Care Coordination in Managed LTSS
Ohio Case Study

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Ohio Department of Medicaid

MAKING OHIO BETTER

MyCare Ohio

- A originally a three year demonstration project that integrates Medicare and Medicaid services into one program, operated by a Medicare Medicaid Plan (MMP)
  - » May 1, 2014: MyCare Ohio went live in its first region (Medicaid only mandatory)
  - » July 1, 2014: MyCare Ohio was live in all regions
  - » January 1, 2015: Full Integration occurred (Medicare)
- August 2015: Submitted formal request to extend the Demonstration for two years, which was approved

MyCare Ohio

- MyCare Ohio includes both traditional managed health care covered services AND long-term services and supports (NF-based level of care).
- Medicaid-Medicare-Waiver-LTSS-BH (all-in)
- A 3-way contract between CMS, ODM, and the managed care plans outlines responsibilities, monitoring activities, and expected outcomes for CMS, ODM, and the Medicare-Medicaid plans.
- Ohio also maintains a separate provider agreement with MCPs for Medicaid-only enrollees.
- Individuals can only "opt-out" on the Medicare side; enrollment in Medicaid is mandatory in Ohio .

MyCare Ohio Eligibility Requirements

Eligibility Requirements:

- Eligible for all parts of Medicare (Parts A, B and D), fully eligible for Medicaid, and
  - » Over the age of 18
  - » Reside in one of the demonstration counties

This includes:

- Individuals in nursing facilities and some home care programs (Passport, Ohio Home Care, Assisted Living Waivers)
- Those who are receiving behavioral health services in community settings

Exempt Groups

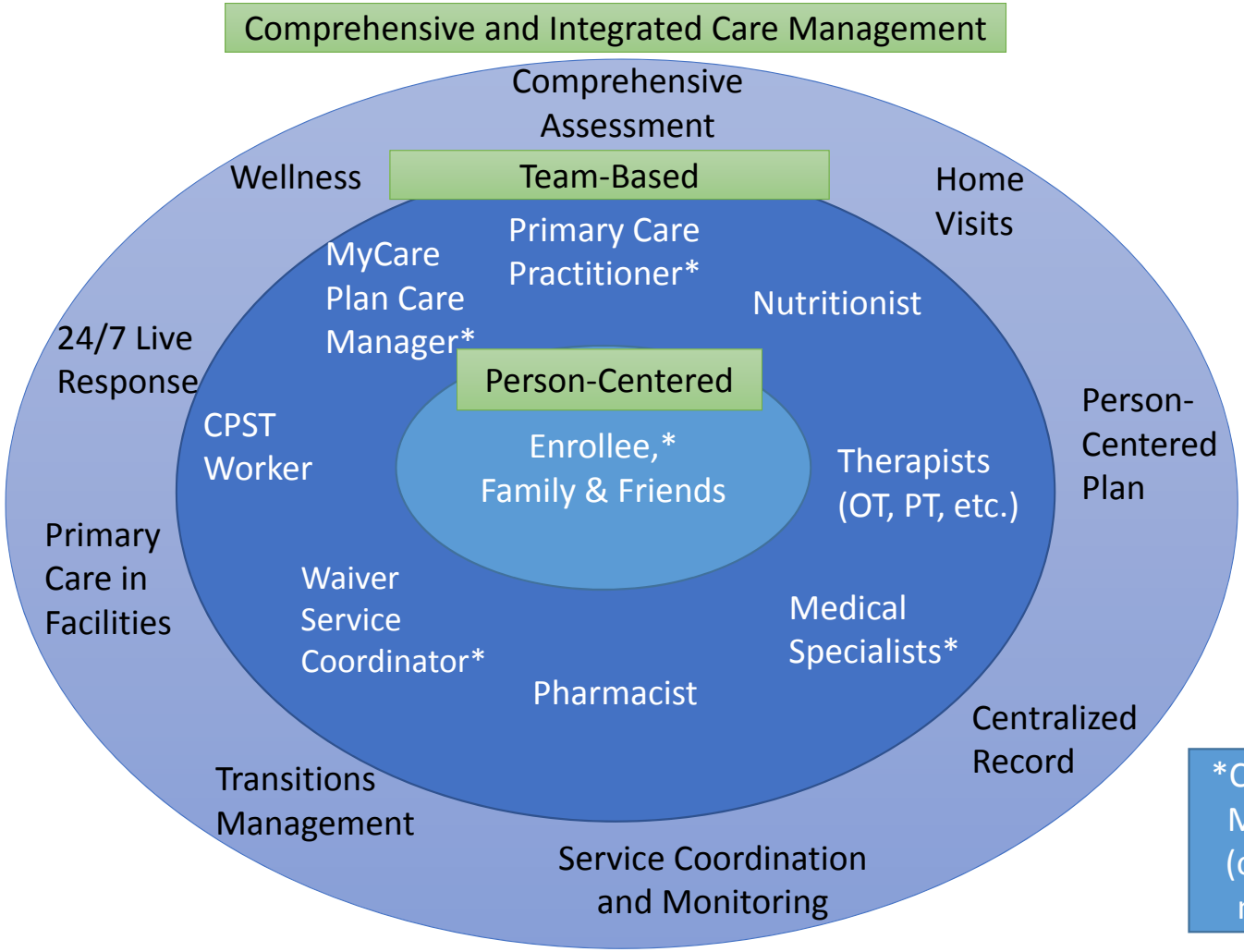
- The following groups are ***not eligible*** for enrollment in the MyCare Ohio demonstration:
  - » Individuals with an ICF-MR level of care served either in an ICF-IID facility or on a waiver administered by DODD
  - » Individuals enrolled in the Program of All Inclusive Care for the Elderly (PACE)
  - » Individuals who have third party insurance, except Medicare
  - » Individuals who are eligible for Medicaid through a delayed spend-down

MyCare Ohio Goals and Benefits

- Single point of accountability and contact for enrollees
- Access to care management for all (integrated approach to care coordination for physical, mental and long-term services)
- Person-centered care, seamless across services and care settings
- Easy to navigate for enrollees and providers
- Focus on wellness, prevention and coordination of services
- Link payment to person-centered performance outcomes
- One ID card and Nurse Advice Line
- Long term program efficiencies

Care Management

The Cornerstone Of The MyCare Program



Ohio Department of Medicaid
John R. Kasich, Governor
John R. McCarthy, Director

MyCare Ohio Plan (MCOP) Contract Requirements

Key care management components:

- Identify eligible beneficiaries
  - » Predictive modeling, IP census, self/provider/UM referrals
- Conduct a comprehensive assessment
  - » Physical, behavioral and psychosocial needs
- Assign to a risk stratification level
  - » Monitoring, low, medium, high, intensive
- Develop an individualized care plan
  - » Prioritized goals, interventions, and outcomes; includes input from the beneficiary, family and providers

MyCare Ohio Plan (MCOP) Contract Requirements

Assign a care manager to lead a multi-disciplinary team and:

- Establish a trusted relationship with the beneficiary
- Engage the beneficiary in the care planning process
- Develop planned communication with the beneficiary
- Help to obtain necessary care and critical community supports; coordinate care for the member with the primary care provider, specialists, etc; collaborate with other care managers to avoid gaps/duplications in services
- Conduct a care gap analysis between recommended care and actual care received
- Implement, monitor and update the care plan

MyCare Ohio Plan (MCOP) Contract Requirements

- Continuously evaluate beneficiary's ongoing need for care management
  - » Goal is to move on continuum from dependence to independence
- Apply evidence-based guidelines or best practices when developing and implementing interventions
- Maintain a care management system that integrates data with other MCOP systems and facilitates information sharing in an effective and efficient manner

Additional Care Management Supports

Additional Care Management Supports Available for MyCare Beneficiaries:

- Integration of waiver service coordination into comprehensive care management model
- Home visits by care managers
- Centralized enrollee record
- 24/7 Care Management Line
- Medication management
- Aggressive management of transitions across care settings

Waiver Service Coordination

- Plans are required to contract for waiver service coordination with the AAAs as an option for individuals **over the age of 60** who are on the MyCare Waiver.
- Must offer other community based options
- Members may select their Waiver Service Coordinator
- Plans may contract with AAAs or other entities, or provide waiver service coordination themselves, for individuals **under the age of 60**
- The Care Manager and the Waiver Service Coordinator may be one in the same

Care Coordination: Additional Aspects

- Plans can fully delegate the function of care coordination or choose to delegate only certain aspects (waiver services). Both models exist today in MyCare Ohio.
- **Person Centered Care is a requirement.** Ohio is actively engaged with CMS and the National Resource Center for Participant-Directed Services on enhanced training for the MCPs on participant direction.
- Initial feedback from advocates is that progress on participant direction has been slow to materialize.

EQRO Audit

- Plans are audited quarterly on their care management performance
- Examination of compliance with requirements around:
  - » risk stratification
  - » comprehensive assessments
  - » individualized care planning
  - » waiver service provisions
  - » care manager and care team
  - » beneficiary interactions
- First quarterly report has shown issues in most areas

Quality Oversight

Examples of our quality measures in MyCare:

- Rebalancing Measure
  - » Percentage of nursing facility residents discharged to a community setting from a nursing facility that did not return to the nursing facility during the measurement year as a proportion of members who resided in a nursing facility for 100 cumulative days or more during the previous year.
- Long Term Care Overall Measure
  - » The number of total patient days in a nursing facility per 1,000 member months for members in the MyCare Plan during the measurement year.
- Assessments
  - » Percentage of enrollees with initial assessments completed within 90 days of enrollment.
- Access to Primary Care
  - » Percentage of members who saw primary care doctor during the past years.

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