



MyCare Ohio

Evaluation 2018

The Ohio Department of Medicaid

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



Department of Medicaid

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

June 29, 2018

Governor of Ohio, John R. Kasich
Ohio House Speaker, the Honorable Ryan Smith
Ohio Senate President, the Honorable Larry Obhof
Ohio House Minority Leader, the Honorable Fred Strahorn
Ohio Senate Minority Leader, the Honorable Kenny Yoko
Joint Medicaid Oversight Committee, Susan Ackerman, Executive Director
Legislative Service Commission Director, Mark Flanders

Re: MyCare Ohio Evaluation

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

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

In designing and implementing MyCare Ohio, Ohio Medicaid routinely engaged with stakeholders – providers, advocacy agencies and, most importantly, individuals served by Medicare and Medicaid – to learn from their first-hand experience. This exchange with stakeholders continues today and is fundamental as Ohio Medicaid and the MyCare Ohio managed care plans make improvements to better the program for members and providers.

May 1, 2018 marked four years for which MyCare Ohio has been operational. The attached report highlights Ohio's success in coordinating Medicare and Medicaid benefits and the value of care management for members enrolled in the program.

Sincerely,

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

Barbara R. Sears
Director

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MyCare Ohio Evaluation: Key Findings

- **Nearly 70 percent of members have elected for their MyCare Ohio plan to coordinate both their Medicare and Medicaid benefits.** This rate is often referred to as the “opt-in rate,” and Ohio leads the country in this measure among duals programs.
- **MyCare Ohio members are pleased with their care manager.** Approximately 70% of members indicated satisfaction with their care manager and over 93% expressed satisfaction in their relationship with their care manager, according to an external quality review survey.
- **The MyCare Ohio managed care plans have been an integral partner in the closures of poor-performing nursing homes.** Since 2015, the plans have been involved in the closure of 13 homes, moving nearly 400 residents. They help residents find new nursing homes and even provide hands on assistance with packing.
- **HEDIS Rates for the MyCare Ohio managed care plans compare favorably to national Medicaid benchmarks.** Approximately 59% of the reported rates across all MyCare Ohio plans exceeded the national 75th percentile benchmarks. For the statewide average, over 50% of the rates statewide exceeded the national 90th percentile benchmark.
- **MyCare Ohio members are getting the services they need.** The managed care plans have approved more than 90% of prior authorization requests received from providers for services during the first four years of MyCare Ohio.
- **Ohio Medicaid now monitors timely payments by specific provider type, and addresses issues with the managed care plans as needed, to better serve providers.** As of January 1, 2018, changes in the contract between Ohio Medicaid and the plans allow for more closely monitored timely payments to behavioral health, nursing facility and waiver providers. Ohio Medicaid continues to adjust this policy based on feedback from providers.
- **MyCare Ohio is improving members’ quality of life and making the Ohio Medicaid program more sustainable.** Enrollment rebalancing, the proactive effort to shift enrolled individuals from a high cost care setting to a more cost-effective care setting, in MyCare Ohio outpaces the fee for service equivalent population. MyCare Ohio allows Ohioans to live independently in the community with supports, while also saving Ohio approximately \$30 million annually above what would have been achieved under the traditional Medicaid fee for service program.

Introduction

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

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

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

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

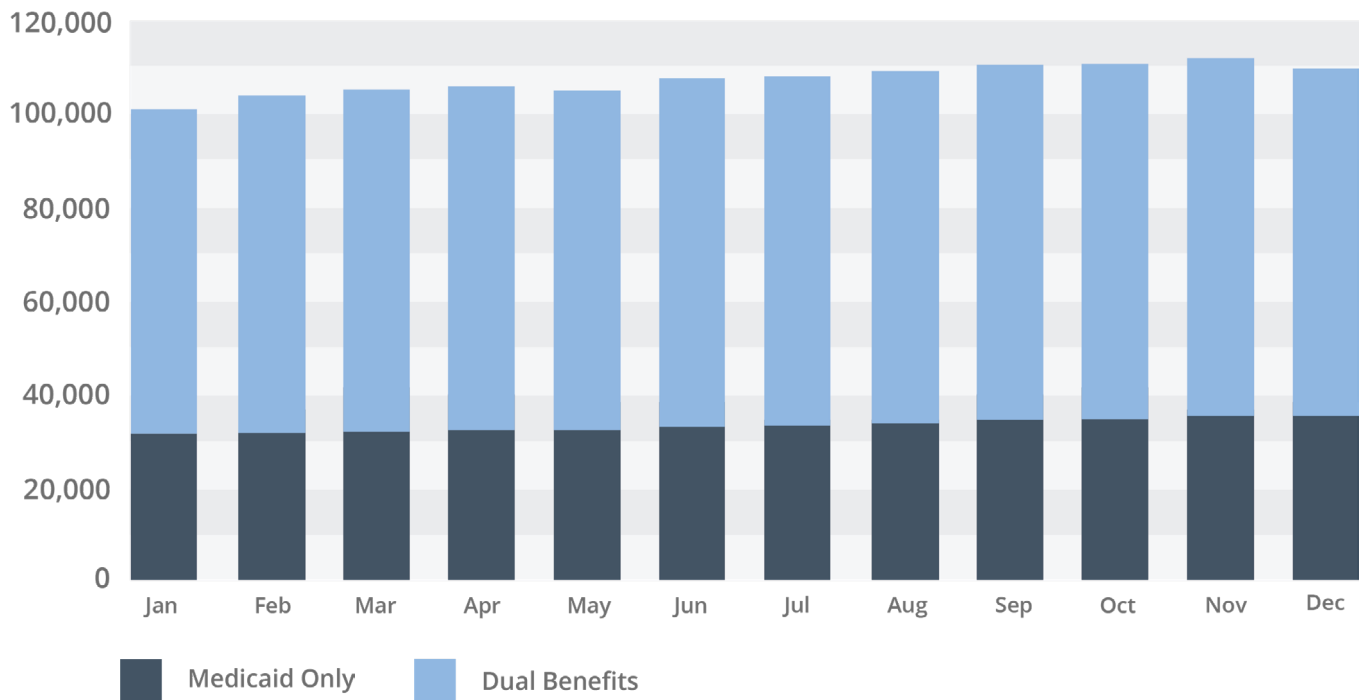
underscored the incorporation of behavioral health and long-term services and supports into MyCare Ohio, the first time the state had extended managed care benefits to Ohioans in need of these Medicaid benefits. In designing and implementing MyCare Ohio, Ohio Medicaid routinely engaged with stakeholders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

Enrollment

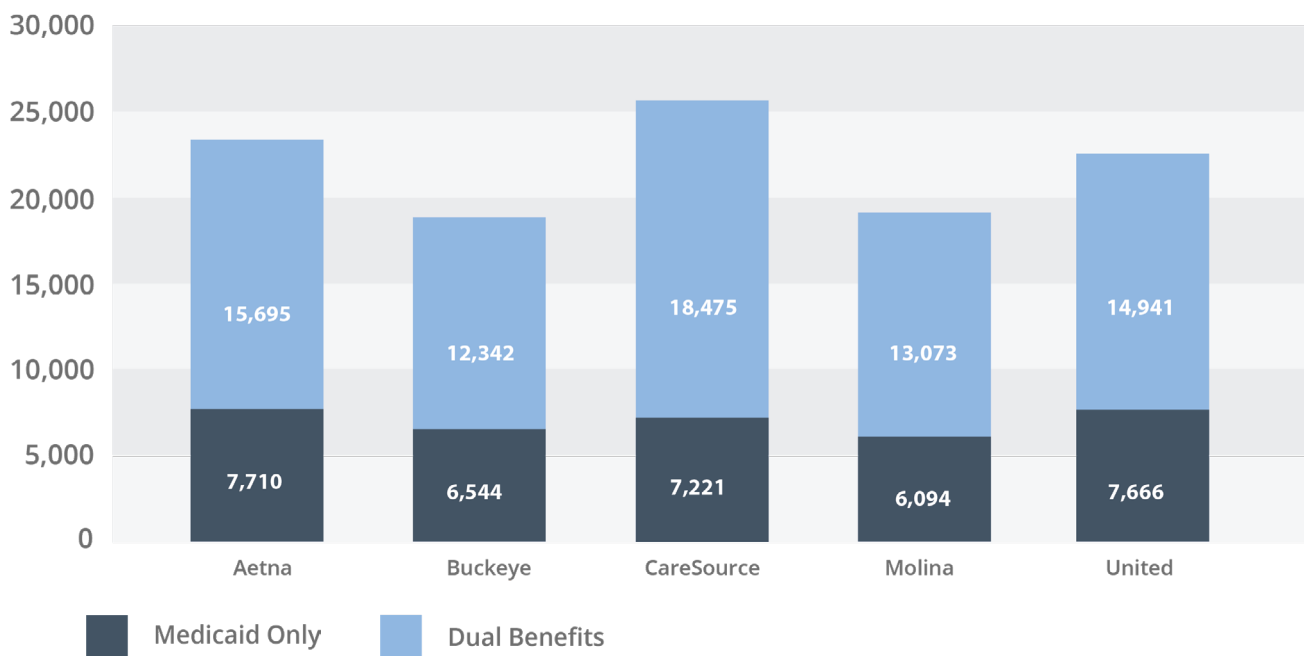
MyCare Ohio operates in seven regions covering 29 counties, including the major metropolitan areas of the state. Individuals who are 18 years of age and older and qualify for both Medicare and Medicaid in these regions are eligible for MyCare Ohio. Participation is mandatory for eligible individuals to receive their Medicaid benefits. Due to federal rules, eligible individuals must have the option as to whether their MyCare Ohio plan also provides their Medicare benefits. They may select traditional Medicare or a Medicare Advantage plan. To date, there are more than 113,000 beneficiaries enrolled in MyCare Ohio, making our state's duals demonstration the second largest in the country.

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

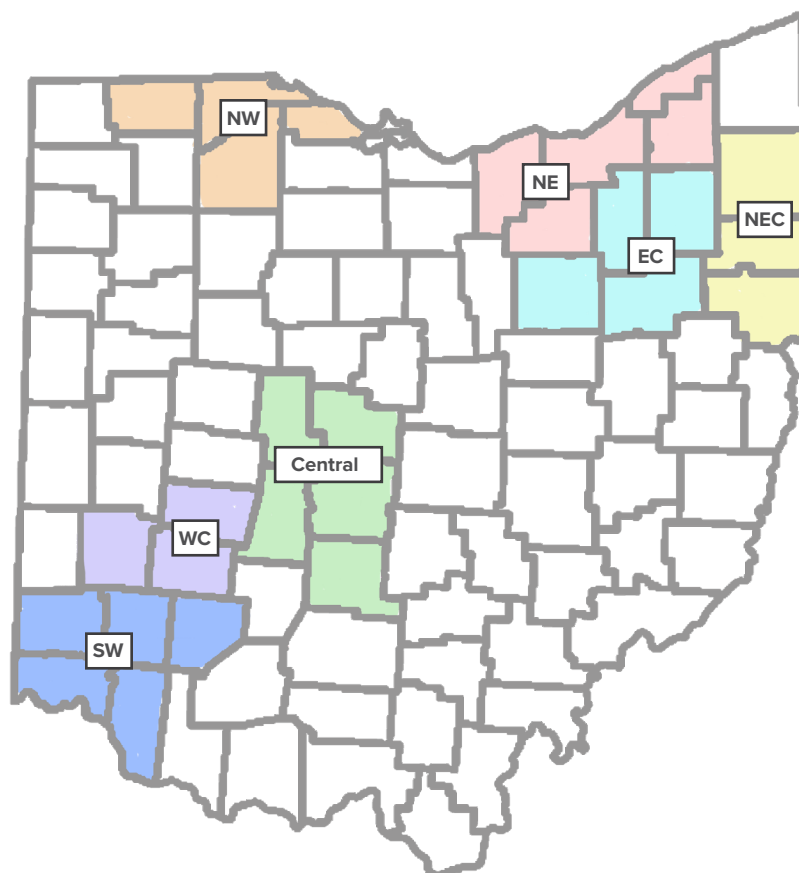
MyCare Ohio Enrollment Trend Calendar Year 2017



MyCare Ohio Enrollment by Plan for Dec. 2017



MyCare Ohio Regions



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

Care Management

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

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

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



Because of MyCare Ohio...

In 2015, a man opted into MyCare Ohio when he was admitted to a facility from his home. His son is a small business owner working 6 or 7 days a week, which limited contact between the two to phone calls. His son discovered that he was not taking care of himself, his residence or his pet dog. Upon being assessed, it was also discovered that the member was forgetting to take medications and hoarding belongings at his home.

The member's care manager worked with the son to identify an assisted living facility that would be a more appropriate setting to meet his father's immediate needs. The member is now doing very well at the facility, and is able to use a cane to walk outside several times a day. He enjoys reading, eating vegetarian meals, and has also taken an interest in painting and sculpting at the facility.

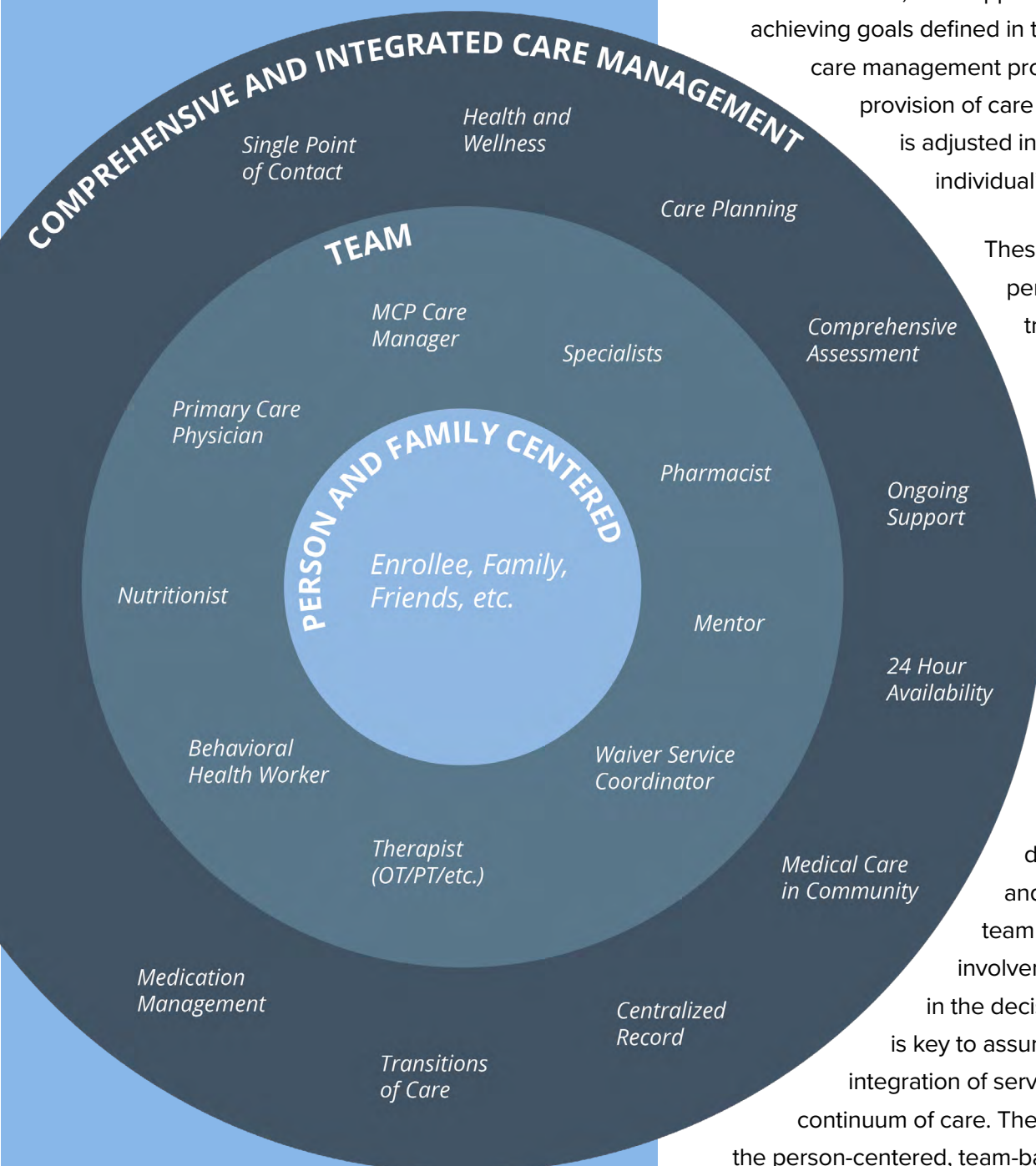
The member is working with his care manager towards a goal of transitioning back to the community when his home is in better condition. In the meantime, he continues to thrive in the new environment and is optimistic about completing the many projects he has planned.

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

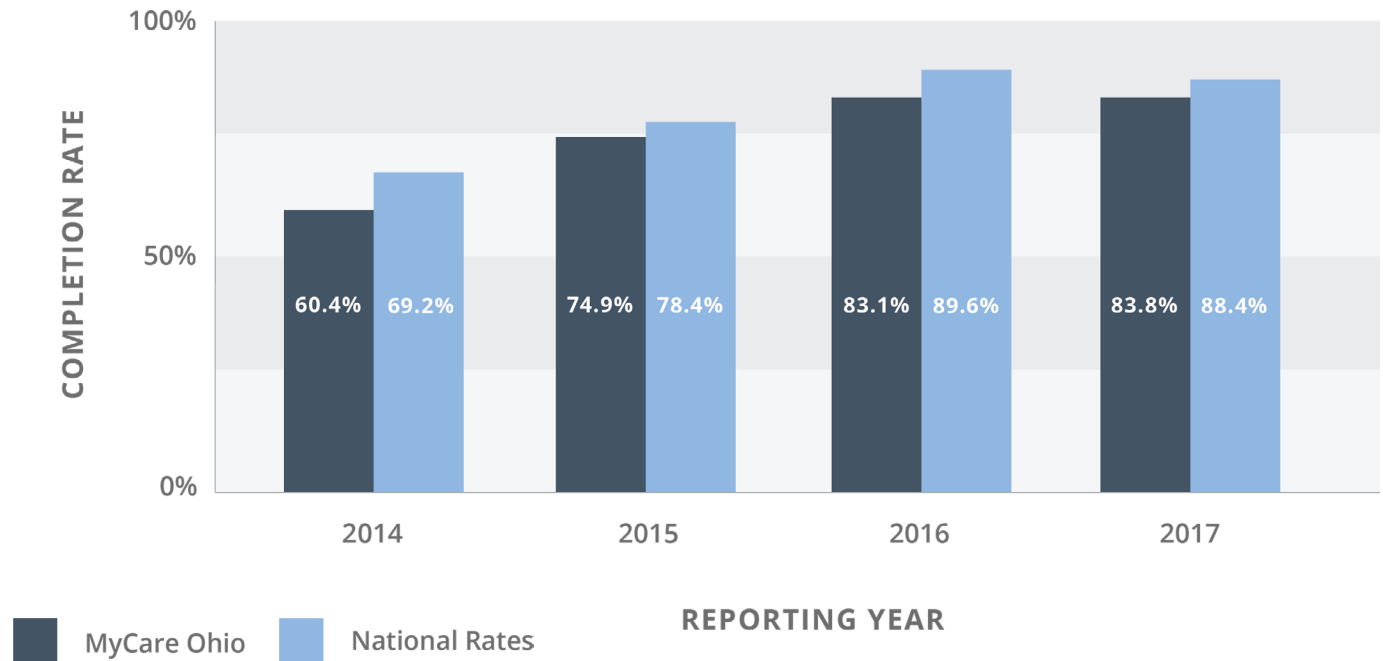
care management process is fluid and the provision of care management services is adjusted in order to meet the individual's needs.

These activities are performed as part of a trans-disciplinary care team approach that includes the individual, the primary care provider, the MyCare Ohio plan care manager, the waiver service coordinator, as applicable, and other members the individual chooses, such as specialists, family members, and caregivers. Facilitating direct communication and coordination between team members with involvement of the individual in the decision-making process is key to assure the comprehensive integration of services across the

continuum of care. The figure below illustrates the person-centered, team-based approach and the MyCare Ohio plans' supports and resources in the outer ring that are vital components of a comprehensive and integrated care management model.



Health Risk Assessment



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

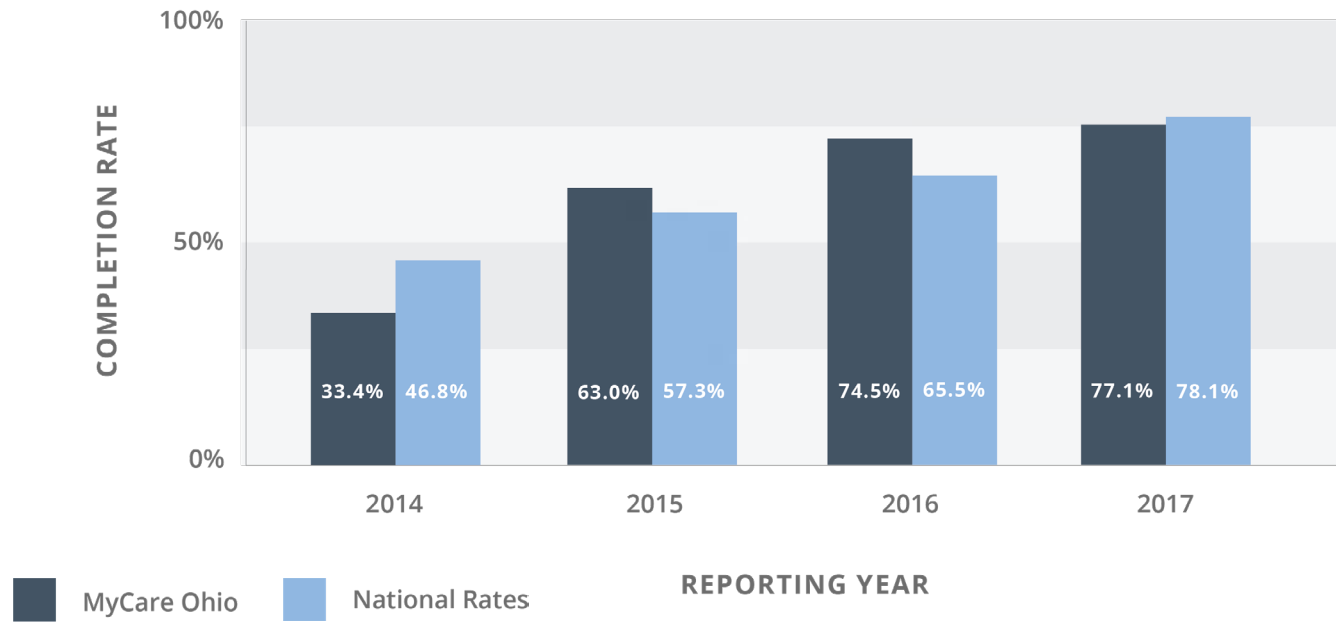
Source: Medicare-Medicaid Plan reported monitoring measure data. Measure data are provided for informational purposes only and do not constitute official evaluation results.

Full measure specifications can be found in the reporting requirements documents, which are available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.

In Ohio, MyCare Ohio plans are required to complete assessments of a member’s medical, behavioral, long-term services and supports, and environmental needs with input from the individual, family, caregivers, and providers. Timeframes for completing assessments are dependent upon the member’s assigned risk level and must be completed within 75 days of enrollment. Overall, MyCare Ohio plans completed assessments for members within 90 days at a rate that only slightly lagged behind the national rates, representative of all states participating in the CMS Financial Alignment Initiative (FAI) demonstration, from 2014 – 2017. Rates continued to consistently increase for Ohio and the FAI demonstration states from 2014 – 2017. In 2014, approximately 60% of MyCare Ohio members had an assessment completed within 90 days with an increase to 75% in 2015, 83% in 2016, and 84% in 2017.

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

Individualized Care Plans



Measure: Percent of members who were reached, were willing to participate, and had a care plan completed within the required number of days.

Source: Medicare-Medicaid Plan reported monitoring measure data. Measure data are provided for informational purposes only and do not constitute official evaluation results.

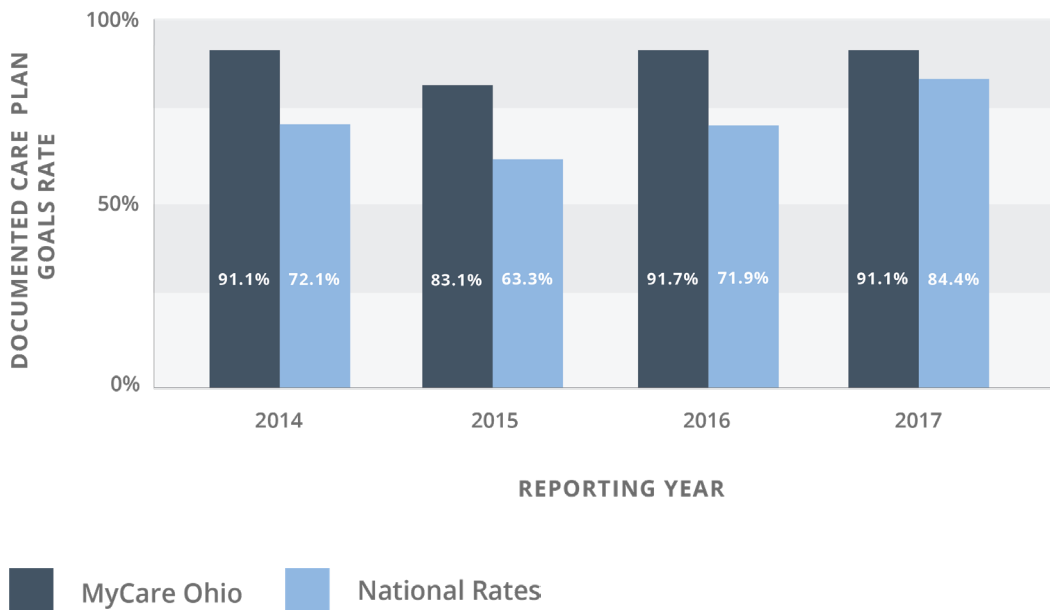
Full measure specifications can be found in the reporting requirements documents, which are available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.

The individualized care plan, the road map for guiding the beneficiary to optimal health, safety, and welfare, is informed by the assessment and includes goals, interventions and outcomes that are person-centered and consider the beneficiary's concerns, strengths, and preferences for care (such as cultural considerations). MyCare Ohio plans are required to complete individualized care plans within 15 days of assessments, which varies significantly from other FAI demonstration states. Michigan and Illinois, for example, require individualized care plans to be completed within 90 days of enrollment¹. Efforts by the MyCare Ohio plans to develop individualized care plans within required timeframes has markedly improved from 2014 to 2017, by an increase of approximately 44 percentage points from 33% to 77%.

In the MyCare Ohio program, the focus of care management exceeds the usual integration of medical and behavioral health systems by encompassing the needs of the entire individual, which often falls outside of the medical model and includes community-based services and supports. Included in a person-centered approach to care management is the view that the individual (and family/caregivers) is an equal partner in the initial care plan development and evolving care planning activities. The MyCare Ohio plans demonstrated a commitment to person-centered care planning processes. MyCare Ohio plans consistently performed above the national rate for all four annual reporting periods for the percentage of initial care plans that had at least one documented discussion of care goals.

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

Initial Documented Care Plan with a Goals Discussion

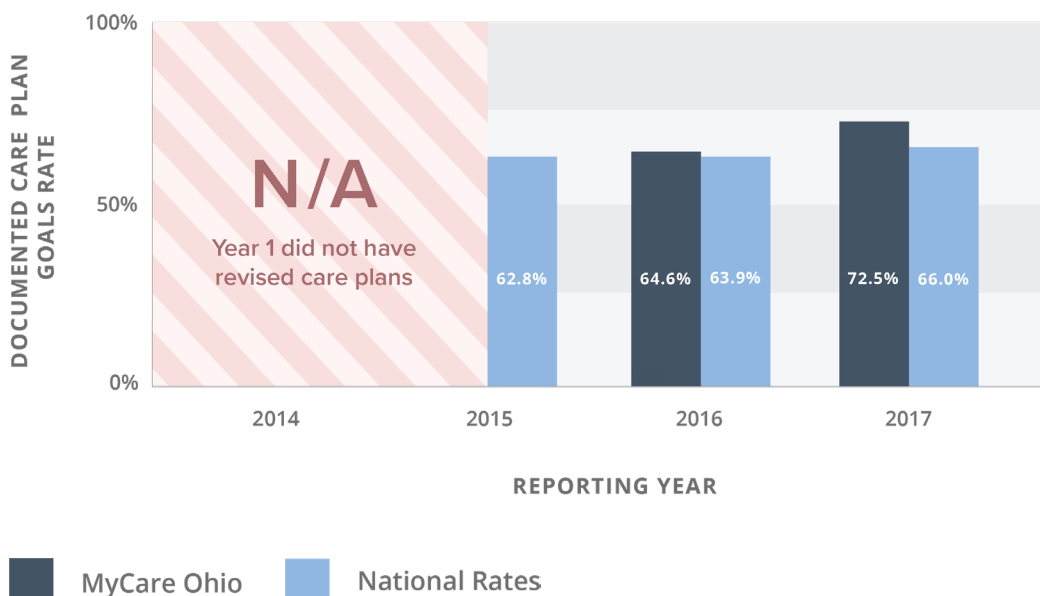


Measure: Percent of initial care plans that included at least one documented discussion of care goals.

Source: Medicare-Medicaid Plan reported monitoring measure data. Measure data are provided for informational purposes only and do not constitute official evaluation results. Full measure specifications can be found in the reporting requirements documents, which are available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.

This trend continued forward with MyCare Ohio plans performing above the national rate for two consecutive years for the percent of revised care plans that had at least one documented discussion of new or existing care goals with the member. In 2017, the MyCare Ohio plans were 7 percentage points higher than the national rate. Despite early challenges with contacting beneficiaries, the results for all three care plan metrics indicate that once plans completed assessments there was successful continued engagement of beneficiaries in the care management process, and at rates higher than the national average.

Revised Documented Care Plan with a Goals Discussion



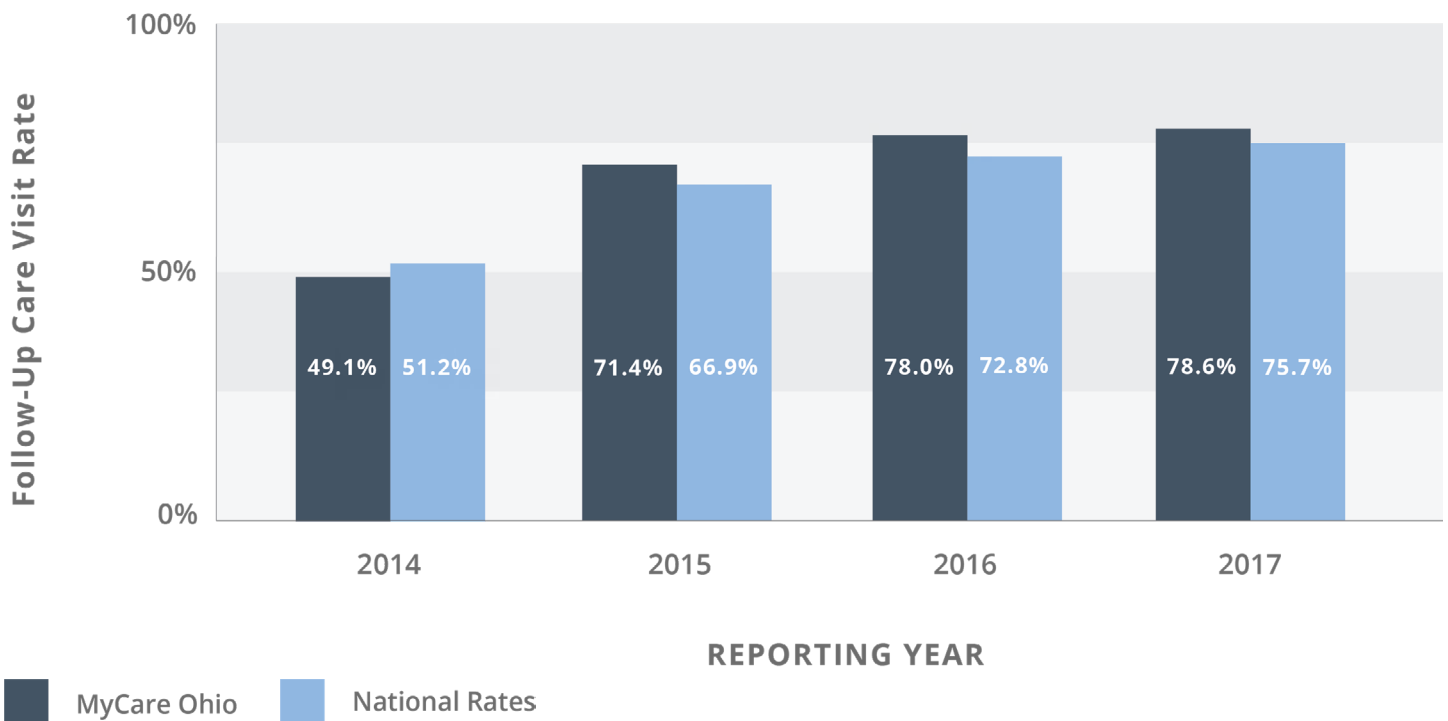
Measure: Percent of revised care plans that included at least one documented discussion of new or existing care goals.

Source: Medicare-Medicaid Plan reported monitoring measure data. Measure data are provided for informational purposes only and do not constitute official evaluation results.

Full measure specifications can be found in the reporting requirements documents, which are available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.

Hospital Discharges

Annual Rate of Follow-Up Care Visits



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

Source: Medicare-Medicaid Plan reported monitoring measure data. Measure data are provided for informational purposes only and do not constitute official evaluation results. Full measure specifications can be found in the reporting requirements documents, which are available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.

All MyCare Ohio members have access to a trans-disciplinary care team led by their plan’s care manager which also includes the individual, the primary care provider, the waiver service coordinator, as applicable, and other members the individual chooses, such as specialists, family members, and caregivers. The care team is designed to effectively manage and coordinate the individual’s services by avoiding fragmentation, gaps, and duplication. MyCare Ohio beneficiaries who participated in CMS focus groups reported that their “care teams were helping them to achieve goals such as increasing mobility, independence and overall functioning.” ²

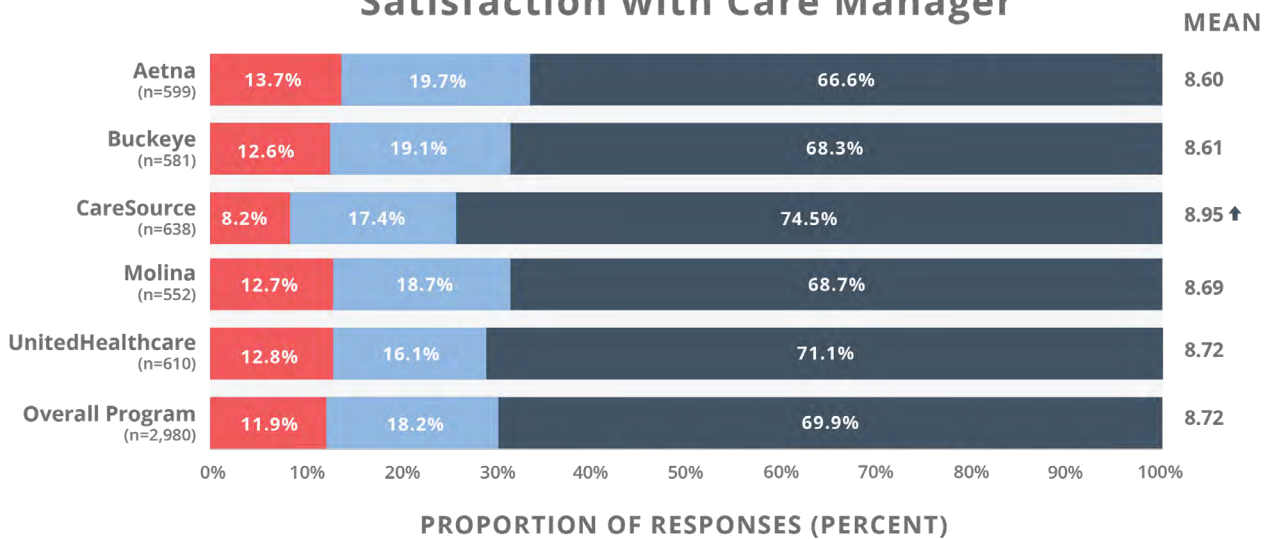
Furthermore, a 2017 evaluation of the MyCare Ohio plans’ care management programs completed by Ohio Medicaid’s contracted external quality review organization³ confirmed that 100% of the randomly sampled cases had a trans-disciplinary care team formed in conjunction with the beneficiary that was based on his or her needs and preferences.

For individuals who receive home and community-based services, the coordination and integration of these services is extremely important to keeping an individual in the community. Ohio recognizes the right for the individual to choose his or her waiver service

² Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative. (March 2017) <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf>. Accessed on April 14, 2017.

³ CY 2017 Aggregate Performance MyCare Waiver Record Reviews, Health Services Advisory Group, January 26, 2018.

Global Rating: Satisfaction with Care Manager



Statistical Significance Note: ↑ Indicates the score is statistically significantly higher than the program average

↓ Indicates the score is statistically significantly lower than the program average

Please note, percentages may not total 100% due to rounding.

coordinator. The individual's selected waiver service coordinator works very closely with the assigned care manager to ensure the comprehensive needs of the individual are being met. MyCare Ohio plans capitalized on the existing waiver service coordination infrastructure available through the Area Agencies on Aging for members over the age of 60. This partnership has been key to the successful integration and coordination of long-term services and supports with medical and behavioral needs. Several of the plans even maximized this partnership by delegating the full scope of comprehensive care management to the Area Agencies on Aging as a means to achieve a single point of accountability for the member.

Another critical component of the MyCare Ohio care management service delivery is to assure effective transitions of care between settings (such as admissions and discharges between hospitals, skilled nursing facilities, and long term facilities) in an effort to avoid future unnecessary hospitalizations and emergency department visits. This includes responsibilities to participate in appropriate and safe discharges by conducting timely follow up and arranging for adequate services and supports. One

of the key post discharge activities is to connect the beneficiary with a primary care provider as directed in the discharge plan, which usually occurs within 2-4 weeks of discharge. MyCare Ohio plans have demonstrated marked improvement from 2014 to 2017 in the percent of hospital discharges that had ambulatory care follow up visits within 30 days of discharge. For the last three years, the MyCare Ohio plans' results were slightly higher than national rates.

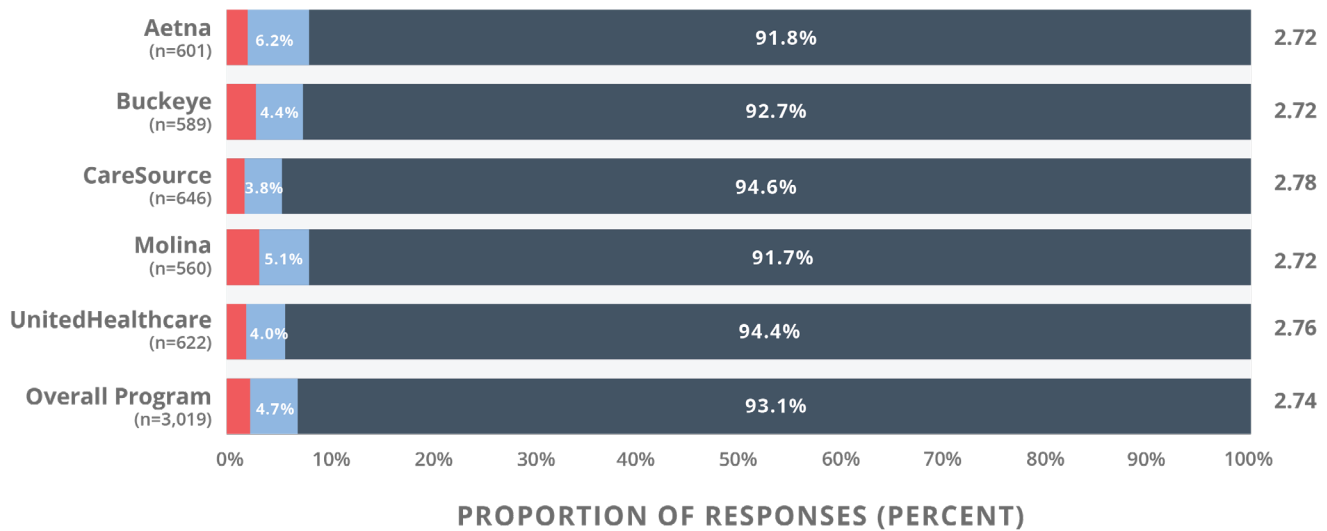
Member Satisfaction with Care Management

In order to evaluate MyCare Ohio plan individuals' experiences with their care managers, Ohio Medicaid's contracted with Health Services Advisory Group, an external quality review organization, to conduct a care management satisfaction and experience survey in April 2017. Five indicators were reviewed: rating of care manager, relationship with the care manager, how accommodating is the care manager, how well the care manager collaborates with the individual, and the individual's involvement in care planning.

As noted in the figure above, approximately 70% of individuals indicated satisfaction with their care manager.

Composite Measure: Satisfaction with Relationship with Care Manager

MEAN



Statistical Significance Note: ↑ Indicates the score is statistically significantly higher than the program average

↓ Indicates the score is statistically significantly lower than the program average

Please note, percentages may not total 100% due to rounding.

Of those same individuals surveyed, over 93% expressed satisfaction in their relationship with their care manager. Satisfaction was evaluated based on the individual's rating of the care manager's ability to listen carefully, explain things in a way that could be understood and treated the individuals with respect. All of the plans scored approximately 90% or above for each composite item evaluated for the Relationship with Care Manager composite measure.

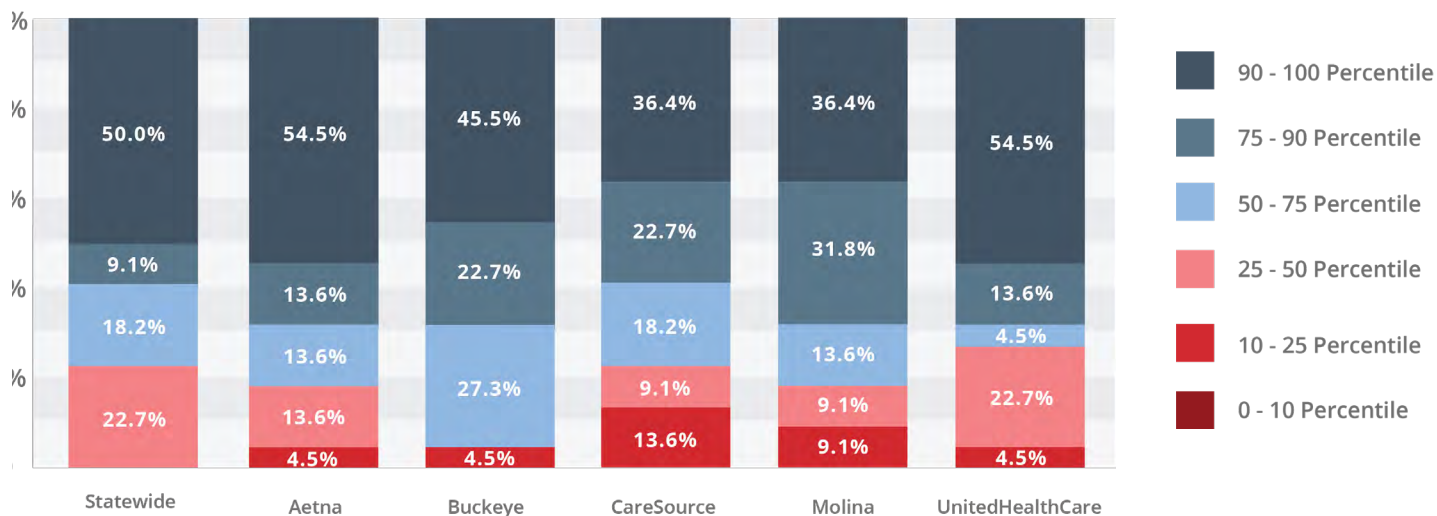
Keeping Ohioans Safe - Closing Poor-Performing Nursing Homes

Governor Kasich's administration has been committed to improving nursing home quality, which provide care to some of our state's most vulnerable residents. An interagency team monitors poor-performing nursing homes, and if a facility does not improve and closure is necessary, the team will mobilize to safely and quickly move residents to new nursing homes. The MyCare Ohio managed care plans have become an integral part of this team. Since 2015, the plans have been involved in the closure of 13 homes, moving nearly 400 residents.

The plans work closely with members to make referrals to other nursing homes or community settings based on members' needs and choices, and are present and actively involved throughout these transitions. The plans have brought staff to closing nursing homes to pack members' belongings in boxes supplied at the plans' expense, which allow for a more dignified move for residents who would otherwise be provided with garbage bags from the nursing homes.

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

MyCare Ohio 2017 (CY 2016) HEDIS Measures Ranked by National Medicaid Percentile



Quality Measures – HEDIS and CAHPS

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

MyCare Ohio – 2017 Quality Measure Results

Source: NCQA/HEDIS 2017: Medicare-Medicaid Plan Compliance Audited Data

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

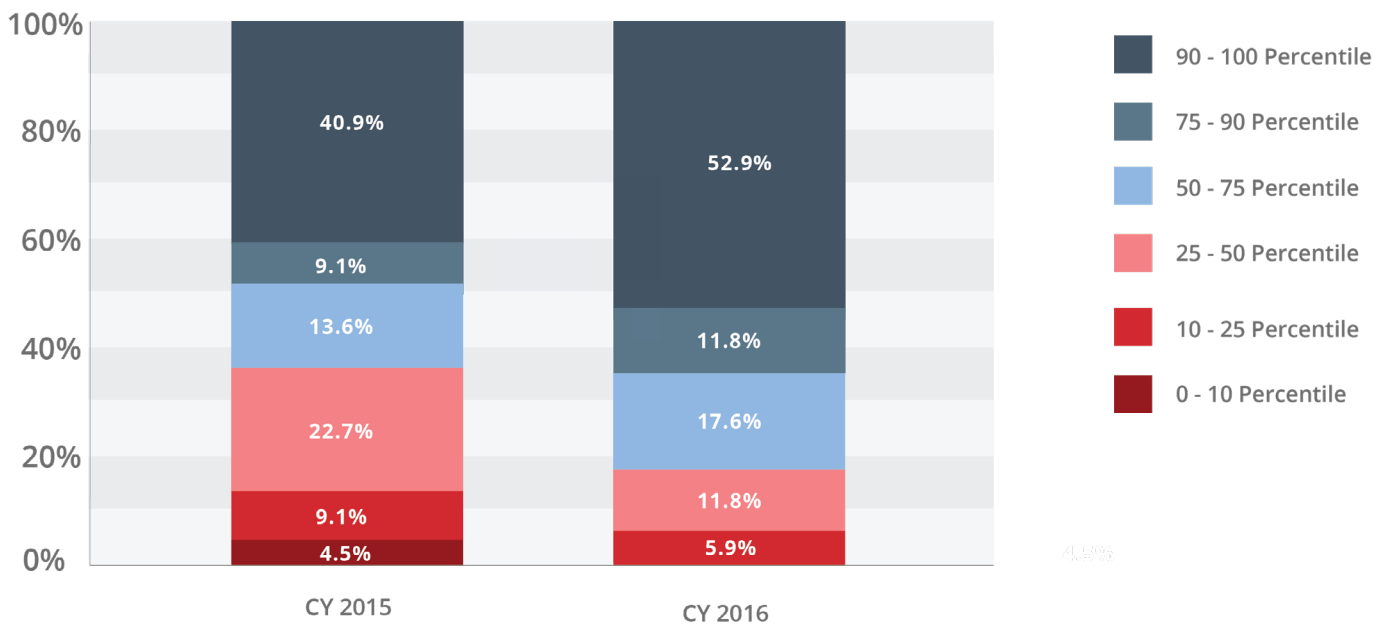
HEDIS measures must meet audit requirements to ensure the validity and integrity of HEDIS data. HEDIS rates are calculated for MyCare Ohio members receiving both their Medicare and Medicaid benefits from a single managed care plan, and reported annually.

The HEDIS 2017 measures (based on calendar year 2016) are the second set of annual rates reported for the MyCare Ohio managed care plans. There were 22 rates reported for MyCare Ohio for CY2016 which include those related to primary care and screenings, chronic conditions (such as diabetes and hypertension), behavioral health and medication management measures. Rates for the MyCare Ohio plans compare favorably to national Medicaid benchmarks. Approximately 59% of the reported rates across all MyCare Ohio managed care plans exceeded the national 75th percentile benchmarks; for the statewide average, over 50% of the rates exceeded the national 90th percentile benchmark.

The 2016 and 2017 comparison below includes the 17 measures that were reported for both HEDIS 2016 (based on calendar year 2015) and HEDIS 2017 (based on calendar year 2016). Because the MyCare Ohio program's first full year of implementation was 2015, certain 2015 measures which required multiple year

MyCare Ohio HEDIS

2016 vs. 2017 Statewide Result



historical data could not be calculated and reported due to the unavailability of data for prior measurement years. When comparing statewide rates between the two years, there is much improvement noted with approximately 64% of rates above the 50th percentile in 2015 increasing to 82% above the 50th percentile in 2016.

Statewide rates exceeding the 90th percentile include adults' access to preventive/ambulatory health services, antidepressant medication management, and persistence of beta-blocker treatment after a heart attack, medication management for people with asthma, annual monitoring for patients on persistent medications, and diabetes HbA1c medical attention for nephropathy. Rates exceeding the 50th percentile include diabetes HbA1c testing, diabetes HbA1c eye exam, initiation of alcohol & drug dependence treatment, follow-up after hospitalization for mental illness and pharmacotherapy management of chronic obstructive pulmonary disease exacerbations.



*Because of
MyCare Ohio...*

Staff from a nursing home that has received more than 20 nursing home residents from facilities that have closed expressed that the plans were essential in making the moves easier. Care managers had been helpful in gathering paperwork from closing nursing homes. The plans are a valuable partner by knowing their members as individuals and assisting with selecting new nursing homes that were a good fit for residents. The care managers are also familiar with each resident's history and share that information to accepting facilities, which provides better long-term matches.

Clinical Performance Measure	HEDIS 2016 (CY 2015 Measurement Year)	HEDIS 2017 (CY 2016 Measurement Year)	Population Stream
Adults' access to preventive/ambulatory health services	>90 percentile	>90 percentile	Healthy Adults
Breast cancer screening	NR	25 to 50 percentile	
Comprehensive diabetes care - HbA1c adequate control (<8.0%)	10 to 35 percentile	25 to 50 percentile	Chronic Conditions
Comprehensive diabetes care - HbA1c	50 to 75 percentile	50 to 75 percentile	
Comprehensive diabetes care - eye exam	50 to 75 percentile	75 to 90 percentile	
Comprehensive diabetes care - medical attention for nephropathy	>90 percentile	>90 percentile	
Controlling high blood pressure	25 to 50 percentile	25 to 50 percentile	
Persistence of beta-blocker treatment after heart attack	>90 percentile	>90 percentile	
Annual monitoring for patients on persistent medication - ACE or ARB	>90 percentile	>90 percentile	
Annual monitoring for patients on persistent medication - digoxin	>90 percentile	>90 percentile	
Annual monitoring for patients on persistent medication - diuretics	>90 percentile	>90 percentile	
Annual monitoring for patients on persistent medication - total	>90 percentile	>90 percentile	
Medication management for people with asthma, 50% compliance	NR	>90 percentile	
Medication management for people with asthma, 75% compliance	NR	>90 percentile	
Pharmacotherapy management of COPD exacerbation - bronchodilator	75 to 90 percentile	50 to 75 percentile	
Pharmacotherapy management of COPD exacerbation - systemic corticosteroid	50 to 75 percentile	25 to 50 percentile	
Antidepressant medication management - effective acute phase treatment	>90 percentile	>90 percentile	Behavioral Health
Antidepressant medication management - effective continuation phase treatment	>90 percentile	>90 percentile	
Follow-up after hospitalization for mental illness - 7 days	25 to 50 percentile	50 to 75 percentile	
Follow-up after hospitalization for mental illness - 30 days	25 to 50 percentile	50 to 75 percentile	
Initiation and engagement of AOD dependence treatment - initiation	75 to 90 percentile	75 to 90 percentile	
Initiation and engagement of AOD dependence treatment - engagement	25 to 50 percentile	25 to 50 percentile	

The HEDIS reporting year (e.g. HEDIS 2017) is applicable to the prior calendar year measurement period (i.e. CY 2016). The HEDIS year is used to reference a managed care organization's reported results, as well as the measures' technical specifications. HEDIS 2018 results will be available late summer 2018.

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

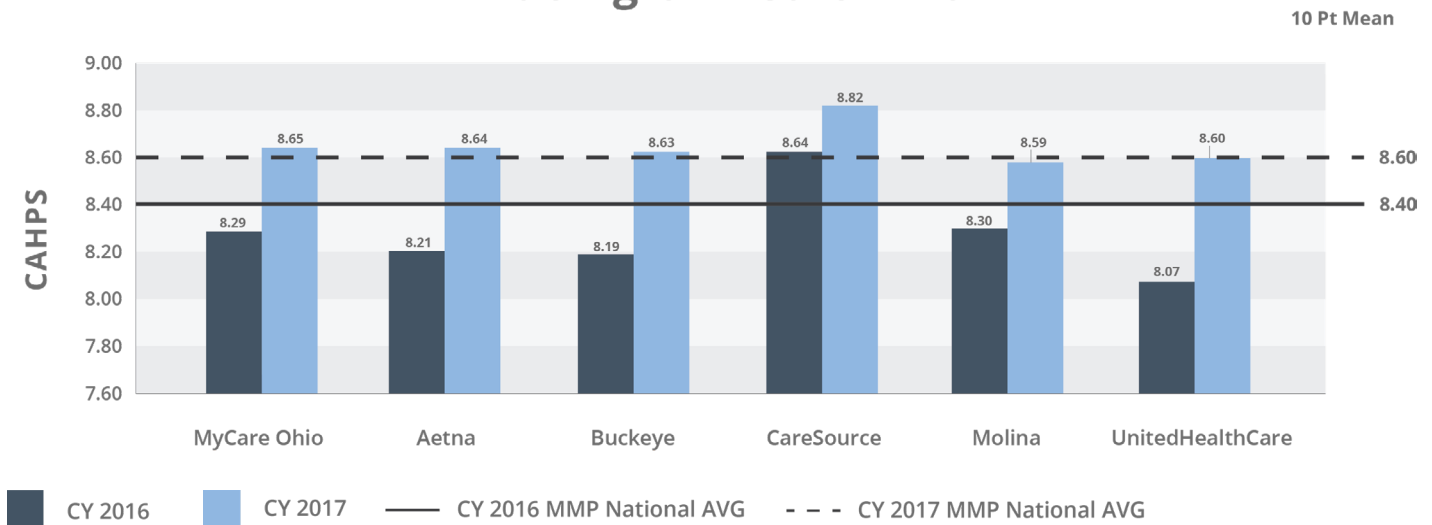
MyCare Ohio – 2017 Member Survey Results

Source: 2017 ODM MyCare Ohio Program CAHPS Member Experience Survey Full Report

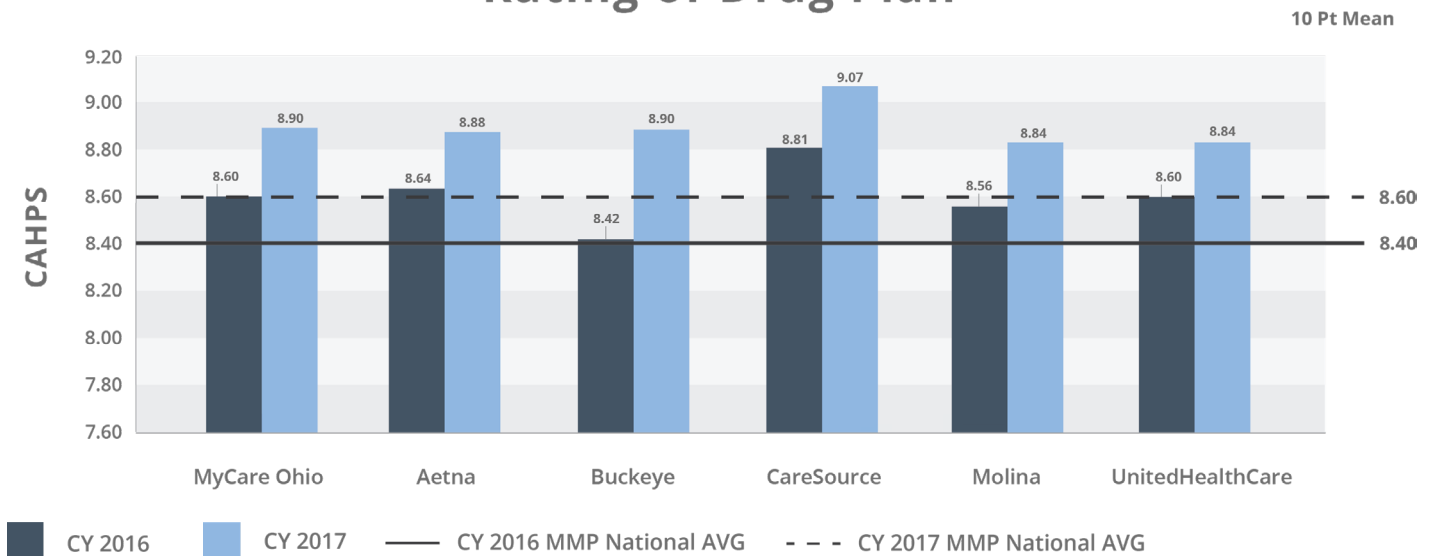
The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instruments and protocols for data collection, analysis, and reporting are standardized to allow for comparisons across users and trending data over time. The Medicare CAHPS survey assesses topics such as quality of care,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

MyCare Ohio plans are required by CMS to contract with a CMS-approved survey vendor to administer the Medicare CAHPS survey to a random sample of

Rating of Health Plan



Rating of Drug Plan



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

Overall, the 2017 CAHPS results show improvement compared to 2016 on a program-wide basis. Results for all eleven core questions improved in 2017, with the overall Rating of Health Plan, Rating of Drug Plan, and Rating of Specialist measures demonstrating the most improvement.

All five MyCare Ohio managed care plans improved their performance on the overall Rating of Health Plan measure from 2016 to 2017. Performance was generally below the Medicare-Medicaid plan national average in 2016, but exceeds the Medicare-Medicaid plan national average in 2017.

All five MyCare Ohio managed care plans improved their performance on the overall Rating of Drug Plan measure from 2016 to 2017. Performance in 2017 continues to exceed the Medicare-Medicaid Plan national average, as it did in 2016. Overall, these results demonstrate the MyCare Ohio plans are viewed favorably by members and this view is improving over time.

Operations and Additional Partnerships

Prior Authorization

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

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

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

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

For pharmacy prior authorization requests, the plans must make a decision within 24 hours for expedited requests and 72 hours for standard requests. The managed care plans operate well within those requirements. In fact, the average turn-around-time for October through December 2017 was 17.48 hours.

For non-pharmacy prior authorization requests, the plans must make a decision within 10 calendar days. The managed care plans are also well within that requirement, with an average turn-around time of 3.8 days for October through December 2017.

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

Prior authorization requests received by the MyCare Ohio plans

January 1, 2017 to December 31, 2017

Total prior authorization requests:

359,497

Total prior authorization requests per 1,000 member months

278.281

Approval percentage

91.66%

Denial percentage

8.34%

Calculation based on ODM member month data: Total prior authorizations requests per 1000 member months = total prior authorization requests x 1000 divided by member months.

Appeal Process

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

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

Appeals received by the MyCare Ohio plans January 1, 2017 to December 31, 2017

Total appeals:

1,997

Total appeals per 1,000 member months*

1.561

Appeals sustained**

1,174

Appeals overruled***

822

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

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

*** Appeal Overruled – means the MyCare Ohio plan’s action is upheld or stands.

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

Grievances

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

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

The top 3 reasons in 2017 that members submit a grievance with their MyCare Ohio plan were billing, administrative issues, and questions about identification cards. On average, across all managed care plans, 17.3 grievances were filed per 1,000 member months in 2017.

Member Assistance Available

The Office of the Long-Term Care Ombudsman is available to help MyCare Ohio members who have a complaint against their MyCare Ohio plan and/or provider, or need assistance in understanding how MyCare Ohio impacts them. Ohio Medicaid has a strong partnership with the ombudsman office, and regular contact allows Ohio Medicaid to learn of any issues MyCare Ohio members are experiencing and address them with the plans as necessary. The ombudsman office is a recent recipient of a grant at the federal level that will allow them to make MyCare Ohio members more aware of their services.

Provider Panel Requirements

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

Holding Plans Accountable

Ohio Medicaid has a team of staff dedicated to ensuring the managed care plans meet contractual requirements. When a plan fails to meet these requirements, the agency may impose sanctions and remedial actions.

The contract between Ohio Medicaid and the managed care plans is updated at least annually. When issues and challenges are identified with the plans, Ohio Medicaid makes changes to the contract to ensure

plans are meeting standards and requirements and improve member experiences.

Timely Payment to Providers

Ohio Medicaid recognizes the importance of providers being paid by plans in a timely manner. The agency monitors this practice and take compliance on plans as necessary. In 2017, the plans' contractual requirements were updated so that Ohio Medicaid has the ability to monitor timely payments by specific provider type and take compliance on plans as necessary. Plans are now required to submit timely payment information by category of service, which allows Ohio Medicaid to track prompt payments by provider type and identify any areas of concern that needs to be addressed. Previously, Ohio Medicaid monitored plans' timely payments requirement on an aggregate provider total. The contract changes allows for more closely monitored timely payments to behavioral health, nursing facility and waiver providers. Ohio Medicaid continues to adjust this policy to better serve providers based on the feedback received.

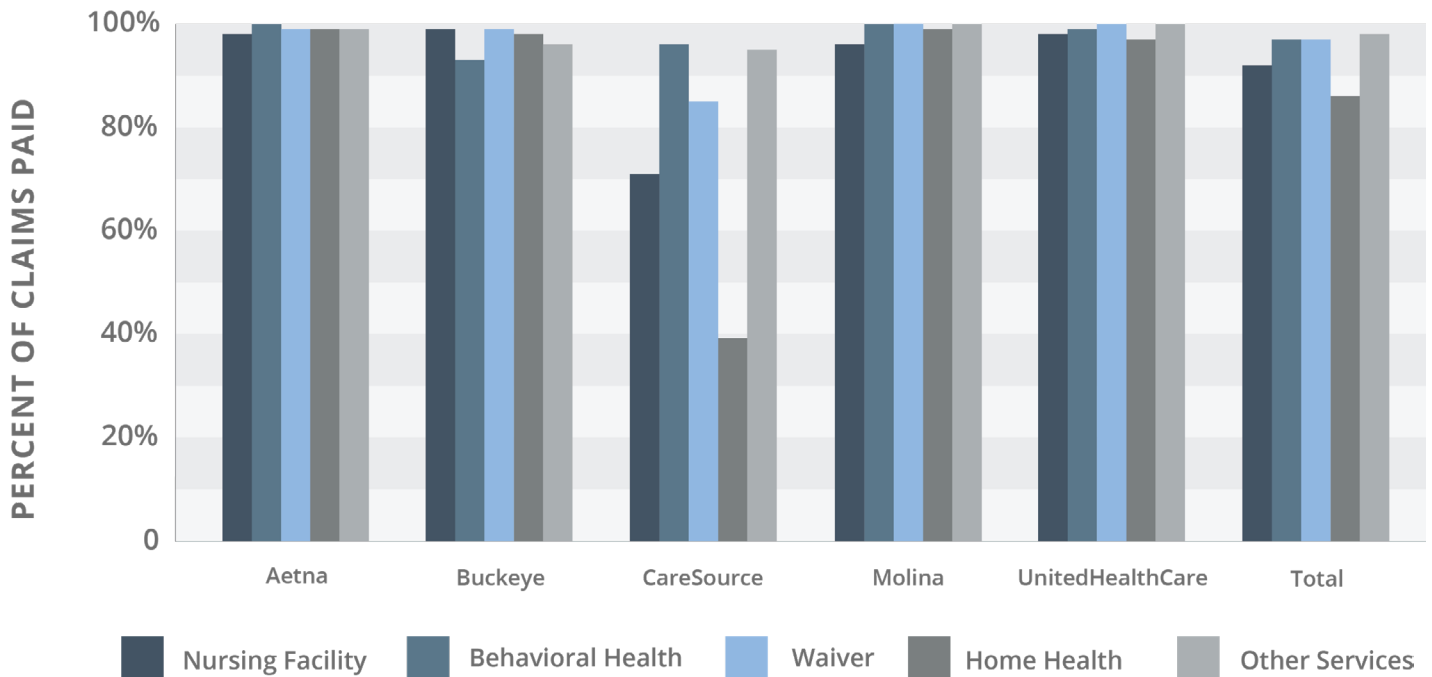


Because of MyCare Ohio...

With six inpatient stays and 23 emergency room visits in a year's time, a member was in need of more supports than what was available in her own home. Her care manager helped her find an assisted living facility. When the care manager visited her after the move, the member expressed how much she loves her new home and how her health had improved. She quit smoking and has had no falls or recent hospital visits.

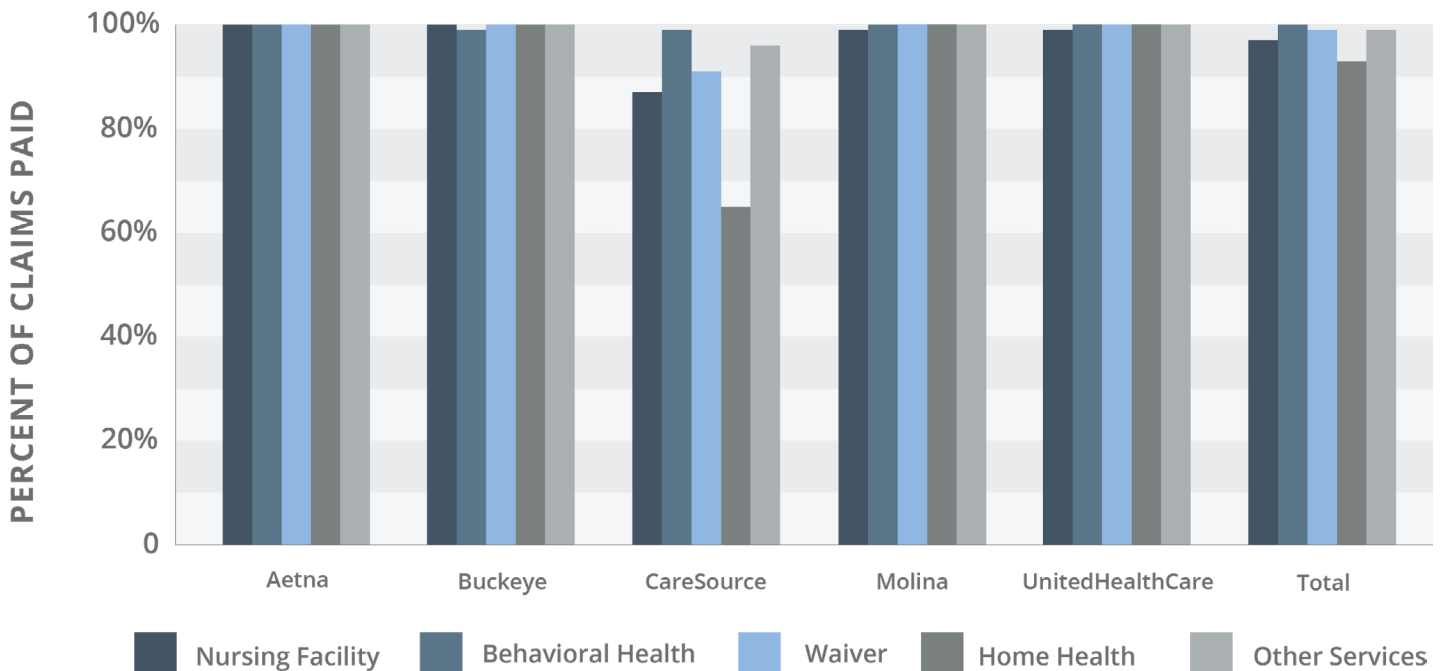
MyCare Ohio Clean Claims Paid Within 30 Days

October 1 - December 31, 2017

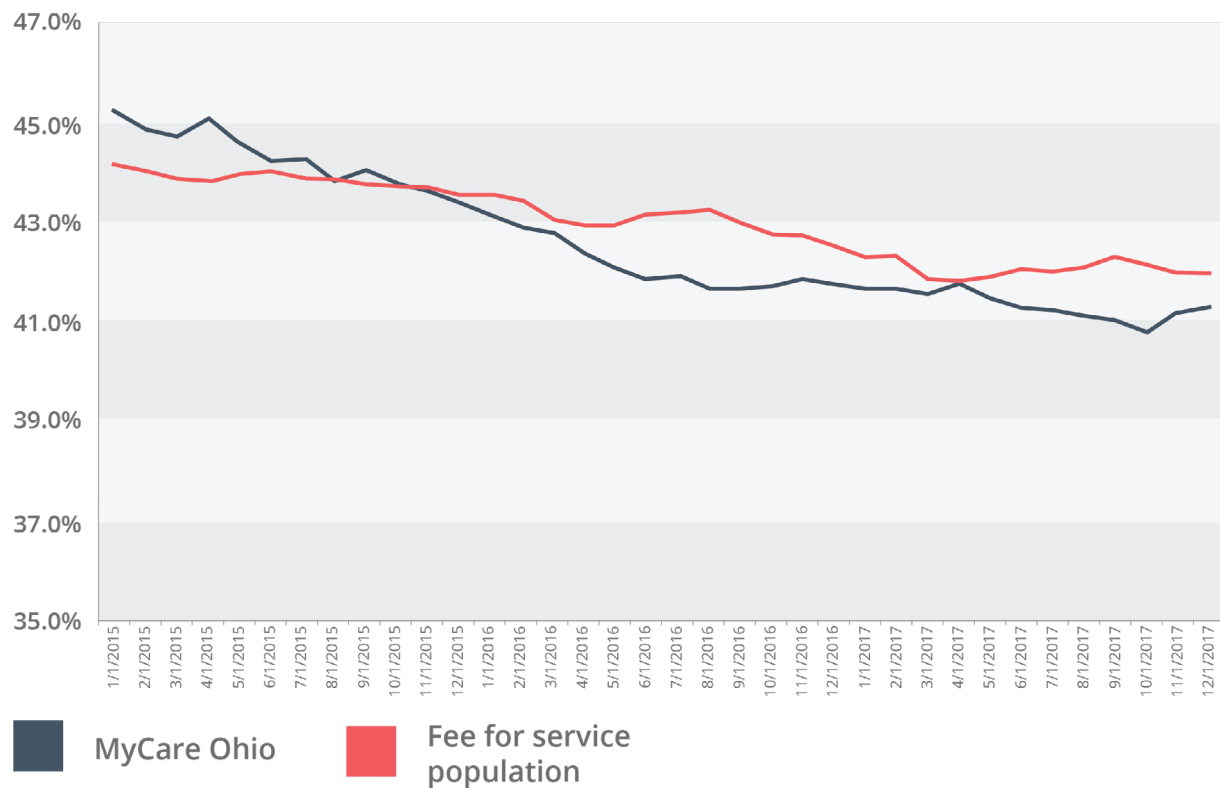


MyCare Ohio Clean Claims Paid Within 90 Days

October 1 - December 31, 2017



Percentage of MyCare Ohio members who are moving from a nursing home to the community



Fiscal Impacts

Enrollment Rebalancing

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

For each individual receiving long-term services and supports⁴ who moves from a nursing facility setting to a waiver setting, the average cost savings per member per month is approximately \$3,000.⁵ Based on an estimated 2% incremental rebalancing achieved by the MyCare Ohio managed care plans, there is an estimated annual savings of approximately \$30 million

above what would have been achieved under the traditional Medicaid fee for service program.

The chart above illustrates the percentage of members in a nursing facility between the MyCare Ohio program and the fee for service equivalent population. Enrollment rebalancing in MyCare Ohio outpaced the fee for service equivalent population. This implies that the MyCare Ohio program resulted in a 2.0% increase in the number of members transitioning to the community.

Cost Trend

MyCare Ohio capitation rates have experienced a general downward trend compared to little to no cost changes in fee for service equivalent populations. As MyCare Ohio managed care plans continue efforts to manage care, there is the potential for MyCare Ohio capitation rates to further reflect such cost efficiencies.

⁴ Includes members in a nursing facility and those receiving waiver services

⁵ Per July 2017 Effective MyCare Capitation Rates and Assumed Enrollment Mix

Conclusion

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

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

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

In general, MyCare Ohio managed care plan rates for the HEDIS clinical performance measures across the ODM focus population streams (Healthy Adults, Behavioral Health and Chronic Conditions) are evidence of access to care and appropriate management of chronic and behavioral health conditions. Approximately 53% of the reported rates exceeded the national 75th percentile benchmarks; the

statewide average of over 45% of the rates exceeded the national 90th percentile benchmark.

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

While a nursing home stay is very often the appropriate place for therapy and improved health outcomes after a health crisis, MyCare Ohio plans recognize that a long-term nursing home stay is not always necessary for everyone in need of long-term care. Savings can be achieved by serving more people in the community, and MyCare Ohio allows Ohioans to be able to live independently in the community with supports.

It is because of these successes that Ohio Medicaid will ask the Centers for Medicare and Medicaid to extend the MyCare Ohio demonstration for an additional three years, through December 2022. With this extension, Ohio Medicaid will be able to continue making improvements in the lives of MyCare Ohio members through better coordinated care and access to services. Individuals receiving long-term services and supports are Ohio's most vulnerable Medicaid population, and their care needs are best served in a coordinated care model, which is the foundation of the MyCare Ohio program.