personnel engaged in quality assurance, information technology (IT), provider relations, recruiting, and training.

ODM facilitated initial introductions between the research team and the MCOPs. To identify appropriate respondents within the MCOPs and AAAs, the research team enlisted the assistance of AAA and MCOP leadership. Personnel were eligible to participate in interviews and focus groups if they were engaged in the provision, supervision, or support of MyCare care management activities or could provide insight into MyCare structures and processes. All but one of the regional respondents had been in their position for a minimum of six months. Table 3

shows the distribution of categories of care management respondents who participated in interviews and focus groups.

Table 3. AAA and MCOP Care Management Respondents by Role

Respondent Role	Number of Respondents	
	AAA	MCOP
Leadership	21	26
Care Management Supervisor	26	44
Care Manager	16*	62
Waiver Service Coordinator	29	N/A
Care Management Support	20	25
Transition of Care	1	13
Behavioral Health	0	11
Assessment and Intake	9	N/A
Waiver Authorization	N/A	6**
Other	16	6
Total Respondents	**138**	**193**

*Fully-delegated waiver care managers
**Respondents were all employed by the same MCOP.

In January 2021, the research team conducted follow-up with MCOP and AAA leadership as needed for clarification of information provided by respondents.

Provider Stakeholders

Between September 1 – November 20, 2020, the research team conducted 23 interviews with organizations providing LTSS or acute care services to MyCare members. All providers were operating within at least one of the four focus regions at the time of interviews, with several providers working in more than one MyCare region. Provider respondents represented home care, durable medical equipment (DME), transportation, nursing facilities (NFs), assisted living (AL), independent living/senior housing, hospice, hospital discharge planning and case management, physician, and case management organizations. Several state professional associations and the focus AAAs assisted in making initial contacts with 40 provider organizations, after which the research team followed up with multiple attempts to schedule interviews with each provider.

Due to the low numbers of providers who participated in interviews in the first phase of data collection, ODM requested that the process evaluation team conduct a second round of data collection with a specific focus on engaging additional nursing facility and assisted living providers. The team again enlisted the assistance of the provider associations to connect with providers with the goal of conducting interviews with providers operating in the four focus regions. Between June – October 2021, the team conducted interviews and focus groups with an additional 13 provider organizations. All 13 organizations provided NF services, 10 of the 13 provided AL services, and seven also provided independent living/senior housing. In total, 87 respondents representing 36 provider organizations participated in interviews between Phases 1 and 2 of data collection.

Table 4 shows the distribution of provider types that participated in interviews. Several respondent organizations reported providing more than one service type.

Table 4. Provider Respondents by Service Type

Service Type	Number
Home Care	11
DME	2
Transportation	2
Nursing Facilities	20
Assisted Living	16
Independent Living/Senior Housing	11
Hospice	4
Hospital Discharge Planning and Case Management	3
Physician	3
Community Case Management	2

Note. Several provider organizations reported providing more than one type of service.

Member Stakeholders

Interviews with MyCare members were not included in the scope of the first phase of process data collection, but were included in the second phase. To ensure feedback from both Community Well and LTSS members from all five MCOPs, the process team set a goal of interviewing 40 members across the four focus regions. These interviews were conducted between June – November 2021. To recruit members, the team provided all five MCOPs and the four AAAs with recruitment materials detailing the opportunity to make available to their membership of the opportunity to participate in an interview. Additionally, ODM and CMS granted approval for the MCOPs to send email and text messages to their membership containing a link to a website landing page on the Scripps

website where members could learn more about the evaluation and the opportunity to participate in an interview. Interested members were prompted to provide their contact information for follow-up by the evaluation team. Referrals from the MCOPs and AAAs resulted in twenty-one member interviews and an additional 19 interviews resulted from members volunteering to participate through the Scripps website. Of the 40 total interviews, 37 were conducted directly with MyCare members and three were conducted with family members serving as proxies.

Of the 37 members directly interviewed, 14 identified as Black, Indigenous, or other person of color (BIPOC) and three identified as biracial, multi-racial, or "other." Just over half (20) member respondents identified as female. Members ranged in age from 34 to 85 with a mean age of 64.5 (SD ± 11.12). Twenty of the member respondents were LTSS waiver, 16 were Community Well, and there was one LTSS-NF member. Twenty-three of the members had opted-in, seven had opted-out, and seven of the members were unable to report their opt-in/opt-out status with certainty. The three member proxies represented LTSS waiver members.

With permission of respondents and in accordance with Miami University Human Subjects protocol, all interviews and focus groups were audio recorded, transcribed verbatim, and checked for accuracy. Members who completed interviews received a $25.00 pre-paid debit card as a token of appreciation for their participation. Interview and focus group data were analyzed by iterative reviews and deductive coding of transcripts by the research team to identify similarities and differences between care management models related to structure, processes, and implementation and to identify emergent themes. Dedoose version 8.0 analytic software was utilized for data management.

Additionally, the research team reviewed official agreements related to MyCare Ohio policies and operations including the three-way contract between CMS, ODM, and the five MCOPs;[25] hereafter, three-way contract); an addendum to the three-way contract executed in February 2020;[26] and the template MyCare Ohio provider agreement between ODM and the MCOPs that was in effect at the start of data collection;[27] hereafter, provider agreement). The MCOP provider agreements effective October 2020 and January 2021 were not utilized in this evaluation.

Limitations

Potential provider respondents were identified through a convenience sampling method and therefore may not be representative of all providers working within the MyCare program. Additionally, MCOP and AAA respondents were selected

by the leadership of those organizations and also may not be representative of all personnel operating in those roles.

FINDINGS

The process evaluation findings are organized into three main sections: (1) Description of MyCare Membership, (2) Description of Care Management Models and Structures, and (3) MyCare Implementation.

DESCRIPTION OF MYCARE MEMBERSHIP

This section presents ODM reported enrollment data for October and November 2021. As shown in Table 5, total MyCare enrollment in November 2021 was 144,000. Enrollment varies slightly across the five plans, with CareSource having the highest proportion of members (23%). While the majority of members (52%) were over the age of 65, a sizeable proportion (48%) were under age 65, including more than one in five members under age 45. Four in ten (42%) of the MyCare members were reported to be classified as Black, Indigenous, and People of Color (BIPOC), and six in ten were women (62%).

Table 5. MyCare Enrollment by Plan, Age, and Gender, November 2021

MyCare Plans	Total MyCare Enrollment November 2021	Distribution by plan (%)	Distribution by Age Under 65 %	Distribution by Age 65 and Over %	Distribution by Gender Number Female	Distribution by Gender % Female
Aetna	28,018	19.5	46.6	53.4	17,275	62.8
Buckeye	27,458	19.1	51.7	49.3	15,330	59.7
CareSource	32,742	22.7	48.4	51.6	19,206	62.6
Molina	27,865	19.3	50.6	49.4	15,335	59.8
United Healthcare	27,956	19.4	44.1	55.5	17,723	62.3
Total	144,039*	100.0	48.1	51.9	84,869	61.5

*Total number of members fluctuates daily.

Tables 6 and 7 show MyCare enrollees who opted-in or out of the integrated Medicare Advantage component of the demonstration. Four in ten (42%) members were opted-out of the Medicare Advantage portion of MyCare. The opt-in/opt-out data show much larger variation by plan than the earlier enrollment data, with United recording an opt-in rate of 46%, in contrast to 63% for CareSource. While opt-out members receive the same care management

services as those that opt-in, care managers have less opportunity to manage and coordinate the Medicare services used by the opt-out members.

Table 6. Opt-in and Opt-out MyCare Enrollment Total and by Plan, November 2021

MyCare Plans	Total MyCare enrollment	Opt-in Number	Opt-in %	Opt-out Number	Opt-out %
Aetna	28,018	16,612	59.3	11,406	41.7
Buckeye	27,458	16,453	59.9	11,005	41.1
CareSource	32,742	20,646	63.1	12,096	36.9
Molina	27,865	17,272	62.0	10,593	38.0
United	27,956	12,988	46.4	14,968	53.6
MyCare Total	144,039*	83,694	58.1	60,345	41.9

*Total number of members fluctuates daily.

As shown in Table 7, there is some variation by age with older members having an opt-out rate of 46% and those under age 45 recording a 29% opt-out rate. There are differences by race, with non-whites (45 vs. 38%) reporting higher opt-out rates. We do see differences by type of membership. Community Well members have a 39% opt-out rate compared to 45% for LTSS waiver and 51% for LTSS long-stay nursing facility residents. United, which had a higher opt-out rate overall compared to the other MCOPs, recorded a higher proportion of those over age 65 as members than the other plans (56% vs. average 50.9 for other plans).

Table 7. MyCare Opt-in and Opt-out Enrollment by Age and Race, October and November 2021				
Breakdown by Age (October 2021)	**Opt-in**	**%**	**Opt-out**	**%**
Over 65	39,017	54.4	32,757	45.6
45-64	25,924	57.3	19,344	42.7
Under 45	15,118	71.4	6,051	28.6
Breakdown by Race/Ethnicity (October 2021)				
White	46,472	61.7	28,831	38.3
BIPOC	28,831	55.3	23,333	44.7
Total Enrollees	75,303	59.1	52,164	40.9
Breakdown by Type of Member (November 2021)				
Community Well	56,416	61	36,061	39
LTSS waiver only	17,605	54.9	14,442	44.1
LTSS long-stay nursing facility	9,673	49	10,065	51
Total Enrollees	83,694	58.1	60,568	41.9

Description of Care Management Models and Structures

Interviews with MCOP and focus AAA respondents revealed that care management structures are generally built around the beneficiary categorizations outlined in the three-way contract and provider agreement. These categorizations also shape the roles and teams engaged in care management and the size and composition of caseloads. Care management for Community Well and LTSS (long-stay) NF members is provided solely by MCOP care management personnel. Within the MyCare demonstration, MCOPs are required to partner with the AAAs in their service regions to coordinate HCBS waiver services for individuals age 60 and older who are eligible for HCBS waivers. The three-way contract allows waiver service coordination for individuals under age 60 to be conducted by the MCOPs or other entities that have experience working with people with disabilities. Outside of these requirements, the MCOPs were given considerable flexibility in designing their care management models. In Ohio, two models of LTSS waiver care management were implemented at the beginning of

the demonstration and remain in effect: fully-delegated waiver care management and waiver service coordination.

LTSS Waiver Care Management Models

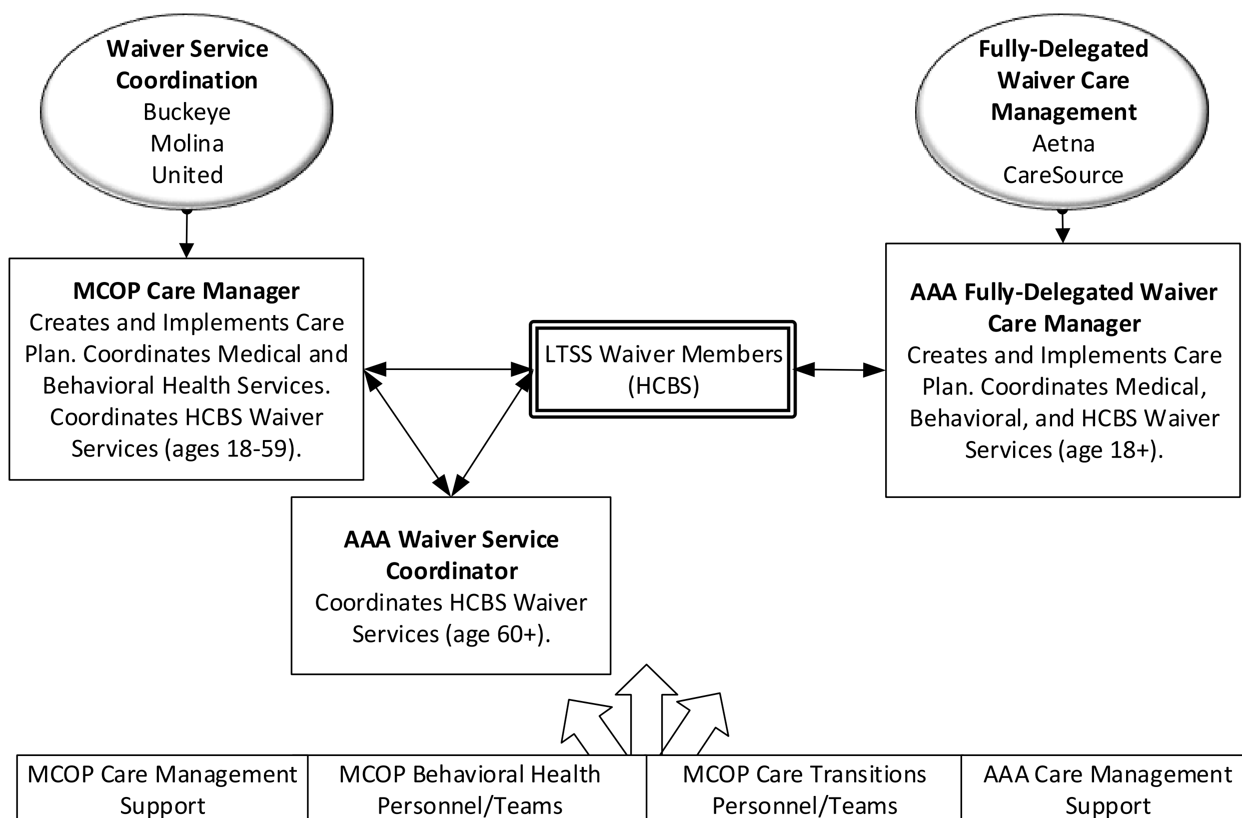
Fully-Delegated Waiver Care Management

Two MCOPs (Aetna and CareSource) elected to operate within a fully-delegated waiver care management model in which care managers employed at the AAAs serve as the care manager of record and are responsible for the care management of all LTSS waiver members age 18+, including their medical and behavioral health needs. The fully-delegated waiver care manager develops and implements the member's care plan and coordinates all HCBS services.

Waiver Service Coordination

Three of the MCOPs (Buckeye, Molina, and United) chose to operate within a model where a MCOP care manager serves as the care manager of record and is responsible for managing medical and behavioral health needs of LTSS waiver members. Waiver service coordinators employed by the AAAs coordinate HCBS waiver services for members age 60+ in such areas as personal care, home delivered meals, DME, and transportation. The MCOP care manager develops and implements the member's care plan with input from the AAA waiver service coordinator. The AAA waiver service coordinator is responsible for conducting required monitoring visits and providing the information necessary to inform the care plan. Figure 2 provides an overview of the two LTSS waiver care management models.

Figure 2. Overview of LTSS Waiver Care Management Models



MCOP Care Management Structures

This section describes the care management structures used in the five MCOPs, as related by interview and focus group respondents. As noted earlier, the approaches vary across plans and whether the care managers are working with Community Well, LTSS (long-stay) NF, or LTSS waiver members.

Community Well

An innovative feature of MyCare is that every beneficiary has an assigned care manager, which provides opportunities for support and connection to resources that were only available to individuals who qualified for NFLOC prior to the demonstration. While beneficiaries have the right to refuse to engage in care management, the minimum required contacts within MyCare provide beneficiaries with social engagement, encouragement for preventative care, and helpful connections to community resources they may not have been aware of otherwise. Care management for the Community Well population is provided solely by MCOP care managers.

It's important to note that although this group is referred to within the demonstration as “Community Well”, this label is somewhat misleading. Comparisons between Community Well and LTSS members in the impact analysis found that while certain health conditions such as diabetes, stroke, and arthritis are less prevalent among Community Well members, they have higher prevalence of tobacco use, chronic pain, and behavioral health conditions.[28] The care management component of MyCare and its focus on preventative care could help to reduce the need for more intensive—and expensive— health care needs further down the road.

Community Well care managers also serve to identify members who may be in need of increased assistance and may qualify for LTSS waiver services. They have the ability to request an LOC assessment if they feel a member’s circumstances warrant it or if a member or their representative requests waiver services. Care managers and support personnel talked about identifying these members through routine contacts and assessments and also during significant change event activities.

LTSS Nursing Facility

MyCare requires care management for all beneficiaries, including individuals who are long-term residents in nursing facilities. Buckeye, Molina, and United reported that they have care managers that work specifically with the NF population. Aetna and CareSource reported that they have some care managers who work with both Community Well and NF members. All the MCOPs reported that they structure their NF caseloads based on geographic regions and by facility so the NFs typically have a single point of contact for each plan’s members, although more than one care manager may be assigned to a facility if a high number of members reside there.

LTSS Waiver

For the MCOPs who operate within the waiver service coordination model, MCOP waiver care managers work with AAA waiver service coordinators to establish and monitor member care plans and services. One MCOP care management supervisor described how she explains the relationship between MCOP care managers and waiver service coordinators:

> *I just had a new care manager that started. We were explaining the different roles of the service coordinators and community health worker and explaining that, ‘As a care manager, you're the driver. You're driving the bus, everyone is part of the team, but you're actually driving the care for that member. You're coordinating with others.’….So, I think too, for*

> *the members sometimes they wonder, 'I have a community health worker, I have a waiver service coordinator.' But once they get that comfort level with their care manager and they establish that trust and that relationship, it makes a difference*.

Some MCOP care managers discussed that prior to the pandemic, they would coordinate their routine visits to members to align with AAA waiver service coordinators visits so they were both meeting with the member at the same time. They felt that doing so was a benefit to members and also helped build relationships between the MCOP and AAA personnel.

Behavioral Health

Behavioral health (BH) is the population stream which seems to have had the most impact on care management structures within MyCare. All five MCOPs have instituted dedicated BH professionals to work with MyCare members, but there is variation between the MCOPs in the role these personnel play within the care management structure.

Aetna has established BH liaisons who are assigned to each of their three regions and do not carry a standing care management caseload, but are available to both AAA and Community Well care managers for support, consultation, and education. The Aetna BH liaisons have established office hours within their contracted AAAs to make themselves more readily available to the fully-delegated waiver care managers. The other four MCOPs reported utilizing specialized BH care managers who either serve as the care manager of record for members with primary BH diagnoses or serve as secondary care managers and consultants for members whose primary diagnosis is medical, but where BH issues and concerns have been identified. BH care managers often serve in a transition of care role or as part of a transition of care team, and Aetna has also established BH transition of care coaches in each of their regions. CareSource utilizes patient navigators that are dedicated to BH.

MCOP Care Management Caseloads

All the MCOPs reported that they align their care management caseload sizes with the case weight requirements and staffing ratios specified in the 3-way contract. In addition, they take into consideration geographic location, member risk stratification, complexity, and care management status (outreach and coordination, engaged, inactive). Whether a member is over or under age 60 is also taken into consideration in some caseloads. At the time of the interviews, all care management contacts were being conducted by telephone due to the COVID-19 pandemic, but some MCOPs reported that under "normal"

circumstances, they have caseloads dedicated specifically to members who receive telephonic-only contact (based on their risk stratification) and that telephonic caseloads are larger in size than caseloads for members who require in-person contact.

The care managers who participated in interviews reported caseloads primarily dedicated to a specific population, but some reported a mix of populations within their caseloads. Care managers with caseloads comprised of under age 60 members reported lower caseload sizes than those with primarily over age 60 members, and cited a higher proportion of BH needs within the under-60 population, which require more time-intensive care management. Additionally, care managers with dedicated caseloads of BH members and care managers with caseloads comprised of mostly LTSS waiver members also reported lower caseload sizes. Table 8 provides information about MCOP care management caseloads including the population composition, average caseload size reported by the MCOP, and the range of caseload sizes reported by MCOP care managers who participated in interviews.

Table 8. MCOP Care Management Caseloads

MCOP	Member population	Average caseload size	Caseload size reported by interview respondents
Aetna			
	Community Well / NF	158	120-140
Buckeye			
	Community Well	Not reported	86-130
	Waiver	Not reported	55*- 88
	NF	Not reported	75-130
CareSource			
	Community Well / NF	91**	111-145***
Molina			
	Community Well	250-275	175-290****
	Waiver	75-90	40***** - 100
	NF	125-150	140-150
United			
	Community Well /NF/ Waiver	Not reported	136-339

*This caseload was comprised of under-60 members.
**The average caseload for CareSource dedicated BH caseloads is 75.
***These caseloads were reported by care managers with only Community Well members.
****This caseload included Specialized Recovery Services program members.
*****This caseload was managed by a team lead and therefore smaller than average due to additional responsibilities.

There is wide variation in caseload composition and size within and across plans. It will be important to gain a better understanding of how these variations impact the work of care managers and ultimately to gain a better understanding of how these differences impact members.

MCOP Care Management Support

All of the MCOPs reported utilizing support positions to assist with administrative tasks and sometimes with locating members, their titles varying by plan (program coordinators, care review processors, care management associates). Additionally, some MCOPs have created roles for externally-focused support personnel who go into the community and directly engage with members (community health workers, patient navigators, community connectors). These support personnel sometimes serve as the primary contact for Community Well members in the lower risk categories. They make contact with new members to introduce themselves and the care team; letting the member know that they have a care manager who will establish a plan of care and is available to them. As one MCOP community health worker explained:

> *…my goal as a community health worker is to aid the care managers. I have a lot of the lower risk individuals who don't have such high needs, maybe are still functional, have some chronic illnesses but aren't so leveled up where they need to have intensive nursing involvement. I screen them and….if there's ever discrepancies that I find, then I will pass that information on over to the care management teams….[the care manager] does his assessments and then I will also touch base with them, depending on their needs, one time a year, three times a year, in addition to what [care manager] does….I kind of piggyback on the activities that he does with them and engage the members, making sure that if their needs have changed, if their meds have changed, if there are limitations, maybe mobility, maybe the pharmacy, maybe they need a backup care, their home health aide didn't show up and they're utilizing their backup plans. That's what I do, I reinforce what they're doing.*

Care Transitions

The MCOPs also reported creating specialized roles and teams to assist in addressing care management requirements and regulations—specifically around transitions of care and behavioral health.

The three-way contract requires that telephone contact be made with the member or their representative by the care manager or waiver service coordinator within 24 hours of notification of a potential significant change such

as an ER visit or hospital admission. If there is confirmation of a significant change, then a face-to-face visit is required within three days. When a member transitions between settings (e.g., hospital or NF to home), the care management team must obtain a discharge/transition plan, conduct timely follow-up with the member and their providers, perform medication review, and ensure the timely provision of formal and informal supports.[29]

Similar to the AAAs, the approach to transitions of care and significant change events varies to some degree across the MCOPs. Often these personnel are titled as “coaches” and they become involved once the care manager or waiver service coordinator has attempted the required 24-hour telephone contact to determine the member’s status. Once it has been determined that a significant change has indeed occurred, they either take the lead on addressing the required transition activities or work in conjunction with the care manager to accomplish them. Transition coaches also have responsibilities for following members for a period of time after a care transition, with most MCOPs reporting follow-up for 30 days. CareSource’s transition of care team operates within very specific parameters: the member must be opt-in and meet one of the following criteria: a hospital re-admission within 30 days, multiple admissions within six months, diagnosis of end stage renal disease, CHF, COPD, diabetes, or BH. This team also has established additional touch points with the member outside of those defined in the three-way contract—at 14 days and 21 days.

AAA Care Management

The AAAs engaged in MyCare are in a unique position in that they each contract with at least two (and in the Northeast region, three) different MCOPs. The AAAs maintain separate staff for each MCOP with which they are contracted, so care management staff only work with the membership of one MCOP.

Fully-Delegated Waiver Care Management

Within the fully-delegated model, care managers serving LTSS waiver members are employed and supervised by the AAAs (in this study, COAAA, Direction Home, and Western Reserve). Interviews revealed variations in caseload size and composition across the focus AAAs. Care manager respondents across all three fully-delegated AAAs were primarily licensed social workers and some registered nurses. AAA leadership and care management supervisors stated that, in general, they have more social workers than nurses serving as fully-delegated care managers and reported difficulties in attracting and retaining nurses; citing competition from local health systems and inability to match the wages offered by hospitals and other health settings. They also described that

having a mix of professions serving as care managers can build upon the strengths of each profession.

Generally, AAA fully-delegated care managers only work with LTSS waiver members residing in the community and in AL. If a waiver member transitions to an NF, the AAA care manager stays involved for up to 90 days in an effort to provide the member with assistance to repatriate back into the community, if possible. After 90 days, the member is disenrolled from waiver services and care management and is then transferred to the MCOP. However, during the COVID-19 pandemic, ODM implemented emergency protocols and requested that the AAAs not disenroll NF members, so there are some AAA fully-delegated care managers who continued working with long-term NF members through most of 2020. If a member residing in an NF voluntarily agrees to withdraw from waiver services, care management can be transferred to the MCOP.

At the time of the interviews, COAAA reported about 60 fully-delegated care managers working in their Aetna program, with care mangers dedicated to AL or having a portion of their caseload comprised of AL-dwelling members reporting higher caseload sizes. Direction Home reported 40 fully-delegated care managers working in their CareSource program. Both COAAA and Direction Home fully-delegated care managers reported that their caseloads include members both under and over age 60 and that the age composition of their caseloads ranged from individuals in their 20s to individuals over age 100.

Western Reserve's CareSource program is structured by age and care manager's caseloads are comprised of members either under age 60 or over age 60, with some exceptions. Earlier in the demonstration, the under-60 population was managed by CareSource MCOP care managers, but recently this population has been transferred back to the AAA for care management. At the time of the interviews, Western Reserve reported about 60 fully-delegated care managers working in their CareSource program. Two fully-delegated care managers (one under-60 and one over-60) from Western Reserve participated in interviews, one working with under-60 members and the other with over-60 members, so a caseload size range is not reported for Western Reserve.

The AAAs reported that consideration is given to whether the member is receiving waiver services in their home or in an AL when determining caseload sizes. Care managers having all or a portion of their caseload comprised of AL-residing members tend to have larger caseloads because they are able to conduct visits with multiple members within a single trip to an AL. The AAAs also reported utilizing "float" care managers that may carry a small regular caseload and then provide coverage during vacations, illness, and periods of turnover.

Table 9 shows information about AAA fully-delegated wavier care management caseloads, including the populations served, and caseload targets reported by AAA leadership.

Table 9. AAA Fully-Delegated Waiver Care Management Caseloads			
AAA	**Member population**	**Caseload Target**	**Caseload size reported by interview respondents**
COAAA (Aetna)			
	Age 18+	50-55	56-86
Direction Home (CareSource)			
	Age 18+	67	70-76*
Western Reserve (CareSource)			
	Under 60	55-60	58
	Over 60	70-75	83

* Direction Home leadership and care management supervisors reported that caseloads were larger at the time of the interviews due to turnover of care managers and new care managers being eased into full caseloads slowly.

The AAAs implementing the fully-delegated care management model have also created specialized roles and teams to assist them in managing the broad scope of care management requirements and activities; primarily to assist care managers with the required activities related to significant change events such as ER visits, hospitalization, and short-term nursing facility stays.

Direction Home has developed a team of Nurse Transition Specialists who are titled as care managers and focus specifically on conducting initial enrollment assessments for CareSource members that are newly eligible for MyCare or transitioning to MyCare from other HCBS waivers and the Specialized Recovery Services (SRS) program. Additionally, this team conducts all required visits and activities for members experiencing significant change events. COAAA has embedded "in-patient" care managers in their fully-delegated teams who carry a very small caseload and then handle the requirements for significant change events for their assigned team. Earlier in the demonstration, Western Reserve also had a specialized team comprised of RNs and LPNs in their CareSource program dedicated to transitions of care, however, this team is no longer in existence. Currently, they utilize three LPN "navigators", which function as support for the care managers. One navigator assists with coordinating home modifications. The other two conduct claims reviews in which they reconcile the claims submitted by providers and the services received by members. The navigators also provide assistance with outreach calls to members for diabetes

management, high blood pressure monitoring, and preventative activities such as flu shots.

Waiver Service Coordination

In the waiver service coordination model, the member's care manager is employed and supervised by the MCOP and is ultimately responsible for the development, revision, and implementation of the member's care plan. The AAA waiver service coordinator (employed and supervised by the contracted AAA) is responsible for coordinating HCBS waiver services for members on the MyCare waiver program who are age 60 and older and working with the MCOP care manager to revise and implement the member's care plan. Some waiver service coordinators and MCOP waiver care manager respondents reported coordinating their required visits so they could meet with the member together. They found this beneficial and an efficient way to educate the member on their respective roles within the program.

Similar to the fully-delegated AAA care managers, AAA waiver service coordinators typically interact with waiver members for up to 90 days after they transition to an NF to set up a safe discharge plan if the member is able to repatriate to the community. Following the COVID-19 emergency protocols, they have also maintained relationships with members in NFs past 90 days unless the member voluntarily disenrolls from the waiver.

COAAA and Direction Home each contract with one MCOP for waiver service coordination. Western Reserve provides waiver service coordination for both Buckeye and United. All of the AAAs reported that their waiver service coordination caseloads contain a mixture of home-dwelling and AL-dwelling members, with waiver service coordinators assigned to specific AL buildings to provide a central point of contact for AL staff. Table 10 presents information about AAA waiver service coordination caseloads, including the populations served, caseload targets reported by AAA leadership, and the caseload sizes reported by waiver service coordinators who participated in regional interviews.

Table 10. AAA Waiver Service Coordination Caseloads			
AAA and MCOP Program	**Member population**	**Caseload Target**	**Caseload size reported by interview respondents**
COAAA			
Molina	Home-dwelling and AL	60	60-65
Direction Home			
United	Home-dwelling and AL	95	95-109
PSA 2			
Buckeye	Home-dwelling and AL	75	88-101
Molina	Home-dwelling and AL	75	80-86
Western Reserve			
Buckeye	Home-dwelling and AL	85	95-100
United	Home-dwelling and AL	85	86-100

The focus AAAs did not report specialized roles for waiver service coordinators, but they do play a part in addressing significant change events and transitions of care. It is their responsibility to communicate the start and stop of services and ensure safe transitioning which includes reaching out to family, housing specialists, building coordinators, hospitals, and NFs to gain the necessary details regarding the significant change so that reporting can be given to the MCOP care manager or transition of care team within three hours of the reported transition or significant change. The waiver service coordinator must call members within 24 hours of their return to the community from any institutional setting to ensure that the transition was safe and services have resumed.

AAA Care Management Support

All of the focus AAAs reported that they utilize support staff to assist in meeting the prescribed care management requirements of the demonstration. These support staff are primarily internally-focused and assist with administrative tasks and processes and communication with service providers. They sometimes also have direct contact with members by telephone to address questions and assist in setting up and monitoring waiver services. Their titles vary by AAA (care coordination assistants, clinical support specialists, program coordinators, clinical

case aides, care specialists). The AAAs also reported utilizing Medicaid specialists who work with MyCare as well as other Medicaid waivers within their organizations.

Communication between MCOPs and AAAs

Both MCOP and AAA respondents talked about steps they have taken in order to build relationships and bridge their different organizational cultures. The MCOPs have structured their team and roles regionally so that AAAs have specific MCOP staff (liaisons, team leads) who serve as their primary contacts and a starting place to address issues and concerns. These liaisons and leads are often engaged in providing AAA personnel with training on new requirements and processes and work with AAA training staff to ensure that annual and other required training is up to date.

The MCOPs and AAAs reported joint trainings and opportunities to meet face-to-face as mostly positive and a helpful way to build relationships. Although some respondents found these joint meetings as “somewhat awkward”, others appreciated the opportunity to “put a face with a name”. Some respondents reported that not all important information is provided to both AAA and MCOP care management at the same time, which can result in confusion when one or the other is not up to speed on a new process or requirement. As one MCOP care management supervisor explained:

> *I think having our team leads and managers and previously, when we were able before COVID, to be in the AAAs and physically present, it was helpful. They had a connection. Not that they don't have it virtually or over the phone now, but I personally miss that interaction with AAAs and being there in person with them. So I think that's been a challenge over the past few months, or six months. But there have been a tremendous amount of improvements over the years. The challenges that we had in 2014 are not the challenges we have now, so I think that's an improvement.*

In addition, joint operating meetings of varying frequency (quarterly, monthly) provide opportunities for MCOP and AAA leadership and supervisors to engage with each other and work together on various issues, although respondents reported that, in some cases, the frequency of these meetings have decreased from the earlier days of the demonstration. The MCOPs and AAAs also engage in (usually) weekly health, safety, and welfare “rounds” in which MCOPs can share utilization information to help AAA care management and waiver service coordinators identify members that may be at risk or have changing needs. Often, BH personnel are included in these rounds as well as MCOP medical

directors and pharmacy personnel. One MCOP reported a similar group has been convened around the home modifications process, which AAA staff also found helpful. Another MCOP reported regular calls with their contracted AAAs to review member eligibility issues. At a more informal level, MCOP and AAA care management supervisors reported frequent (sometimes daily) telephone and email communication with each other.

One MCOP respondent shared that a lot of the work of relationship-building and around figuring out how to "check the boxes" of MyCare requirements (e.g., assessments, visit schedules, documentation) has been addressed and that a more robust discussion and understanding pertaining to cost savings is finally starting to happen. MCOPs reported providing training to AAA care management personnel, and that social workers (who are often without medical training or backgrounds), in particular, are understanding the importance of preventative screenings and tests and proper A1C levels. As one MCOP care management supervisor explained:

> *We're getting data now that we never had before on these people, that members didn't have their breast exams, or their colonoscopies, or their colorectals. All the diabetic retinopathy exams. Things that we didn't have from a data perspective.*

One AAA shared that they have developed a robust process around quality data within their fully-delegated care management program that has been extremely useful to their organization. However, the majority of AAA respondents expressed a desire for more data and information-sharing between AAAs and MCOPs.

MyCare Implementation

This section discusses the themes related to program implementation that were revealed in interviews and focus groups and during review of program data. The themes have been grouped into three main categories: (1) care management at the core, (2) program design, and (3) program operations. Table 11 provides an overview of the program implementation categories and themes.

Table 11. Program Implementation Themes

Section	Themes
Care Management at the Core	Total care management requirement; care management with different MyCare member categories (Community Well, LTSS waiver, LTSS long-stay nursing facility); benefits and challenges associated with the two care management models; challenges identified with care management documentation systems
MyCare Design	Understanding of the program; opt-in/opt-out status of members; and combining rules and regulations within the demonstration
MyCare Operations	Enrollment and assessment; care transitions; access to information; interactions with providers; specific service challenges; behavioral health; pragmatic innovations

Care Management at the Core

Care management is the core element of MyCare. Although care management has been widely used for individuals with severe disability, in the MyCare demonstration this was expanded to include all members. Nearly all respondents agreed that this total care management requirement is a strength of the demonstration and particularly beneficial for the Community Well population. As one MCOP BH field advocate explained:

> *I think that in a lot of other programs that aren't Medicare-Medicaid Plan you don't find the person until their costs are so high and there's been so many hospitalizations.... Because there can be people that are struggling that maybe should be reaching out for healthcare and haven't. Our community health workers can identify those people and we can work hand-in-hand.*

Community Well care management

Community Well care managers discussed the opportunity to assist and guide members not only with health-related needs but also identifying issues related to social determinants of health.

> *I think one of the biggest benefits of MyCare is that it's 100% case managed. All of our members…have a direct link to a case manager. If they ever have questions about anything that may be going on, whether it be a health condition, a claim, or just needing help in the community.*

In the community, we see different types of barriers, and concerns. Maybe it's a housing concern, or utilities are going to be shut off and things like that. So we can provide that holistic approach with them having that direct link, and that person that can help guide them. - MCOP Community Well Care Manager

Care managers also described serving as advocates for members and encouraging them to engage with their health providers and others.

The fact that we're empowering a lot of our members to take control of not only their homes, but their lives. That they feel like they have control. That's one of the things I really love about our position is that we're able to give them a little bit of a push and support. And from there a lot of them realize that they have the ability to take control. - MCOP Community Well Care Manager

Respondents also shared that even prior to COVID-19, care management provided important opportunities for socialization and connection for isolated Community Well members.

I love the fact that I'll get one of my people call me and say, "I miss talking to you." I have Community Wells that are level threes that do not want me to reduce the level because I'm their only touchpoint. I'm the only person that calls them up and they don't have people. - MCOP BH Field Advocate

Effective care management with the Community Well population hinges upon engagement with the care team. Yet one of the most-frequently discussed challenges reported by MCOP staff who work with Community Well members was the inability to reach members. The three-way contract requires the MCOP to attempt to reach beneficiaries at least three times during the first 75 days of enrollment.[30] MCOP respondents reported repeated frustration with receiving incomplete and incorrect contact information for new members at the time of enrollment. They also cited members running out of cell phone minutes and frequently changing phone numbers as barriers. The visit restrictions imposed by the COVID-19 pandemic have exacerbated this challenge. Prior to the pandemic, care managers reported being able to often find members at home by making unannounced visits if unable to reach them by phone. Without that ability, some respondents reported that their caseloads now contain higher proportions of “unable to reach” members.

Community Well care managers and support staff described the “detective work” that they perform to try and locate members that they have been unable to reach.

> *There's always a primary care physician populated, which may or may not be their primary physician. We do that. Trying to find claims, once we find a claim, we can kind of connect the dots and make calls to that provider to get a phone number. I'm googling people. Once the medications populate by the 15th of the month, we can call the pharmacy or see who prescribes the medication to, again, call that provider to try and get the phone number for the member, using different Google search engines, like fast people search to try to locate people and phone numbers. - Community Well Care Manager*

Respondents also shed light on why beneficiaries might not want to engage in care management.

> *And then we have the ones who really for whatever reason don't want to be involved with case management. In my experience, the majority of them are either receiving case management services elsewhere, perhaps they have a behavioral health case manager, or they just simply don't have conditions that they feel need case management right now. They feel they have the support that they need and they just don't feel that they need us. - Community Well Care Manager*

A few respondents reported that the pandemic has created an opportunity to engage members who previously refused care management, because the contact with the care team helps to reduce the isolation they are experiencing. Further, significant change events and transitions of care often provide an opportunity to connect with non-engaged members. If they receive an alert from an emergency room or hospital, care managers will call the member and ask, *"Hey, we saw you were in the emergency room. What's going on? Do you need anything?"* Inpatient hospital or short-term NF stays also can facilitate engagement with care management as members often appreciate that someone is reaching out to help them with home-going needs such as securing DME and setting up personal care or therapy services.

Community Well members who spoke about their care managers were largely positive and identified their care manager as someone they could turn to if they needed assistance. One member shared, *"They make me feel real comfortable because I know if something goes wrong, I can always call them."* Another member echoed that sentiment and talked about how their care manager helped them keep organized, "*[They're] always there for me. Always. They keep me on top of things. I never need anything because they're right there for me."* When asked how their care manager had been helpful to them, this member replied,

> *I'm on oxygen, and it'll be like something so simple as maybe not completely understanding about their billing or how to get a hold of the right person to get things done….Or even stuff that I need in general, and she leads me to the right people, if she don't do it herself.*

LTSS Waiver care management

MCOP respondents expressed that the total care management component of MyCare and their engagement with the Community Well population has increased members' awareness of and access to LTSS services that can help them avoid institutionalization or return to less-restrictive environments through repatriation efforts.

> *I know prior to the demonstration, waivers were very limited in the state of Ohio. I think maybe 20,000 people had a PASSPORT waiver. And from what I've seen in the demonstration that number has seemingly grown significantly, because we've moved our thought process on how to leverage those waivers to keep people in the community and out of the nursing facilities, so more people than ever now have access to waivers as a result of the demonstration. - MCOP Leadership*

At the same time, AAA "front door" assessors expressed some concerns that MCOP Community Well care managers need further education about what is required to meet waiver level of care and the services that waiver provides. They stressed the importance of care managers providing education about the waiver enrollment process, including the required level of care assessment. They reported that they frequently get inappropriate assessment referrals for members who clearly would not meet level of care and that, in some circumstances, members are not even aware that they have been referred for an assessment.

LTSS waiver personnel described challenges around required incident reporting, and referenced a fairly recent change to the requirements that mandates incident reporting if there are any changes to the member's care plan. For example, if a member is discharged from the hospital and now needs physical or occupational therapy, that is considered a reportable incident, and a report must be completed. One MCOP respondent shared, *"Just looking at the acuity of our members in MyCare, I would say that definitely 80% of our waiver that come back into the community from a transition are gonna require an incident report for that."* The respondent further questioned whether a time-consuming report was truly necessary for those kinds of member changes.

LTSS waiver members we spoke with were mostly positive about interactions with their care managers. However, in the case of Buckeye, Molina, and United members (the plans utilizing the waiver service coordination model), the person

the members identified as their “care manager” was often the AAA waiver service coordinator rather than the MCOP care manager. LTSS waiver members, including Aetna and CareSource members, expressed close relationships with their care managers, as one member shared, *“Over the last four years we’ve developed a friendship.”* One member expressed disappointment about the need for telephonic care management, *“I just love her to death. I'm kind of disappointed that they don't get to go to people's houses right now.”* Another member described how her care manager went to extra lengths to check in on her on days when she did not have aide services scheduled.

> *[Care Manager] keeps up with checking on me and finding out how I'm doing from time to time and asking me if I need anything, if I'm doing okay. Like if my caregiver is not going to be here for a couple days, because she comes Monday through Friday, and sometimes she takes off because she needs a day to herself or she's sick or so. [Care Manager] will call and say, "Well, are you doing okay? Is there anything you need?"... Because I don't have any family and that kind of helps a lot, to know that somebody is there thinking of me.*

Nursing Facility care management

Interviews with MCOP NF care managers and support personnel provided information about the role and functions of MyCare care management for beneficiaries residing long-term in nursing facilities. The circumstances of these members differ significantly from Community Well and home-dwelling LTSS members in that they have 24-hour supervision and care available to them by facility staff. Some provider respondents raised questions about the usefulness of additional care management in these settings.

> *…the reality is that the care is managed on a daily basis by the provider. They're there, you know? And the case managers for the plans are not there….And so it's more like a check in every so often, and not really an ongoing involvement with the care.…care managers don’t make sense for people who are in [nursing facilities]. - NF Provider*

However, MCOP care manager respondents were passionate about the importance of their role in the lives of NF members. They discussed the benefit of having a “second set of eyes” on members and their ability to provide an additional layer of engagement for members who may not have close connections with family and friends. For those members who do have family and friends involved, care managers shared that they are often contacted by family members and that they too appreciated the extra attention their loved ones receive; sometimes reaching out to the care manager for their perspective on the member’s status and care. They also reported that NF members are often willing

to share things with them that they may not share with facility staff because they view the MCOP care manager as a neutral party.

MCOP care managers also saw themselves as additional support for the NF staff who they felt may not be able to dedicate as much time as they would like to the member due to staffing challenges. NF care managers reported that they attempt to attend interdisciplinary team (IDT) meetings and care conferences when possible and also that their regular visits to members afford them the opportunity to identify changes in member condition and bring them to the attention of the staff. Several care managers spoke of building good relationships and rapport with facility staff over time and that being assigned to particular NF facilitated those relationships.

Care managers reported that access to the NF electronic medical record (EMR) is incredibly helpful and allows them to gather the information required for assessments without having to rely upon facility staff as their sole source of information in cases where the member is not able to provide it. However, very few care managers reported having access to EMR, and the majority reported that the NFs they worked with would not grant it. Not having this access has made NF care management particularly difficult during the COVID-19 pandemic as MCOP staff have been unable to visit, many members are unable to communicate with them by telephone or do not have a telephone available to them, and NF staff often do not have the time to engage. They also stated that frequent staff turnover in NFs affects their ability to maintain productive relationships and secure the information needed for assessments.

Identification of members who may be able to transition back to the community or to a less restrictive setting such as an AL, was also reported by MCOP respondents as an important function of the care management role. NF care managers shared many stories of successful repatriation and felt good about their efforts on behalf of members. They also recognized that this focus on repatriation may put them at odds with providers, who view them as trying to “steal” residents. They speculated that these “competing goals” contribute to strained relationships at times and NF staff reluctance to share information about members.

When asked about working with the MCOP care managers, a few NF and AL respondents reported positive experiences and good communication when they were able to work with one care manager consistently over a long period of time. One NF provider described how having a care manager in the community helped secure needed equipment for a recently discharged member,

…I keep her informed on every case and when the care conferences are, and what the discharge plan is, and "can you help with this?" You know, I had a patient that was discharged home, did not want a hospital bed at the time of discharge. But later, after discharge, called me back and then, "Hey, can you help me get a hospital bed?". But we can't do that since they're no longer a patient, but I can call the case manager and say, "Hey, patient now needs a hospital bed. Can you help coordinate that?" So that's... Comparing the two, that's the advantage I see with the other case manager I work with closely. We email, we talk. I feel like she's really part of the team, part of my team when it comes to dealing with the patient.

However, this type of consistent collaboration was rare and the majority of NF and AL respondents reported that they did not know the MCOP care managers who worked with their residents. They reported little communication with MCOP care managers except for fulfilling requests for information and documentation,

….it's mainly just a request for documents that I'm providing them. It's not like they're really doing anything. So it's just another cog in the wheel that we're trying to keep moving, make sure everybody gets what they need.

Other NF and AL providers referred to MCOP care management as a "redundancy" because the care managers are not fully-integrated into the facility care team,

And having that extra case manager on the other side, sometimes it's just is an extra step without a better outcome.

The concept, the framework is logical. I can buy into it, but you know, like they say, the devil's always in the details and the details just are not facilitating good collaboration.

Care Management Success

Care management respondents reported their work with members to be beneficial and expressed a strong sense of purpose and desire to affect positive outcomes. They shared stories of how their connection with members is often a "lifeline" and that even with all the challenges faced during the COVID-19 pandemic, they have been able to make a difference. In particular, personnel engaged with Community Well and BH members shared many success stories about how the involvement of MyCare care management impacts members in small ways, but also in dramatic ways. One community well care manager described how her scheduled appointment with a member living in a senior high

rise building potentially saved his life when she knocked on his door and he didn't answer.

> *Come to find out he had had a stroke and was on the floor for nine hours. And if MMP wasn't involved and I wasn't scheduled to come out to see him, he probably would have been there all day, all night. He probably would have died. So this program works. We are saving lives*.

Another Community Well care manager related how her focus on preventative exams resulted in an early cancer diagnosis for one of her members with dentures.

> *A lot of times they don't know that they should have an oral gum screening yearly. They're just like, "Oh, I didn't know I needed to go."….Well, she ends up taking my advice, went and had the screening done. She called me and said, "Thank you so much. You saved my life." She ended up having cancer of the tongue that was diagnosed. She goes, "I would've never known I was supposed to go to a dentist if I didn't have teeth. I didn't think I had to go."*

This Community Well care manager shared a powerful story about the benefits of coordination within care management.

> *I had a member who does not have family support and was really struggling with his diabetes. Having really high sugars to very low sugars. Multiple ER utilizations. I was able to collaborate with the primary care doctor, and she actually called me every time he came in for a visit so we could collaborate on what can we do for this gentleman. Because I was seeing him in the community, I was seeing a lot of barriers. I was seeing that he did not have good access to food…so I was able to find resources for him in the community to get him to a food pantry to get his food. He did not meet level of care for waiver services, so I was not able to give this gentleman on waiver services in order to get him delivered meals. But I was able to advocate for him, along with his primary care doctor.*

In their interviews, the majority of both Community Well and LTSS waiver members who discussed care management expressed satisfaction with the arrangement and found having a care manager helpful. There were several Community Well members who were aware that they had a care manager, but reported that they hadn't had much reason to be in communication with them. When asked who they contacted if some sort of need arose, these members typically called the MCOP customer service line for assistance. In most cases,

members MCOPs who utilize a waiver service coordination model reported more frequent communication and closer relationships with their AAA waiver service coordinators than with their MCOP care managers.

Members also talked about things that are working well for them related to MyCare as a whole. Multiple members expressed their appreciation for the prescription coverage provided by their MCOP and for the monetary incentives offered for completing preventative and routine health screenings and vaccinations (although several members also expressed frustration at the time it takes for them to receive the monetary incentives after completing the required steps). This LTSS member talked about how important it was for them to have the benefit of gasoline reimbursement from their MCOP.

> *Because I have social anxiety. I don't like being on [buses]. I don't like being around a bunch of people. And with COVID, I got a double whammy…because I'm a germaphobe. So to be able to afford gas to transport myself is valuable.*

A Community Well member shared that they had received a “flu season care box” from their MCOP containing a digital thermometer, a box of Kleenex, Chapstick, hand sanitizer, and a few other items. The over-the-counter benefits provided by the MCOPs were also popular with member respondents (although several members from different MCOPs mentioned that the items available through these benefits are somewhat limited and often repetitive).

> *That is wonderful for getting all those medical supplies, basically like medicine cabinet supplies that then you don't have to spend. That was the first time I ever encountered that kind of benefit, that kind of perk. – Community Well Member*

Other members talked about the convenience of having a “one-stop shop” where all their health needs can be met. One LTSS waiver member shared, *“I don't have to make several different calls or this is covered by this one, this is covered by that one. I like that it's all together and cohesive.”* When asked if there was anything they needed, this LTSS waiver member shared,

> *…if I didn't have [MyCare], I would not be getting my medications. I wouldn't be going to the doctor. I wouldn't be getting my aide twice a week. I mean, there's nothing that I can think of that I would need. I have everything.*

Review of MyCare's Two LTSS Waiver Care Management Models

The research team endeavored to more fully understand how the two different MyCare care management models function differently within the AAAs and MCOPs and how they interact with MyCare members and service providers. The interviews and focus groups with leadership and care management personnel at both the MCOPs and the focus AAAs provided valuable insight into how these interactions work and the challenges and benefits experienced by those providing care management within each model. Three of the four focus AAAs were engaged in both fully-delegated care management and waiver service coordination and were able to provide perspectives on their experiences with operating both models within the same organization.

Fully-Delegated Waiver Care Management

Benefits

Respondents working in the fully-delegated care management model expressed that full-delegation is less confusing for members, because they have fewer people with whom they have to interact and fewer layers of bureaucracy to address issues for members. The fully-delegated care manager is a "one-stop shop" who handles all their needs.

> *We see fully delegated as a preferred model because it's just better and more seamless for the consumer in terms of who they're interacting with. But also in terms of how quickly they get what they need. Having to bounce things back to another case manager, who then has to bounce things through their system, definitely slows the process of getting consumers what they need. I don't think it's the only reason things are slowed. I do think the managed care company makes a difference….But fully delegated just seems like it makes more sense. - AAA Leadership*

AAAs reported that full-delegation provides them access to more and better data than they receive in their waiver service coordination programs, which is a benefit to the whole organization. In general, they do not feel that they have comparable quality of data and reporting ability as in the PASSPORT program, and that there is still much room for improvement with data-sharing that could strengthen their partnerships with MCOPs. However, one AAA shared that they have been able to develop multiple "scorecards" with the data they receive from the MCOP. They utilize that data to help care management staff identify issues and areas for improvement around certain metrics and care management requirements such as timely completion of assessments, re-assessments, required contacts with members, and service plans.

So with [MCOP], because of our fully-delegated role, we have access to more data. And we've really been working with [the MCOP] since the start of MyCare to try to get the data that we need to perform in the role that we're in…. if there's a field in an IT system that data is entered, they can pretty much pull it and provide it to us. And so, they do so through a report called vendor report. They also have different reports that they drop on our FTP site for us. We then take that data, we go through that data, and we use that data to drive performance. - AAA Leadership

The MCOPs engaged in the full-delegation model also expressed their belief that it reduces confusion for members to have a single point of contact for all their needs. In addition, they spoke of the mutual benefits of partnering with community-based organizations.

I think it's a win-win for both [the MCOP] and the AAAs, and the members….we get the expertise of an organization that have been entrenched in the communities for years and years, and that expertise in serving people in the community... For the AAAs, they get that insurance and that expertise with serving with healthcare. So with that, their staff have learned to be more clinically focused, and we've given them a lot of training to make sure that their clinical focus is beefed up. And we've been benefited by learning how we can be more community-focused. - MCOP Leadership

Challenges

A consistent challenge shared by the AAA respondents within the fully-delegated model was "scope creep", referring to increasing numbers of "asks" requested of the AAA fully-delegated care managers with no real ability on AAA leadership's part to decrease caseload sizes due to stagnant rates from the MCOPs.

The problem with full delegation, the biggest problem, is that there's no end to what that means. And so we actually have a spreadsheet now where we track the new asks from [MCOP]…the spreadsheet literally says, What's the ask? Who's the ultimate source of the ask? When is it supposed to be implemented? And then we talk about how we operationalize it. But that's the struggle with fully-delegated…six months ago we were doing 10 less things for them. Now we're doing 10 more for the same amount of money and we don't have the ability to drive down the caseload. - AAA Leadership

I will say that one of the constant issues of contention that we have with [the MCOP] and full delegation is, we believe we need lower caseload

levels to be more effective. And the amount of money we've been able to negotiate for that has been limited. - AAA Leadership

One fully-delegated AAA care manager talked about the difficulty of being held to the same expectations as MCOP care managers without having the same access to and familiarity with their IT system.

…it's daunting…For example, if somebody needs something that is covered by Medicare, member services can type in a couple of things and tell me when the last thing that they bought, when the last time they got a power chair was, the date, who provided it. And I could probably find that by searching through the claims, but that will take me hours…And my client mentions it to me, and I document that they mentioned it to me, even if I can't get it for them, I'm responsible for making sure that they get it…even though I can't purchase one because it's covered under Medicare, it's not a waiver item. I'm responsible for following up, so the more information I could access for that would be useful. - AAA Fully-Delegated Care Manager

MCOP respondents also expressed challenges with the fully-delegated model and being ultimately responsible for the member's well-being and health outcomes but not having direct supervision over fully-delegated care managers to address issues as they arise.

It does create such a barrier when they aren't doing things, there's no direct interaction or part from us to be able to meet with that case manager to try to help them….Because we're being held to doing the audit….So it just makes it difficult when we're not directly supervising those case managers to have any input. - MCOP Waiver Care Management Supervisor

Waiver Service Coordination

Benefits

Benefits reported to the waiver service coordination model included effective teamwork between MCOP care managers and waiver service coordinators which allowed them to "divide and conquer" to address the needs of members.

And I would say that an advantage of this model is that…everything is just not lying on [the waiver service coordinator] as it was when I was a case manager in PASSPORT. So for instance, if there was any kind of medical equipment that was needed, that was paid for by insurance, we had to do all of that. Whereas in this model…they can task the [MCOP]

> *case manager….So even though some people look at that as a disadvantage, that's kind of an advantage in a way too, in a sense too, because they're not having to take on the responsibility of getting all that done. - AAA Waiver Service Coordination Supervisor*

The ability to draw upon each other's expertise was another reported benefit of this model. The MCOP care managers have an understanding of medical/acute care issues and they have access to more information about claims. AAA waiver service coordinators have a better understanding of waiver rules and have long-standing relationships with local providers and close community connections.

> *And it seems like with somebody else helping there's a more integrative type of care plan where we as the AAA focus more on the waiver type of services, but the plan case manager would focus more on the diagnoses, the health issues, and it creates a connection that way. How can we implement some services to address certain things with that member's health condition? - AAA Leadership*

Challenges

One of the challenges reported within the waiver service coordination model included members' lack of understanding of the waiver service coordination model and their comprehension of the different roles of the care manager and waiver service coordinator. Respondents reported that despite attempts to educate members, some call waiver service coordinators for assistance with medical issues and non-waiver equipment or call MCOP care managers with questions regarding waiver services.

AAA waiver service coordinator access to and ease of use of MCOP documentation systems was also cited as a barrier. Waiver service coordinators reported frustration with the extra steps they must take to work within MCOP systems when they are not able to directly document in them and use them to generate service plans, sometimes having to upload Excel documents, then remove them from the system to make revisions, and re-upload them. Within one MCOP, the AAA waiver service coordinators were brought into the same documentation system as the MCOP care managers in September 2020 for the first time in the seven years of the demonstration.

Both MCOP care managers and AAA waiver service coordinators reported some strain regarding division of labor and communication. AAA waiver service coordinators expressed frustration with MCOP care managers limited understanding of waiver services and rules. They also perceived a reduced professional status and lack of empowerment to work directly with local service

providers and address and resolve issues for members within the MyCare system.

> *…sometimes they'll get emails or communications through the task system from [the MCOP] case managers that feel very directive and very like, "You need to take care of this." And almost like, "I'm the boss and you have to do what I tell you to do."….it's always hard in written communication of course. But there's just that sense that comes through, especially more with certain case managers and others. That's tough for people. It's tough for building relationships. - AAA Waiver Service Coordination Supervisor*

In turn, some MCOP staff reported that they sometimes feel that they have to provide a significant amount of guidance to waiver service coordinators and that turnover within AAA staff has eroded the level of waiver expertise and community connections the AAA personnel bring to the partnership.

> *I know the AAAs were set up because they were going to be the experts for those members that are over 60, but over the years, with turnover…the staff that they're pulling in....they don't have experience in the waiver space or the [Ohio Administrative Code] rules, or any of those components. So while at some point maybe they were that group that might have been the experts once it comes to managing waiver services and costs savings…now that they've had so much turnover… they're not knowing those answers to things, so they're relying on us to be really be those experts and then try to tell them what to do, even though we want to be able to give them that autonomy and be the experts. - MCOP Waiver Case Management Supervisor*

Nearly all AAA and MCOP respondents reported that the quality of relationship and teamwork between waiver service coordinators and MCOP care managers very much *"depends on the person."*

Care Management Documentation Systems

Care management documentation systems drive all care management activities, which requires AAAs to be able to either directly access or communicate in some way with MCOP systems. Issues related to documentation and the ability to quickly resolve IT issues with the MCOPs were reported by nearly all AAA respondents and there is variation in how much of the system AAA staff can access, depending on the MCOP. Respondents across the AAAs shared that MCOP documentation systems frequently "lock them out" or "go down" and when

this happens and can take a while to resolve, causing major hassles in their very packed schedules.

> *…about a year ago, [MCOP] did an upgrade that caused a major issue….we had to keep pushing and pushing up the ladder…So it takes a long time to resolve when issues come up. That was a big disruption and it had to do with their update and whatever update they did collapsed the connection to outside parties. That eventually got resolved through a lot of advocacy on our part and [AAA IT Director's] team talking to their IT team. - AAA Leadership*

> *They make changes and there's a ripple effect, they often don't consider with the AAAs. And they're such a large entity and you contact them to try to explain, "Hey, we've got to work through this." Sometimes they're just unsure of who you are and what your relationship is. So you have to work through trying to get the right people to help you…. And that's challenging because when you're in a crisis, you feel like "I just want to get the right person immediately and get started on fixing." But you go through all these cycles of trying to get a hold of somebody that actually understands what you're asking them to do. - AAA IT Personnel*

One MCOP recently provided AAA waiver service coordinators direct access to their internal documentation system for the first time in September 2020. Since the beginning of the demonstration, the waiver service coordinators had been documenting in a separate platform and they reported many challenges in that arrangement. One MCOP waiver team member expressed excitement about this change and felt that it would facilitate improved communication in the waiver authorization process.

> *When we originally were working with the Area on Aging, we did have two separate platforms….But that's all changing, and they've now integrated into our system which I think is phenomenal, and I think it gives them so much more insight as to what we are seeing and able to coordinate with us better. They can also look up notes in the chart, and they can view the authorizations just as we do. So that we can all be on the same page when we have conversations about whether a service is appropriate or not. - MCOP Waiver Team Member*

One AAA fully-delegated care manager discussed how issues related to operating within multiple systems can cause daily frustrations that waste precious time:

> *We work in [MCOP] system, we have to monitor [MCOP] email. We have our [AAA] system, and [AAA] emails so we're monitoring two emails, and it seems like [MCOP] gets hacked off if we don't respond to their email quickly. I don't think that they understand that we're actually negotiating two systems. The other problem is that if I create a service authorization in [MCOP's documentation system], and I want to email it to my [AAA] email, I have to type in, "[MCOP] General Business Send Secure," to get it to go through because it reads it like it has a social security number or something in the service auth. Then it shows up in my [AAA] email as secured on that side so now I've got to log in again to open up my secured email that I sent to myself from my secure [MCOP] email. Just there is a lot of wasted time in logging in and out. It's unbelievable the amount of time we waste doing stuff like that.*

Another fully-delegated care manager expressed frustration with the lack of a seemingly minor documentation system feature that would save them time.

> *I just wish that all of the information would pull through to all parts of the same system. So if I generate a service authorization letter, and the person has moved, I've inputted the new address, I would like that information to pull onto the letter. Not that deep.*

AAA leadership respondents reported frustration with having limited data and reporting ability within MCOP documentation systems.

> *I thought this whole project was about being able to get more information and see if we're improving care. And we actually have over the years had less information than we ever had in PASSPORT on clients. So that has gotten much better with [fully-delegated MCOP]; they've developed software that gives us more ways to check how we're doing. Less so with [waiver service coordination MCOP]. And it's funny, in conversations when I bring that up, I've had [MCOP contact] say, "Yeah, why can't we do that? Why can't we give them that information?"…but these are big software systems that are hard to move at a national level and on down to Ohio level. - AAA Leadership*

Without data, AAAs reported that it is difficult for them to fully participate in value-based agreements and arrangements, because they have no way of determining if they are meeting outcome measures. Respondents in various roles across the MyCare system, including providers, also commented on having a lack of data to judge whether the demonstration, as a whole, has been successful in meeting its goals and lowering costs.

This is a pilot, is it doing a better job than what we were doing before? Can you tell? I can't tell….We used to have to control those service dollars. They'd say "Get that service package from $1400 down to $1100." and we could do it because we could follow it that closely. We couldn't do that now for anything because we don't follow or access data like we used to. - AAA Leadership

MyCare Program Design

Issues related to continued lack of understanding of the MyCare program, the opt-in/opt-out status of members, combined rules and regulations, and the boundaries of the demonstration were shared by respondents in regional interviews and focus groups.

Continued Lack of Understanding about the MyCare program

It was explicitly clear from the state-level, regional, and member interviews that there continues to be significant confusion about what MyCare is and how it works. This is not altogether surprising, as the concepts and structures involved in MyCare are extremely complex and, at times, difficult even for professionals in the aging field to understand and explain.

So the whole original project was supposed to make this easy for clients. They were like, "Oh, there's five different waivers, and we're going to simplify it all." And really it has made it so complex. I would guess there are a handful of people, or just maybe a few at every area agency that understand it enough to make it work. - AAA Leadership

MCOPs and consumer advocates talked about different education initiatives conducted at the beginning of the demonstration and reported continuing education efforts. However, MyCare education should remain a constant priority. One hospital discharge planner shared, *"I don't know that we've ever been given a lot of education on the program itself."* A few providers related that some of the confusion stems from the fact that some MCOPs offer other types of programs related to Medicaid.

I still think there is some confusion within the provider community, within the physician community, of the difference between MyCare and traditional Medicaid, given that you've got a few plans that administer both. - Physician Provider

Nearly all respondents reported that MyCare members are often surprised that they have been enrolled in MyCare. Even though the written information provided to beneficiaries focuses on their ability to choose, respondents felt that the

majority of beneficiaries do not make a choice (often because they are not aware that they should or can) and are surprised when they are passively enrolled.

> *They just know that all of a sudden, they're in a managed care program. And they're like, "What's going on?"…I don't know if consumers read all their mail. I don't know whose fault that is. - Consumer Advocate*

Many respondents felt that notification letters are insufficient in helping beneficiaries understand MyCare enrollment and that more contact needs to be made with beneficiaries to educate them *before* they are auto-enrolled into a plan. They felt that someone needs to personally connect with beneficiaries to explain MyCare and go over their list of providers so they can make an informed choice about which MCOP to select. As one provider noted, *"when someone goes to the same person for 20 or 30 years, they do not want to switch all of a sudden. Especially after just being pushed into a plan randomly."*

And, despite significant efforts by MCOPs and AAAs to educate members once they are enrolled and to connect them with care management personnel, advocates reported that they still receive inquiries from enrolled MyCare members about who to contact for issues and questions.

> *People don't know in some cases that they do have a single point of contact or a care manager that they could call when they've got a problem or an issue or a concern. Or somebody that can help them to coordinate some of those benefits that they have, like transportation and so forth. - Consumer Advocate*

While there were a few members who seemed clear about MyCare and what it offers, the majority of member respondent interviews reinforced that significant confusion exists among members about how they were enrolled in the program, what it is, and how it works.

> *I think so many people, we really don't know who deals with what, who covers what. And I know there's handbooks out there, and it's all over probably on the internet if I search for it. But it's just very confusing to me to know. I just know things get paid and we get readouts on what got paid through Medicare or not through MyCare so much, but just for Medicare and different things….I just don't know who covers what. – LTSS Waiver Member Proxy*

> *I don't know how I got into [MCOP]. MyCare was sort of decided for me, and I may have just lucked out that it turned out to be a really good program. - Community Well Member*

> *I think there is a great gap in general as far as people receiving the correct information about MyCare. I mean, for the most part you have to dig on your own to find out the information, and they'll tell you anything. But you have to know enough about it in order to ask questions. And most people when they first get on it don't know enough about it to ask questions...But I just think it would be a lot better if they had a way that they could have an explanation of benefits. - LTSS Waiver Member*

Opt-in/Opt-out

In addition to general lack of understanding about the MyCare model, respondents also reported a significant lack of understanding among members related to opt-in/opt-out status. As previously stated, members have the right to opt-out of the Medicare portion of the demonstration at any time after enrollment. Respondents understood and respected beneficiaries' right to and desire for choice but also felt that the majority of members are not making informed decisions and often do not realize the implications of opting out of the fully-integrated component of MyCare.

> *I don't think they have a great understanding of what it means to opt out of one portion of the benefit. I think they're left at the counseling of others. It's great when that counseling is done without bias and just for patient advocacy, but I don't know that that always happens like that. - Physician Provider*

> *You know what's interesting is sometimes you can see where a particular Medicare Advantage sales person has hit a building, because everybody in that building all of a sudden has opted out that month. And it could be some of the people that don't understand what they're signing up for. - MCOP Leadership*

AAA respondents related that opt-in/opt-out status is at times confusing for waiver service coordinators because MCOP transition of care teams and personnel often only get involved with opt-in members. Depending on whether the member is opted-in or out, the waiver service coordinator may need to complete additional activities and communicate with different MCOP personnel. As one AAA supervisor shared, *"they follow this avenue if a member is opt-in and going into the hospital and they follow this avenue if members are opt-out and going to the hospital."* Some respondents also reported this challenge of different processes in relation to certain services such as transportation and that this can vary by MCOP.

> *So for [MCOP], waiver service coordinators are calling directly to [MCOP] contracted transportation providers. Anyone who is opt-in calls [Centralized Transportation Organization] and [Centralized Transportation Organization] gets their transport set up for them. - AAA Leadership*

Both AAA and MCOP care management respondents frequently cited opt-in/opt-out status of members as a major barrier to fully realizing the integrated care goals of the demonstration. Opt-out members are entitled to all the same care management benefits as those who opt-in, but respondents likened coordinating care and services for opt-out members to *"trying to work with one hand tied behind your back."* Care management personnel also talked about the difficulty of collaborating with the Medicare provider for opt-out members when *"you're working with 14 unique Medicare providers and there's no standard way for which to work with those 14."*

MCOPs related that they feel they can best serve members when they are opted-in. They talked about the difficulty of coordinating durable medical equipment when there are two different payors, because they do not have control over the Medicare entity.

> *So obviously, ideally we would love all our members to be opt-in. That is the greatest scenario. We can be their true single point of contact for both their Medicare and Medicaid, and really get things streamlined. If they are not opt-in for Medicare with us, they have a different Medicare company, then that really makes it a little bit more challenging... We do reach out and we try to advocate on their behalf with their Medicare payer, but it just is a little more complicated, and it's not as smooth. - MCOP Leadership*

The frequency with which MyCare members are able to change their opt-in/opt-out status and change their MCOP was universally mentioned by respondents as a frustration and barrier to providing care management, effectively implementing care and service plans, and advocating on the behalf of members. Here again, members have the right to change plans at any time. Many respondents suggested that an improvement to the demonstration would be to limit the frequency of these status changes through an annual open-enrollment period.

Some providers felt that they understood the opt-in/opt-out piece of MyCare, but many were not clear as to how it works. Several providers voiced concerns that MyCare beneficiaries are almost "forced" to opt-in because MCOPs make it difficult for members to receive items like DME if they are opted-out and have a different Medicare provider.

We're their "go to" provider and they want something that's a Medicare item and they've opted out and chosen a Medicare that we cannot bill….They don't understand when we've provided bath safety items or their incontinence products… these members do not understand the intricacies of what is going on when they opt out of their Medicare and how it may limit their options for providers….They think we're just being difficult and not getting them something they need…but we try to explain that we're not in network and we have to bill that item to Medicare. - DME Provider

MCOP respondents noted that a higher proportion of members living long-term in NFs are opted-out, with one MCOP reporting that over 50% of its membership in long-term care are opted-out. There was some speculation among several types of respondents that NF staff actively counsel members to opt-out because the fee-for-service Medicare payment structure is more beneficial. NF providers reported that residents and their family members often do not understand the opt-in/opt-out option and turn to the facility staff because they receive little guidance elsewhere. This NF provider shared that at the beginning of MyCare, there was education provided to the residents and staff, but that this education has not been ongoing,

And the residents and their families don't even really know. I know when they rolled out [MyCare], they came in and they educated the residents about opting in and opting out and educated myself and other staff members about that. But since that time, there has not been any ongoing information provided. It's just like potluck when we find out if they've been enrolled or if they've received the letter, unless a family calls and said, "Hey, I got this letter. What should I do?" Which we're not allowed to tell them what to do, but that's few and far between that somebody calls and actually asks about it.

Some NF providers posited that members with more health problems may choose to opt-out, because keeping traditional Medicare will allow them to get a longer length of stay without restrictions and receive the care they need to avoid re-hospitalization.

Whereas with the MyCare, then you are going to be in and out of the hospital more because they just do not always allow you the opportunity to get better before you go home. - NF Provider

And it seems they really do probably receive more skilled care if they opt out. – NF Provider

Multiple NF providers talked about difficulties getting timely prior authorizations for Part B Medicare services for opt-in members.

> *Because with Medicare, you can just bring them in and then if they need part B, you can just get them in to part B. It's super easy to do….But if they're opted into the plan for their Medicare, then you've got this pre-cert that comes into play. – NF Provider*

> *I would even throw in there as a redundancy, having to get pre-certification for part B, as opposed to…even a part A stay as opposed to how traditional Medicare works. We know if the patient is going to meet the level of care, if they have the three-day qualifying stay with the exception of being in a health emergency. And if we screw up, and we've made mistakes occasionally and we have the claim denied. What does a pre-certification do? How is that ultimately in the best interest of the patient?" – NF Provider*

BH personnel noted that a large amount of Specialized Recovery Services enrollees are opted-out. This affects the overall care coordination because Medicaid requires that they closely collaborate with the SRS recovery manager, but they do not have the full picture of what's going on with those members.

Most member interviews reinforced that there is confusion regarding opt-in/opt-out status and that more and continuous education for members is needed. When opt-in members were asked if they had ever considered opting out, several members indicated that they did not know that they could do so. However, one member shared that they thought it was a positive thing that MyCare does not require members to opt-in,

> *There's no perfect plan and the good thing about being in Ohio, we do have options, we do have some freedom where we're not required by law to combine both of our coverages if we choose not to. – Community Well Member*

A few members shared that they had been directly advised by a health care provider not to join a specific MCOP or not to "combine their cards" and opt-in to a Medicare Advantage plan through their MCOP. These warnings typically came from physicians or physician office staff who told members that they had problems getting payment from the MCOPs.

Challenges with Combining Rules and Regulations

While respondents recognized that the combining of multiple waivers into one offers additional benefits and flexibility to MyCare beneficiaries, they discussed

that MyCare waiver rules often refer back to PASSPORT and Ohio Home Care Waiver rules and that it can be confusing as to which rules should be applied. They expressed that further alignment of rules and regulations to be specific to the MyCare waiver would help reduce confusion. Several respondents longed for the development of a "universal MyCare playbook" with a set of rules that is consistently applied across plans and settings.

AAA personnel responsible for certifying waiver service providers reported that despite efforts to align rules, it feels as if there is some oversight duplication for MyCare providers. Waiver service providers are certified and reviewed under ODA provider rules by the AAAs, but then are also accountable to the Provider Oversight and Incident Management Services for Ohio Home and Community-Based Waivers program in which ODM has contracted with Public Consulting Group (PCG) to conduct provider oversight within MyCare. Respondents reported that when PCG communicates with MyCare providers, they frequently reference back to the Ohio Home Care Waiver rules and there is often confusion around which rules apply and to whom providers should be held accountable. One AAA provider relations respondent questioned the interpretation and practicality of some rules.

> *They're citing providers for answering to the waiver service coordinator for missed services, but not also notifying the case manager from the plan…. if it's what they want, that's fine. But then they're saying, "Well, you were 15 minutes late. Why wasn't that reported?" And we get it. I mean, the rule says "any period of time", but it's so nitpicky and some of these providers are like, "I can't report every time an aide is 10 minutes late to PCG, and to the waiver service coordinator, and the case manager.*

This provider expressed frustration over what seems to be a disconnect in communication between ODM and the MCOPs resulting in some duplication of efforts.

> *Sometimes I feel like Medicaid and [MCOP] are not communicating to each other. We're going through Medicaid's portal, we're entering everything, and then [MCOP] keeps calling wanting the same things that we've already provided. – NF Provider*

MyCare Operations

Issues related to communication, access to information, and the accuracy of available information were a recurrent theme throughout regional interviews and focus groups in regards to operations within MyCare.

Enrollment and Assessment

The availability and accuracy of eligibility and enrollment information was frequently mentioned by respondents as creating operational challenges and barriers. In fact, these issues occur so frequently that the MCOPs and AAAs reported engaging in regular meetings specifically to discuss and troubleshoot enrollment and eligibility issues.

> *When our system is populated with our new enrollees, a lot of times they come across with no contact information whatsoever. So you have to play detective to try to find phone numbers for these members….It can be very time consuming. So we'll get 10 new enrollees that month and out of 10 of them, five only have phone numbers. You're looking at a lot of time devoted to attempting to locate these people before you can even try to get them engaged. - MCOP Community Well Care Manager*

Respondents explained that issues related to eligibility can have major impacts on members and care management personnel.

> *So some of our county [Job & Family Services] agencies are a little bit better than others, and some of them are a little bit slow to process paperwork, so when that happens and a member becomes ineligible and then is retroactively eligible again, that causes an interruption for their pharmacy. They may have prescriptions that they need get filled, and all of a sudden it's rejecting….Anything that needs an authorization, that can really cause a big disruption. - MCOP Leadership*

> *I would say our biggest concern about the level of care assessments is the fact that the information that we get about who needs an assessment or a reassessment is often incomplete or inaccurate... We may not find out for months that we should have been doing a reassessment on this group of people five months ago…. And so we run PIMS reports to tell us who needs a reassessment. And we have to run that report several times a month because it changes all the time, people drop off, people get added. So we go back, retrospectively, and run that report again to see who we missed the first time that we didn't realize had been added. And I know all of the MyCare AAAs experience the same thing. It's just poor data that we're getting. - AAA Leadership*

MCOP respondents reported that they face barriers with being able to access information even across MyCare regions and if a member transfers across regions, HENS does not allow them to see the member’s initial level of care or assessment information.

The demonstration requires that level of care assessments and re-assessments must be conducted by the AAA “front door” staff, and AAA assessors reported that this can be confusing to members. They reported that often members will not initially speak with them because they do not understand the assessor role. In some cases, they may have recently had a routine care management assessment with their MyCare care manager or waiver service coordinator and do not see the need for another. Assessor team members also reported some duplication between the questions asked in the various required assessments as well as duplicative language around assessment and redetermination used across the demonstration which adds even more confusion.

> *A lot of the language and terminology is extremely similar across the things too. So we'll say things like, "A reassessment or a redetermination." It's the same language that they use for the annual reassessment for the services plan and for their Medicaid redetermination. So when they have to turn in their income documents and stuff to Job & Family Services, they use that same language. So I understand why it's so confusing. - AAA Assessor Team*

Here again, communication emerged as a significant barrier. Assessors reported poor communication between their team and the MCOPs and the limitations of HENS as a communication platform, especially if the information in the system is not accurate. One assessor stated,

> *The only thing that goes through HENS from us is the outcome of the assessment. It just says, "Complete" and what the level of care is….And there's no contact person or they aren't open to contact and getting information to us, to be able to actually do this assessment.*

Other assessor team members reported challenges with getting timely communication back from MCOPs once they identify missing or incorrect information and that they are often communicating through a generic mailbox, rather than having a specific point of contact, which they felt would improve communication. Assessors also described that they often feel powerless in their role.

> *It's been very frustrating for me with [initial assessments]. They'll say, "When can I expect services?" And I'm like, "I cannot give you an exact on that." And then they ask, "Well, can you talk about what services I'm going to get and stuff?" "I can't talk about your services, that has to go through whoever they assign you." "Oh, who is that?" "I don't know, sorry." - AAA Assessor*

Assessor team members reported lags between when they identify an individual as eligible for waiver services and when the individual actually ends up getting services put in place. They shared that individuals who were assessed a month prior have contacted them and asked "Where are my services?" and they have to explain that they do not make the final waiver determination and that there is nothing they can do to speed up that process. The assessor team also expressed frustration with trying to identify a member's assigned care manager to alert them that the member was inquiring about services—even trying to reach out through the MCOP 1-800 telephone number and being told that the MCOP representative did not have permission to share that information.

The assessor team respondents also described frustration around wanting to be good collaborators and notify MCOP care managers of issues they become aware of during assessments but not having a way to communicate more than basic information with them. MCOP care management staff also expressed a desire for better communication when members transition from other waivers into MyCare.

> *I think it would be really helpful if there was more communication between the PASSPORT care managers and the Ohio Home Care managers with the new MyCare waiver, when they transition. I think for continuity of care, to know that they're coming, what their service plan is, if they have any other special needs, would be very helpful, because we currently get minimal information. - MCOP Care Management Supervisor*

Care Transitions

Despite significant efforts by MCOPs and AAAs around addressing transitions of care and significant change events, many respondents spoke about room for improvement around transitions for both opt-in and opt-out members. Primarily, challenges come from "hefty" demonstration requirements. In particular, the contact and follow-up requirements were mentioned as posing major challenges for care management personnel because the timeframes allowed for contact and follow-up are very short and can disrupt the flow of an already full schedule of required routine activities.

> *I think it also speaks to the fact that we actually had to have an entire department dedicated to making sure that we meet just a huge amount of requirements as far as transitional care, especially with our waiver members. It kind of speaks to the volume of the requirement, that we needed a whole team to be hired in order to address those issues and meet those requirements. - MCOP Care Management Supervisor*

At the same time, care management personnel reported some confusion and duplication of efforts at times with regards to transitions of care, even with specialized roles and teams in place. While separate transition of care teams within the MCOPs were appreciated by most care managers in terms of meeting transition of care requirements and identifying members who go into a hospital or NF more quickly, some MCOP and AAA respondents shared that, at times, having a separate team for transitions of care complicates the communication process. Some AAA waiver service coordinators reported being “left out of the loop”, which is problematic because they play an integral role in setting up services for members upon discharge to home.

Some care managers expressed that they prefer to remain involved with their members during transitions of care rather than “handing them off” to the transition of care team, because they have relationships with members and knowledge about their history, home situation, and support systems that is often vital during discharge planning. As one MCOP care manager stated, *“They don’t know these folks like we do.”*

Poor communication during transitions between settings poses serious barriers to ensuring that those transitions are smooth and that members have needed services and equipment in place in a timely manner. Care managers and waiver service coordinators reported that they are often not made aware when a member is discharged, even if they have been successful in making contact with hospital and NF staff while the member is inpatient. An inability to secure discharge summaries from hospitals and NFs, despite multiple attempts, was a universal complaint and source of great frustration to both MCOP and AAA care management personnel. Respondents felt that the busyness of hospital and NF staff and a general misunderstanding of MyCare and the care manager role were contributing factors. Respondents reported that if they are able to make a connection and build rapport with someone inside the hospital, it is certainly a benefit.

> *If it's at a hospital where you have someone that you can connect with, that you have rapport with, it's much easier to get the documents that you need. But if you don't, regardless if they were opt-in or opt-out, it's like pulling teeth sometimes to get the documents you need. - MCOP Care Manager*

Many MCOP and AAA respondents discussed how a member’s opt-in/opt-out status often plays a significant role in successfully managing transitions of care. When members are opt-in, care management staff have the ability to see their Medicare claims and get alerts when members have an emergency room visit or

hospitalization, which allows them to reach out to the member right away and follow-up with them. With opt-out members, care management personnel may not know for a few months that a member had a hospitalization, especially if an incident occurs right after their last routine contact with the member.

Yet, some NF providers reported challenges in connecting with MCOP and AAA care management when members are admitted from the hospital,

> *I usually have to call in and find out if they have a case manager, care manager, who is it, and get in touch with them, to find out what services they had at home, what's my discharge plan going to be? I just feel that the care managers should be following their patients closer if they're in the hospital, end up going to a nursing home, that kind of stuff.*

For provider respondents, prior authorization requirements and processes were perceived as a barrier to an efficient transition back to the member's original living arrangement, causing an unnecessary delay in discharge. Hospital discharge planners reported that prior authorizations for medications often cause delays even when they have been "escalated" due to discharge because MCOPs have 24-48 hours to respond to the authorization. Discharge planners also related that MyCare members discharged on weekends sometimes cannot get their medications from the pharmacy upon discharge because they are told it needs a prior authorization. They most often reported prior authorization issues when discharging members to NFs.

> *So even for intermediate or long-term care, sometimes a patient will be from a facility and we have to wait and delay discharge because they need prior authorization to return back to where they came from. The other obstacle is if we're sending a new referral and it gets denied for skilled care then it still sometimes takes a day or two for them to get approval for intermediate care. Where I feel like if it's denied skilled, why does it take so long to get the intermediate level care when it's the same patient? So, those are the two things that are frustrating from my end that delay discharges. - Hospital Discharge Planner*

Hospice providers reported that issues related to unnecessary prior authorization requirements by the MCOPs are very problematic and frequently prevent members from accessing hospice care.

> *They're requiring two physician signatures under the preauthorization for hospice patients, and hospice patients already require two physicians to sign off before they elect hospice care. So it's completely*

unnecessary for that requirement to exist, but yet it still exists and that's causing a lot of problems with access to care. - Hospice Provider

….the [MCOPs] are requiring a prior authorization, which can take up to two weeks. And about a third of our hospice patient population is only on hospice services for seven days. And so what providers are finding is the patient often dies before they can even get the prior authorization to go through …If this is a straight Medicaid patient, there is no prior authorization that's required. It's sufficient to have the two physicians certify that this patient is eligible for hospice services. - Hospice Provider

Some NF providers expressed the belief that skilled rehab days are purposely limited by the MCOPs as a cost-saving measure, which ultimately results in poor outcomes for members.

…they think they're saving money because ...instead of being an average of a 30-day stay, it's an average of probably a 17-day stay, which sounds wonderful so long as you're not creating bounce back to the hospital or having people be satisfied with being at a lower level of ability than they were prior to whatever started that loop. - NF Provider

I think that the patients that come in for skilled nursing…a lot of times they cut them too soon, when they are not strong enough to go home. And then they end up going back to the hospital because they do not allow them to get well enough to go home. - NF Provider

It is important to acknowledge the numbers of interactions and communications that acute care and long-term residential providers may be engaged in. For example, in one AL facility, there is the potential for multiple care management personnel from AAAs and MCOPs serving in various capacities—a AAA fully-delegated care manager, a AAA waiver service coordinator, an MCOP waiver care manager, and MCOP care management support staff member (community health worker, etc.). At the same time, AL staff may also be engaging with a care manager from the traditional (non-MyCare) AL waiver. It is easy to understand how there may be misunderstanding and confusion around the responsibilities of all these personnel and challenges in maintaining effective communication.

Access to information

Many non-MCOP respondents expressed disappointment that the MyCare demonstration has not resulted in better access to information and information sharing between the MCOPs, AAAs, and providers.

I think the AAAs would really like it if they could have access to more information. And I will say that a couple of the plans have been particularly good about trying to provide that. But one thing we were thinking about early on was, "Oh, this is great. We'll have access to people's acute care episodes and those type of things, and that helps in providing their long term services and supports." But it didn't work out that way. - AAA Respondent

Respondents offered suggestions to receive greater access to member information, electronic medical records, and health histories to provide better services.

And that's why our thought was in the next procurement, if there could be a centralized data portal so that the state would have access to the data and everyone was reporting in the same way and having access to the data in the same way. - Provider Association

…a way for us to be able to have access to the most up-to-date information on these people rather than spend so much time….chasing them down, trying to find out where they are, getting phone numbers, getting diagnosis, all of that stuff. If there was a way that we could all be able to get into a universal system where we're all working off of, I think I would save us all a whole bunch of time. Are they in the hospital? Are they in the nursing home? What services are they getting?... things that you don't have to continually ask them. - AAA Assessor

So if there was some way to integrate the electronic medical records with health information exchanges or something like that, these are things that would improve it quite a bit. It really would benefit an interdisciplinary team. - Provider Association

If all the companies would come together and just keep all that information on one portal. So we could just go there, no matter which Medicaid product it was, that would be ideal. - Hospital Discharge Planner

Several respondents felt that the demonstration needs to demand two-way sharing of information between facilities and care management, between MCOPs and AAAs, and between MCOPs and providers.

I think anything that demands a two-way sharing of medical information. I can't tell you what meds the patient got in the hospital or in the long-

term here because they don't tell me. Then I'm relying on discharge paperwork to figure out, "Okay, what do they have in their medicine cabinet? What did they think they sent them home on and has anybody done the medication reconciliation? I got 32 meds here and she's only supposed to be on 12. What do I do about that? I have nowhere to go, except to look at the pieces of paper they send. That is not a good way to do it. We call the pharmacy lots of times. You look at all the prescription bottles and you find that there's three pharmacies and you call every single pharmacy and go, "Okay, what do you guys have for Sally?...Or are there pill bottles I haven't found yet? It's like you've gotta be a detective or a sleuth. - Home Care Provider

Value-oriented payments are encouraged in the MCOP provider agreement as a way to "cut waste, reflect value, or both".[31] Some MCOP respondents shared that they are engaged in such payment arrangements with AAAs and some providers (mainly around HEDIS measures, hospitalizations, and preventative care activities) but did not provide much detail on the specifics of the arrangements. AAA respondents expressed a desire for more data from the MCOPs so they could better engage in discussions about establishing value-oriented payments and also evaluate their performance toward metrics in the value-oriented payment arrangements they already have in place.

The timely sharing of information has been a long-standing challenge across acute care settings. When long-term services providers, both institutional and community-based, are included, a difficult problem becomes even more complex. Despite considerable efforts to address information issues, respondents consistently identify information access and sharing as a continual concern.

Several member respondents also expressed frustration with the quality of information they are able to access on their MCOP's website. They talked about the challenge of locating accurate provider information, reporting that when they contact providers listed on the website as being "in network", they are often told that the provider no longer contracts with the MCOP or no longer accepts MyCare. A few members stated that this also happened when their care manager or waiver service coordinator provided them with a list of potential providers. A few more tech-savvy members expressed disappointment at the functionality of their MCOP's website,

You sculpture your own personal page. It seems a disconnect between it and the main website like some of the things that you should already have in the system….none of my doctors were listed….There was one instance I was trying to place the information in myself and found the

doctor, but things like the wrong address or the auxiliary address for the physician....Or the opposite would happen, that a doctor that's no longer within the network, they would still be listed. You try to update your information. The next time you go see, it's still there…Most of it's little minor things like that….There was no way for me to go from my personal page directly back into MyCare Ohio or [MCOP]….It just seems to be it should be a smoother link to go back and forth. – Community Well Member

One of the major issues I have with them is how they communicate with me and the fact that their website is not as interactive as it should be for a patient or their customer. Because I get excessive paper mail….And I have literally begged them to update their electronic data system because a lot of the information that they send me in the mail is there, like my EOB statements as well as claims.

Interactions with providers

MCOP respondents shared steps they have taken to work with providers and to establish points of contact to facilitate communication. Two MCOPs shared that they have created “post acute” positions specifically dedicated to working with NF and hospice providers to serve as a single point of contact; addressing questions about authorizations, coordination of care, claims, and assisting to streamline those processes. The MCOPs recognized the competing goals that exist in the long-term care space with the MCOPs focused on diversion and rebalancing, while providers continue to be paid largely on a fee-for-service model. They saw these positions as important to building better relationships with providers and exploring how to move to value-oriented payment models.

In their interviews, regional provider respondents consistently focused on inadequate rates and reimbursement, difficulty working with MCOPs to resolve billing issues, and service delays caused by added authorization requirements. Provider respondents repeatedly reported a desire for a streamlined billing process across the MCOPs and discussed many administrative burdens associated with working with multiple billing systems. Several providers related that they had to hire additional staff to manage the increased workload. Numerous providers mentioned that billing under PASSPORT is easier and faster and felt that simplifying the billing and reimbursement process would lead to more provider options for members.

…we always thought it would've been better if the billing process was the same for all of the individual MyCare companies. Reason we say that is that we are quite frankly receiving so little in reimbursement for

the assisted living Medicaid waiver clients, that the thought of adding extra people to learn five different systems and bill them is certainly not going to encourage people to be Medicaid waiver providers. - AL Provider

We've had providers who have completely shut down because of payment flow issues….and providers probably won't admit it, but some of them might, that if they had a preference to accept and staff a case between a traditional waiver consumer versus a [MCOP] consumer. I'm pretty positive that they would pick the PASSPORT consumer. - AAA Leadership

In general, our [members'] experience with managed care is that it's very much not care management. It's more managed payments. And by that, I mean a lot of denials and administrative hassles that we have to go through to get paid for services that were already rendered. - Provider Association

Providers also reported that while some aspects of billing have improved over the course of the demonstrations, there is still much work to be done around this issue and that trying to investigate and address billing issues is an incredibly time-consuming and frustrating process that can take months to resolve, if resolved at all. Several providers reported trying to recoup significantly large sums for services already rendered, sometimes due to repeated under-payment.

They'll shorten us with no reasoning. Like we'll get a payment and it will be short $15, $2, $20 with no reasoning saying it's paid in full when it's not. So it's extremely frustrating where they're not paying. We're doing our end of the contract where they're not. So, and it's been a pile of paperwork to find out why and half of the time we don't get an answer. - Home Care Provider

Many provider respondents also expressed frustration with the payor sequence within MyCare and felt that it contributed to delays in members receiving necessary services and equipment.

One of the rules that the MyCare plan has…is waiver won't cover an item if it's covered by Medicare or Medicaid. Sometimes there are upgraded custom items, maybe a standard walker could be covered by the Medicare or Medicaid part of their insurance, but the member needs a rollater, which has additional features. So it's more of a custom item and it's not billable to Medicare or Medicaid. So we will send them a quote for a waiver price and oftentimes they'll press for that item to be

> *billed or ask for a denial from the insurance. And that's where that disconnect is. There's no way for us to get a denial, number one, or, number two, we don't have a code to bill that particular item to Medicare or Medicaid….They're asking us to obtain a denial and it's impossible. And until we get that "denial", they do not want to approve it under waiver, but what they're asking for is impossible. - DME Provider*

Several providers also stated that it seems to take longer to get items traditionally covered by waiver to be approved under MCOP waiver services.

> *It takes a little bit longer to get things approved under their waiver services…I'm referring to specifically approvals for items under their waiver funding. So maybe not items that are in their Medicare and Medicaid covered items, but something that a case manager might approve under their waiver funds. There is a lot more to the approval process and that's something that the case manager does on their end. So I don't know if I would technically call that prior authorization, but there seem to be a few more things that they have to do. Like they're requiring a lot of physical therapy evaluations for items that other payers don't require. - DME Provider*

Multiple member respondents reported challenges and delays in getting approval for items such as electric wheelchairs and scooters, lift chairs, wheelchair ramps, stair lifts, bariatric equipment, and certain medications. While the members perceived these items as necessary to achieve their best possible quality of life, in several cases they had been waiting many months for approval, or had been denied approval and were engaged in an appeal process. One member shared that the reason given to them for delay in a home modification was that there was "no money left this year" for the items they requested. The member explained that his case manager had to seek special authorization for the request because it was over a certain amount of money, in this case, $7500.00,

> *The way this works is that [MCOP] budgets for a certain amount of money for each individual. But yet they also don't use money for certain individuals, so that in essence becomes money that is available for others….But I guess whatever amount of money is appropriated originally….they basically spend that on needs. And here we are in July, the seventh month of the year, and they're already out of money. – LTSS Waiver Member*

Providers reported frustration that MCOPs have granted exclusive contracts for some products (in one circumstance, to an out-of-state provider), citing two

different MCOPs who now utilize a single provider for incontinence products. They reported the negative effect this had on providers and consumers.

> *We had to completely restructure our business back in…2014-2015. And then again, a couple of years ago when [MCOP]…took all of their incontinence business and contracted it to a provider in [other state]….we actually had to let people go because it was such a huge chunk of our business. We were not notified. We were not given the opportunity to bid for a reduced contract....if their goal was to spend less money…we literally were not even told that they were doing it. We found out when our clients started calling us saying they'd got these letters that they have to start using this other preferred provider. - DME Provider*

> *So any of their members who receive incontinence items has to go through [Incontinence Provider]. They have absolutely no choice where they get their items from. And we've had a lot of customers who don't like that. They don't like to be limited to one provider. We've lost a lot of incontinence customers because of that limitation and it really affects consumers' choices. - DME Provider*

Both AAA and MCOP care management personnel reported limited success and many challenges with engaging and communicating with primary care physicians, even to the point of struggling to verify whether a member is a patient because physician offices would not confirm, citing HIPAA restrictions. While some physicians respond to inquiries and participate in reviewing and approving care plans, care management respondents stated that the majority do not and respondents speculated that while having a physician fully-engaged in the care team is very positive, it creates more work for the physician and they may be "overloaded" with information.

There were few physicians among regional interview respondents, but one physician shared that the two biggest differences they have found working with MyCare patients is receiving increased communications and having to deal with increased prior authorizations for medications. While the physician appreciated "targeted communications" (i.e., pertaining to medical review, suggested therapeutics, tests), they did not typically review *"comprehensive 'War and Peace' care plans"* because the care plans are too long, and they felt much of the content does not pertain to the interactions with the patient on which they are focused. Physicians reported that the process for prior authorizations for medications is cumbersome and that the individual MCOP plan seems to make a difference as to how cumbersome.

Physician respondents also reported that they were aware of transportation issues for MyCare members and that this affected members' ability to receive dialysis, attend scheduled appointments on time, and get in to see providers quickly if last-minute appointments become available. Difficulties in finding in-network specialists for MyCare patients were also reported and were, again, often associated with specific MCOPs. One provider respondent speculated that a state change around payment for dual eligible beneficiaries that occurred close to the time the demonstration started, but not part of the demonstration, may have caused some physicians to view MyCare negatively.

Providers reported several changes they would like to see in how the MCOPs work with them, including the re-evaluation of how timely claims payment are measured. They suggested that the measurement should start from the date of service rather than from a "clean" claim. Multiple provider respondents reported issues with being able to get a "clean" claim and struggling for many months with little assistance from MCOPs to resolve the issue. These issues are compounded when a member changes plans and the provider can no longer identify the member in the MCOP's system. They also wanted to see better communication and quicker resolution of payment issues and expressed frustration that even when they have a designated contact within an MCOP who is supposed to assist them in resolving issues, it often takes repeated contacts and escalation through multiple layers of hierarchy to accomplish this.

> *For example, right now [MCOP] has not been paying us the proper amount for all of our bath safety products….I have went through five different people, starting with the provider rep going all the way higher up, maybe like five people above her. And they still have not corrected that. So they've been short-paying us for items. It's now almost October and I've alerted them in February. So that's a really large problem with [MCOP] and the length of time that it takes them to correct a large claims issue like that. And that's not out of the ordinary that it would take them anywhere from six to 10 months to fix a large claims issue. - DME Provider*

AAA provider relations respondents reported that some providers have stopped dealing with certain MCOPs or all the MCOPs in their regions due to the many frustrations they have experienced. One provider relations respondent shared that some providers will say that they accept a MCOP, but then not actually bill the MCOP for the services they provide:

> *I had a meal provider who would accept [MCOP] and [MCOP], but they never billed it. They billed it to their [local tax levy program] because they*

> *said it's just too difficult and too time consuming. They said, "I can't allow my staff member to spend that much time following up because part of the month would get paid, and part of the month would not get paid."*

In their interviews, some members reported challenges in finding providers who accept MyCare or their specific MCOP, with the most commonly-mentioned provider being dentists. Both Community Well and LTSS-waiver members across different regions expressed major difficulties in securing dental care, even with the assistance of a care manager or waiver service coordinator.

> *I've got two different workers over there trying to find me a dentist. They said they'd call me back when they did. The last time I talked to them was over a month ago. When I call in and check, they're still looking. – Community Well Member*

Most members stated that they were able to keep the same providers upon their enrollment to MyCare, but there were a few who reported that they had to change providers because their provider would not accept the particular MCOP to which they belonged. A few members stated that they had purposely selected their MCOP because it would allow them to continue care with a specific provider.

Specific service challenges

Shortage of in-home personal care providers

Care management personnel consistently identified a shortage of in-home personal care providers (and *quality* providers) as one of their biggest challenges in working with members and providing effective care management. Home care providers also discussed challenges with recruiting and retaining personal care staff. While COVID-19 has exacerbated home care staffing challenges, respondents pointed out that this issue was significant prior to the pandemic. Some respondents felt that this challenge is exacerbated by the requirements independent providers must meet.

> *I really want to drive home the emphasis of what a dire situation our state is in regarding caregivers. Though I don't think that [MCOPs] really had a direct impact on the lack of caregivers, I do think that the process that people have to go through to become a caregiver is such a long drawn out process and it's such a hassle that people just ... First of all, they don't get paid enough to do this, but second of all, to go through what they have to go through, it's not worth it. - Consumer Advocate*

One MCOP provider association respondent shared how the MCOPs worked with the state and independent providers at the beginning of the demonstration when the claims administrator used by many independent providers decided not to process MyCare claims:

> *And so we worked with the state. The state had all the independent providers in their system and gave that over to the plans. The plans worked to connect with those independent providers who were providing services for their members to let them know there are other options you can use. You know, "We've got portals for you. You can still do paper claims. Let's get this figured out for you"…. And at the end of the day, it actually saves them money because that billing entity was taking a percentage of their claims as their fee to process those.*

While participant/self-direction is an option within MyCare and in some cases has helped to alleviate staffing challenges, most care management personnel reported none or very few members in their caseloads utilizing this option. One AAA reported having a care manager specifically dedicated to work with self-directed members. When asked, some care management personnel attributed the low utilization of the self-direction option to members not wanting to take on the responsibility of managing the process and potential independent providers having difficulty navigating the requirements to become certified.

Home care worker shortages have become a nationwide challenge, but were not discussed by members in their interviews with the exception of one member who shared that they had been trying to get a new personal care aide for over four weeks since their last aide left their position to go back to school. The member stated that their care manager provided them with a list of about 10-12 providers to contact, which they had, and that they had contacted an additional 20 providers that they identified on their own. According to the member, all the providers they contacted told them either "We don't serve your area." or "We serve your area, but we don't have enough personnel."

There were two member respondents, from different MCOPs, with experience working through the process of a family member becoming an independent provider. Both respondents expressed challenges with the process. One respondent reported that it had taken six months to get approved as a provider through Medicaid and the MCOP, with about four months of that spent trying to get contracted with the MCOP. The other respondent also reported that the majority of the challenge lay in getting recognized by the MCOP as a provider. When asked if they had been given any reason for the delay, both respondents said that they were given multiple reasons such as a back-up of applications,

mistakes in the completion of the applications, lost applications, and mistakes in processing the applications.

Transportation

Issues with transportation availability and reliability were the most frequently-mentioned service provision challenge by care managers and waiver service coordinators after PCS shortages. Lack of available transportation and problems with scheduled transportation was reported as a major challenge and a barrier to members being able to adequately address their health needs and contributing to issues related to social determinants such as securing food and engaging with social supports. Providers described numerous incidents where members were unable to access transportation in their needed timeframe (e.g., being able to accept a short-notice appointment with a physician) and experienced very long wait times for pick-up (or were never picked up).

> *One of the biggest, everybody had this complaint was that the transportation process has been really difficult across all the MyCare Ohio plans. Using their transport provider has really proved challenging. So, we've had all kinds of issues with transport, either not showing up for appointments or not showing up on time…even if the transportation does show up, they would just sit out there and not notify anybody that they're there…after whatever time period, they'll just go ahead and leave without any kind of communication. So it's constant problems." – NF Provider*

> *"We've had some patients even miss appointments due to transportation issue. And so, I think that's been a complaint since day one with the MyCare Ohio plans, and it's just still has not really been addressed or resolved." – NF Provider*

Member respondents also talked about transportation and detailed challenges that they have experienced around the flexibility of transportation in relation to their medical needs,

> *One of the things I kind of don't like is I have to give them at least three business days to schedule the transportation. And if all of a sudden I'm ill and I need to go to the doctor's and they're wanting to see me later today or first thing in the morning, it's impossible to get transportation scheduled that quick. – LTSS Waiver Member*

> *But I've been left by them and had to put in a complaint because I spent $30 on Lyfts getting home because they abandoned me… And I've had*

to wait two hours on a sun-drenched 95-degree day and just about passing out of the heat. – Community Well Member

So I just said, “Forget this. I’m not using them anymore.” Even though it was free, it was not worth waiting for a long time, sitting outside a grocery store or a doctor’s office for two hours. – LTSS Waiver Member

Consumer advocates and MCOP leadership shared that transportation has remained a consistent source of member complaint throughout the demonstration. The majority of MCOPs have established contracts with organizations that provide central administration for transportation and who then contract with other local transport agencies. Care managers and waiver service coordinators reported having little ability to resolve transportation issues due to having to work through a centralized service rather than being able to contact specific transportation agencies directly. One NF provider shared that reliability of transportation directly can have a direct effect on their ability to accept certain patients, such as those on dialysis,

I think it affects our ability sometimes to admit people from the hospitals. Dialysis is really a primary example, especially when there's a routine service that is going to have to be scheduled three days a week. - NF Provider

The MCOP’s use of transportation administrative organizations, at times, create unique circumstances. One transportation provider related how one MCOP terminated their contract, but they were still transporting some of that MCOP’s clients through their contract with the MCOPs transportation administrator.

Behavioral health

The challenges of providing care management and services for members with behavioral health came up frequently in interviews and focus groups. Respondents reported that housing issues and substance use disorder are major factors within the BH population, and there is much more homelessness and unstable housing with these members. One MCOP estimated that over 50% of their membership have some sort of BH diagnosis in addition to chronic disease. The fact that BH was carved into MyCare from the beginning of the demonstration and that SUD residential benefits are covered by Medicaid was reported as a huge benefit.

As discussed earlier, the MCOPs have built roles and teams dedicated to BH to address the needs of this population and to provide support and education for care management staff. Both MCOP care managers and fully-delegated AAA

care managers were very complimentary of the support they receive from MCOP behavioral health personnel.

Our behavioral health liaison is excellent…. I email her a lot when I have a difficult case….sometimes it can be hard with the BH members or those who have substance abuse, getting them engaged and wanting to pursue treatment. And our behavioral health liaison has a wealth of experience, and so it's good to be able to use her as a resource to help provide guidance on how to navigate through those difficult situations. - MCOP Community Well Care Manager

In addition to having a wealth of knowledge about community behavioral and mental health resources, these MCOP BH personnel are valuable to care managers because they often have strong relationships and good rapport with providers and can assist in keeping members engaged in their treatment. Care managers particularly appreciated the assistance of BH personnel in working with younger members as these members tend to have higher incidence of BH diagnoses and issues. A MCOP BH supervisor described one of the many ways that BH professionals try to engage with community providers:

In the behavioral health area, we work a lot with the community mental health centers. One of the challenges we had when we started is getting them to call us back. And we really need to work closely with them. A lot of times, our members are not mentally stable, so they don't want to let us in the door, they're not going to answer the phone for us, and we really need to get in there. So, we really have to work closely with the community case managers. So, one of the things that we started doing is meeting with the community mental health centers more regularly. So, once a year, we tried to go in with all the care managers on my team and meet with all of the case managers at their centers with one of the ones that we work with, we actually meet with all their managers quarterly just to keep those lines of communication open and develop relationships, and that's really helped.

BH personnel are also engaged in providing education on BH issues to both MCOP and AAA staff. Aetna respondents reported utilizing the RELIAS online platform to provide BH education and continuing education offerings for care management staff around the areas of mental health, addiction, and substance use disorder. BH respondents were complimentary about AAA fully-delegated care managers' increased understanding of and capacity to address BH issues since the beginning of the demonstration.

I can say when I first started it seemed like the waiver care managers were a little more apprehensive about working with the behavioral health issues, but in the time I've been here we've put so much effort into skill building and helping them understand how to approach those individuals, that it seems more a natural part of their care management process. And I offer consults with them frequently. - MCOP BH Personnel

Pragmatic innovations

To assist with meeting all the requirements and demands of the demonstration, MCOPs and AAAs have implemented a variety of pragmatic innovations within and across their organizations. AAA respondents talked about engaging with other demonstration AAAs to discuss challenges and best practices. In addition to the health, safety, and welfare “rounds” and minor home modification committees discussed earlier, several MCOPs reported efforts to engage the AAAs around quality improvement.

The two MCOPs engaged in the fully-delegated waiver care management model shared that they have instituted teams that focus on the incident reporting process; reviewing incident reports from care management staff, reviewing corrective action plans and developing resolutions for them, and working with the AAAs to look at root causes and trying to remediate some problems before a corrective action plan is needed. One MCOP reported having teams focused on clinical quality auditing to decipher metrics and assist their contracted AAAs to work on specific HEDIS metrics. The HEDIS metrics are broken out by performance of each of the AAAs and then as an aggregate, so all the AAAs can see how each one is performing and can compare to how the MCOP internal care management teams are doing on those metrics (acknowledging that the AAA and MCOP care management teams are managing different populations). A reporting team creates vendor reports that are shared monthly with the AAAs. The report puts together HEDIS metrics as well as medication adherence metrics. It also includes upcoming assessment deadlines and late assessments; providing a good overview of care management activities. The other MCOP discussed how they have made their pharmacy team available to their contracted AAAs to assist in making medication reconciliation calls. The AAAs have the option of using the team or managing the process on their own.

MCOPs also discussed steps they have taken to improve processes within their own organizations, such as utilizing the CliniSync Health Information Exchange. One MCOP leadership respondent described their “engagement team” which functions to connect newly-enrolled members to care management personnel.

> *So when we get the enrollment over, we go through and we start making outreaches, and our process is making three calls to the member. If we can't get a hold of them, then we'll send a letter. We also do demo claim searches to find better contact information and then we have to send the second letter. So, hopefully, within that outreach process, we will engage the member. And then, that's when we complete the health risk assessment and all the other assessments that go along with getting them engaged in case management.*

MCOPs talked about contracting with other types of organizations to improve member outcomes. One has hired a company that works collaboratively with the primary care physicians to provide additional oversight and support for members' health in the community. Advanced practice nurses visit with members in their homes and conduct wellness screening and disease management activities, also performing a visual assessment of the member's environment and communicating back with the primary care physician. The MCOP then uses the information provided by the company to identify members who may be at risk and disseminates that information to the care managers so they know to monitor the situation.

One MCOP respondent shared that the demonstration has provided a unique opportunity for the MCOPs to collaborate with each other.

> *Health, safety, and welfare had come up as we were moving through the demonstration. And ODM actually set up an opportunity for the plans to meet together collectively with ODM to discuss hard, difficult cases, and get some best practice and feedback on, "Have you tried this? Have you done this? Yeah, we've had a similar situation."….I thought that was a pretty significant best practice in that when we think of managed care, you usually think of these corporate entities that don't collaborate and work together and it's the exact opposite here in Ohio.*

Issues for Future Consideration

Concerns about the fragmentation that exists across health and long-term services providers have been raised consistently for the last four decades. A major cause, but not the sole reason, for this has been the lack of coordination and cooperation between the Medicare and Medicaid programs. The FAI programs, including the MyCare demonstration, have been designed in response to the Medicare/Medicaid concerns. The MyCare goal of integrating these two large and complex programs includes an array of design and operational challenges and opportunities. Our state and regional interviews, along with a

review of data and documents, have identified a set of programmatic issues for future consideration. In this section, we discuss those issues and how they may affect MyCare implementation and evaluation.

One of the challenges in the design of a demonstration involves standardization. On one hand, it can be beneficial to have the health plans innovate and design an intervention that is flexible and builds on their organizational strengths. On the other hand, having a core intervention that is structured in a similar way across the state allows both for the state to better evaluate demonstration outcomes and also ensures that similar benefits and services are available across the state. The MyCare demonstration design did allow significant variation to occur across MCOPs. One of the questions, as we enter year seven, is if the state continues MyCare, should it become more standardized?

For example, three MCOPs use a waiver service coordination care management model and two plans use a fully-delegated care management model. We also see variation in other operational issues, such as caseload size, reimbursement rates for both the care management tasks and providers, and the type of information and communication practices between the plans, AAAs, and providers. Provider respondents reported a desire for a streamlined and transparent billing process across the MCOPs and discussed many administrative burdens associated with working with multiple billing systems. As programs move from a demonstration to ongoing phase, we typically see more standardization. To this point however, there is very limited information on the association between design decisions and member outcomes, making it more difficult to standardize program design and operations.

The high degree of plan autonomy also means that demonstration quality improvement initiatives, which do occur, are seen as a special activity, rather than as part of the ongoing program. Again, the balance between plan individuality and a standard structure walks a delicate balance in this arena as well. Our process analysis identified areas where individual plans and their AAA partners piloted and implemented innovative practices, but in many cases, these remained individual plan practices, rather than a demonstration practice.

An overall design issue that has a large impact on the demonstration is the opt-out rate. The Medicaid dashboard data report that four in ten (42%) members opted out. This means that, for a large number of members, the benefits of Medicare and Medicaid coordination, which was a major goal of the demonstration, does not exist. A further complication is that the LTSS population has a higher opt-out rate than those members classified as Community Well. Because the LTSS group has higher rates of disability and on average use more

services, the higher opt-out rate for this group further limits the strength of the intervention.

The high rate of opt-out members also impacts day to day operations for plan and AAA care managers and waiver service coordinators. For example, communication with providers, particularly with hospitals and physicians, was a common challenge reported and for those members who opt-out, the challenges are heightened. These issues are compounded by data concerns, as less information is available for opt-out members, making it doubly-difficult to manage care for these individuals. The coordination goals of the demonstration are compromised when Medicare is excluded from the picture.

Study respondents were thoughtful and insightful about MyCare design and operations. As is true for any organization, respondents identified practices that would be good candidates for quality improvement initiatives. However, because of ongoing and consistent changes by CMS, ODM, and the MCOPs, many respondents felt that the demonstration had not yet achieved stability or a steady state. This means efforts to incorporate quality improvement strategies into day-to-day operations are limited. It also means that some of the impact and implementation findings will change when steady state can be achieved. If ODM continues to operate MyCare as currently configured, a plan to arrive at steady state and a plan to incorporate demonstration-wide quality improvement activities will be an important step forward.

This process evaluation provides an important opportunity to hear directly from MyCare members and the professionals within the demonstration responsible on a daily basis for implementing the core features of MyCare – care management and service provision. Care managers, waiver service coordinators, support personnel, and providers shared the realities of working in a very complex program and have outlined areas for improvement. It is essential that future work in the demonstration is focused on increasing effective communication and information-sharing between the many entities involved in MyCare so that care management staff and providers can effectively serve members.

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