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Financial Alignment Initiative MyCare Ohio: First Evaluation Report

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FINANCIAL ALIGNMENT INITIATIVE
MYCARE OHIO
FIRST EVALUATION REPORT

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Executive Summary

The Medicare-Medicaid Coordination Office and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative (FAI) to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. CMS contracted with RTI International to monitor the implementation of the demonstrations and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation will include a final aggregate evaluation and State-specific evaluation reports.

MyCare Ohio is a capitated model demonstration that began on May 1, 2014.[1] It was originally scheduled to continue through December 31, 2017, and has been extended through December 31, 2019. Five competitively selected Medicare-Medicaid Plans (MMPs), called MyCare Ohio plans, are paid a blended, capitated rate to provide integrated primary, acute care, behavioral health, and long-term services and supports (LTSS) Medicare and Medicaid services to enrollees in 29 counties.

This first Evaluation Report for the MyCare Ohio demonstration describes implementation and early analysis of the demonstration's impacts. The report includes qualitative evaluation findings through December 2016 and quantitative results through December 2015. Data sources include key informant interviews, beneficiary focus groups, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results for 2015 and 2016, Medicare claims data, the Minimum Data Set nursing facility assessments, MMP encounter data, and other demonstration data. Future analyses also will include Medicaid claims and encounters as those data become available.

Highlights

- Of the more than 100,000 Medicare-Medicaid enrollees eligible for MyCare Ohio, approximately 69,000 had enrolled in the capitated model demonstration as of December 2016.

- The results of preliminary Medicare cost savings analyses using a difference-in-differences regression approach do not indicate savings or losses due to the Ohio demonstration over the period May 2014–December 2016. However, statistically significant savings are observed in the first demonstration period. The costs savings analyses do not include Medicaid data due to current data availability, but these data will be incorporated into future calculations as they become available.

[1] The Ohio Department of Medicaid (ODM) considers MyCare Ohio to be two programs: a demonstration that includes dually eligible beneficiaries receiving Medicare and Medicaid benefits through a MyCare Ohio plan, and also a separate program that includes dually eligible beneficiaries who receive only Medicaid benefits from a MyCare Ohio plan. ODM refers to the latter beneficiaries as the "opt-out" population because they opted out of receiving Medicare benefits through a MyCare Ohio plan. Likewise, ODM refers to beneficiaries who are in the Financial Alignment Initiative capitated model demonstration as "opt-in" because they receive both Medicare and Medicaid benefits through a MyCare Ohio plan. For the purposes of this evaluation, we refer to the "opt-out" population as non-enrollees and the "opt-in" population as enrollees.

- Inpatient admissions, both overall and for ambulatory care-sensitive conditions, were lower for the demonstration eligible population versus a matched comparison group. In addition, both skilled nursing facility and long-term nursing facility admissions were lower. Conversely, preventable emergency room (ER) visits were higher, although there was no effect on overall ER visits. Physician evaluation and management visits were lower.

- MMPs' lack of experience with LTSS and behavioral health care payment and delivery, together with LTSS and behavioral health providers' lack of experience with managed care, led to significant payment challenges in the demonstration's first year. Through ongoing collaboration, plans and providers were able to resolve the systemic payment challenges, and they continue to meet regularly to address the remaining plan- and provider-specific payment issues.

- Early in the demonstration, care managers were overwhelmed with a large influx of new members and struggled to meet care management requirements. State, enrollee, and provider representatives believe that care management has improved but has not reached its full potential. Ohio Medicaid officials believe that prescriptive contract health risk assessment (HRA) requirements have led MMPs to focus more on meeting compliance deadlines than on meeting enrollees' needs, and proposed changes to the demonstration's care coordination model to address the issue that went into effect October 1, 2017.

- Most MyCare Ohio enrollees responding to the CAHPS survey gave their MMPs high ratings. Nearly all respondents felt that their personal doctors understood how their health problems affected their everyday lives, and most had the same doctor prior to enrolling in MyCare Ohio.

- MyCare Ohio plans have conducted extensive outreach and education to increase enrollees' awareness of their care managers, and State officials and stakeholder groups reported that enrollee awareness of care managers has increased. Focus group participants' experiences with care managers varied.

- Nearly all focus group participants said they had been seeing their current primary care providers (PCPs) regularly for at least a year, and many had the same PCP for many years. Participants often reported that their health or quality of life was the same or better since enrolling in MyCare Ohio plans. Focus group participants generally were aware of MyCare Ohio's beneficiary protections. They often showed familiarity with the ombudsman program, and a few had contacted the ombudsman's office.

- The ombudsman's office has received many complaints about access to durable medical equipment (DME) and home modifications, and CMS and the Ohio Department of Medicaid have required MMPs to address the issue. During the December 2016 site visit, an enrollee stakeholder reported that plans have been

making efforts to reduce the time frame for DME approvals. CMS staff did not believe this issue was limited to the demonstration alone.

- MMP representatives reported mixed views about the adequacy of payment rates, and no plan has expressed intent to leave the demonstration.

- MyCare Ohio plan staff reported cost savings from reductions in hospital admissions, readmissions, and use of skilled nursing facility and emergency department services. However, State officials did not have data on cost savings.

- We find evidence that the Ohio demonstration resulted in significant changes in utilization patterns, including changes in quality of care and care coordination. An overview of the results from impact analyses using only Medicare and Minimum Data Set data is provided in ***Table ES-1***. The direction of all statistically significant results at the $p < 0.1$ significance level (derived from 90 percent confidence intervals) is shown.

- As measured across all eligible beneficiaries, the demonstration resulted in a 21.3 percent reduction in inpatient admissions, a 14.3 percent reduction in the probability of ambulatory care sensitive condition (overall) admissions, a 13.2 percent reduction in the probability of ambulatory care sensitive condition (chronic) admissions, and a 15.3 percent reduction in skilled nursing facility admissions. Conversely, the demonstration resulted in a 10.3 percent increase in preventable emergency room visits.

- Although the results on the measures above for those with severe and persistent mental illness were in the same direction and to a different degree as for all eligible beneficiaries, results for those with any LTSS use were higher and in the opposite direction than for all eligible beneficiaries for both skilled nursing facility admissions and the probability of ambulatory care sensitive condition (chronic) admissions.

Table ES-1
Summary of MyCare demonstration impact estimates for demonstration period (May 1, 2014 to December 31, 2015)

Measure	All demonstration eligibles	Demonstration eligibles with LTSS use	Demonstration eligibles with SPMI
Inpatient admissions	Lower	Lower	Lower
Probability of ambulatory care sensitive condition (ACSC) admissions, overall	Lower	NS	Lower
Probability of ACSC admissions, chronic	Lower	Higher	Lower
All-cause 30-day readmissions	NS	Lower	NS
Emergency room (ER) visits	NS	NS	NS
Preventable ER visits	Higher	Higher	Higher
Probability of monthly follow-up after mental health discharges	NS	NS	NS
Skilled nursing facility (SNF) admissions	Lower	Higher	Lower
Probability of any long-stay nursing facility (NF) use	Lower	N/A	N/A
Physician evaluation and management (E&M) visits	Lower	NS	Lower

LTSS = long-term services and supports; N/A = not applicable; NS = not statistically significant; SPMI = severe and persistent mental illness.

NOTES: The relative direction of all statistically significant results at the $p < 0.10$ significance level (derived from 90 percent confidence intervals) is shown.

SOURCE: RTI analysis of Medicare and Minimum Data Set data.

1. Overview

1.1 Evaluation Overview

1.1.1 Purpose

The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative (FAI) to test integrated care models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees, with the expectation that integrated delivery models would address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives.

This Evaluation Report on the Ohio capitated model demonstration under the Medicare-Medicaid Financial Alignment Initiative, called MyCare Ohio, is one of several reports that will be prepared over the next several years to evaluate the demonstration. CMS contracted with RTI International to monitor the implementation of the demonstrations under the Financial Alignment Initiative and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes both a final aggregate evaluation and State-specific evaluations.[2]

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on the beneficiary experience, monitor unintended consequences, and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for special populations (e.g., people with behavioral health conditions and/or substance use disorders, users of LTSS). To achieve these goals, RTI collects qualitative and quantitative data from Ohio each quarter; analyzes Medicare and Medicaid enrollment, claims, and encounter data; conducts site visits, beneficiary focus groups, and key informant interviews; and incorporates relevant findings from any beneficiary surveys conducted by other entities. In addition to this Evaluation Report, monitoring and evaluation activities will also be reported in subsequent evaluation reports, and a final aggregate evaluation report for the Financial Alignment Demonstration.

1.1.2 What it Covers

This report analyzes implementation of the MyCare Ohio demonstration from its initiation on May 1, 2014, through December 31, 2016. For this reporting period, qualitative data through 2016 and quantitative data based on Medicare claims and the nursing facility Minimum Data Set 3.0 through 2015 are included. It describes the MyCare Ohio demonstration key design features; examines the extent to which the demonstration was implemented as planned; identifies any modifications to the design; and discusses the challenges, successes, and unintended consequences encountered during the period covered by this report. It also includes data on the

[2] The Aggregate Evaluation Plan is available on the CMS website at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf.

beneficiaries eligible and enrolled, geographic areas covered, and status of the participating Medicare-Medicaid plans (hereafter referred to as MyCare Ohio plans or MMPs). Finally, the report includes data on care coordination, the beneficiary experience, stakeholder engagement activities, and, to the extent that data are available, analyses of utilization and quality, and a summary of preliminary findings related to Medicare savings results in the first demonstration year.

1.1.3 Data Sources

A wide range of data sources informed this first Evaluation Report of the MyCare Ohio demonstration, as follows:

Key informant interviews. The RTI evaluation team conducted three site visits: October 27–29, 2014; December 14–17, 2015; and December 5–8, 2016. During these site visits, and in pre- and post-site visit telephone calls, the team interviewed Ohio Department of Medicaid (ODM) officials; the State's Long-Term Care Ombudsman, who also serves as the ombudsman for MyCare; officials from the CMS regional office; representatives from MyCare Ohio plans; representatives of Area Agencies on Aging (AAAs); as well as stakeholder organizations representing Medicare-Medicaid enrollees and providers.

Focus groups. To learn about beneficiary experiences in MyCare Ohio, the evaluation team conducted eight focus groups from April 5–7, 2016. A total of 47 individuals participated (including 39 MyCare enrollees and eight proxies); all were using LTSS and/or behavioral health services. Two groups were conducted in Toledo, and six were in Cleveland.

Surveys. Medicare requires all Medicare Advantage plans, including MyCare Ohio plans, to conduct an annual assessment of the experiences of beneficiaries using the Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument. The 2015 and 2016 surveys for MyCare Ohio plans were conducted in the first half of 2015 and 2016, respectively, and included the core Medicare CAHPS questions, and 10 supplemental questions added by the RTI evaluation team. Survey results for a subset of 2015 and 2016 survey questions are incorporated into this report. Findings are available at the MyCare Ohio plan level only. The frequency count for some survey questions may be suppressed because too few enrollees responded to the question. Comparisons with findings from all Medicare Advantage plans are available for core CAHPS survey questions but not for the RTI supplemental questions.

Demonstration data. The RTI evaluation team reviewed data that Ohio provided quarterly through the State Data Reporting System (SDRS). These data included eligibility, enrollment, and information reported by Ohio on its stakeholder engagement process, accomplishments on the integration of services and systems, any changes made in policies and procedures, and a summary of successes and challenges. The report also uses data for quality measures reported by MyCare Ohio plans and submitted to CMS's implementation contractor,

NORC at the University of Chicago (hereafter referred to as NORC).[3,4] Data reported to NORC include core quality measures that all Medicare-Medicaid Plans are required to report, as well as State-specific measures that MyCare Ohio plans are required to report. Due to some reporting inconsistencies across plans in 2014 and 2015, plans occasionally resubmit data for prior demonstration years; therefore, these data are considered preliminary.

Demonstration policies, contracts, and other materials. The RTI evaluation team reviewed official agreements between CMS and the State of Ohio on demonstration policies and operations, including the three-way contract between CMS, the State of Ohio, and MyCare Ohio plans (CMS, 2014, hereafter, three-way contract, 2014); an addendum to the three-way contract executed in May 2016 (CMS, May 2016; hereafter, addendum to three-way contract, 2016); the Memorandum of Understanding (MOU) between CMS and Ohio (CMS and the State of Ohio, 2012a; hereafter, MOU, 2012); and the State's demonstration proposal to CMS (Ohio Department of Job and Family Services, 2012; hereafter, proposal, 2012). The team gathered State-specific documents from the Ohio Department of Medicaid website (http://medicaid.ohio.gov/), the Governor's Office of Health Transformation website (http://www.healthtransformation.ohio.gov/), and the Ohio behavioral health redesign website (http://bh.medicaid.ohio.gov/).

Conversations with CMS and ODM officials. To monitor the demonstration's progress between site visits, the RTI evaluation team had periodic telephone conversations with ODM staff and CMS. These could include discussions of issues such as new policy clarifications designed to improve plan performance, quality improvement work group activities, and contract management team activities.

Complaints and appeals data. Complaint (also referred to as grievance) data are from three separate sources: (1) complaints from beneficiaries reported by MyCare Ohio plans to ODM, and separately to CMS's implementation contractor, NORC, under Core Measure 4.2; (2) complaints received by ODM or 1-800-Medicare and entered into the CMS electronic Complaint Tracking Module (CTM)[5]; and (3) complaints received by the Office of the State Long-Term Care Ombudsman and reported to ODM and the Administration for Community Living (ACL), the Federal agency that provides technical assistance to ombudsman programs for demonstrations under the Financial Alignment Initiative.

Appeals data are based on reports from MMPs to ODM and CMS's implementation contractor, NORC, for Core Measure 4.2 and the Medicare Independent Review Entity (IRE). Data on critical incidents and abuse reported to ODM and CMS's implementation contractor by MyCare Ohio plans are also included in this report.

Although a discussion of the five MyCare Ohio plans is included, this report presents information primarily at the MyCare Ohio demonstration level. It is not intended to assess

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[3] Data are reported for calendar year 2015.

[4] The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

[5] Data are presented for the time period from May 2014 through September 2016.

individual plan performance, but individual plan information is provided where plan-level data are the only data available, or where plan-level data provide additional context.

Service utilization data. Evaluation Report analyses used data from many sources. First, the State provided quarterly finder files containing identifying information on all demonstration eligible beneficiaries in the demonstration period. Second, RTI obtained administrative data on beneficiary demographic, enrollment, and service use characteristics from CMS data systems for both demonstration and comparison group members. Third, these administrative data were merged with Medicare claims and encounter data, as well as the Minimum Data Set.

Although Medicaid service data on use of LTSS, behavioral health, and other Medicaid-reimbursed services were not available for the demonstration period and therefore are not included in this report, CMS administrative data identifying eligible beneficiaries who used Medicaid-reimbursed LTSS was available, so that their Medicare service use could be presented in this report. Future reports will include findings on Medicaid service use once data are available.

1.2 Model Description and Demonstration Goals

The MyCare Ohio demonstration began on May 1, 2014, and was originally scheduled to continue through December 31, 2017 (Ohio three-way contract, 2014). In May 2016, the State and CMS signed an agreement to extend the demonstration for an additional 2 years, through December 31, 2019 (addendum to three-way contract, 2016).

The goals of MyCare Ohio are to: improve the beneficiary experience in accessing care; increase individuals' independence and engagement; improve quality; reduce health disparities; meet both health and functional needs; improve transitions between care settings; eliminate cost-shifting between Medicare and Medicaid; and achieve cost savings for the State and Federal governments through improvements in care and coordination (MOU, 2012, p. 1).

Financial model. MyCare Ohio plans are paid a blended, risk-adjusted capitated rate covering all Medicare and Medicaid services. Medicare Parts A and B and Medicaid payments reflect the application of savings percentages and quality withholds (see ***Section 7.1, Rate Methodology***).

Eligible population. Full-benefit Medicare-Medicaid enrollees age 18 and older are eligible for the demonstration. Beneficiaries who are not eligible for the demonstration include individuals with intellectual and developmental disabilities (IDD) who are served through an IDD 1915(c) home and community-based services waiver or intermediate care facilities for individuals with IDD (ICF-IDD), individuals with third-party creditable health care coverage, and enrollees in the Program of All-Inclusive Care for the Elderly (PACE).

MyCare Ohio waiver. In conjunction with implementing the demonstration, Ohio Medicaid created a 1915(c) waiver that consolidated features of five "legacy" home and community-based services waivers[6] into a new MyCare Ohio waiver for enrollees who meet the

[6] The five legacy waivers are PASSPORT, Choices, Assisted Living, Ohio Home Care, and Transitions II Aging Carve-out.

State's criteria for receiving a nursing facility level of care. Under the new waiver, homemaker and home attendant services—previously not offered under all legacy home and community-based (HCBS) waivers—are now available to all enrollees.

MyCare Ohio plans. Five competitively selected health plans (called MyCare Ohio plans) provide integrated Medicare and Medicaid services, including primary, acute, behavioral health, and LTSS, to enrollees in the demonstration. Additionally, since the time of the demonstration's launch in May 2014, Medicare-Medicaid enrollees in the 29 demonstration counties (see below) have been required to receive Medicaid benefits from the same five plans, even if they opt out of the demonstration. Four of the five MMPs also provide coverage for individuals covered by Medicaid only enrolled in the State's mandatory Medicaid managed care program, which ODM calls "traditional Medicaid." The five participating MMPs are Aetna, Buckeye Health Plan (Centene), CareSource, Molina Healthcare of Ohio, and UnitedHealthcare.

Health plan operations under the demonstration are governed by a three-way contract between the State of Ohio, CMS, and MyCare Ohio health plans. MyCare Ohio plans also must comply with a "two-way contract" with ODM, referred to as the provider agreement. The provider agreement includes some provisions related specifically to coverage of the MyCare Ohio opt-out population[7] (e.g., requirements related to provider panels under HCBS waivers) that are not included in the three-way contract. ODM updates the provider agreement every 6 months, and as needed if the MyCare Ohio three-way contract amendments impact the provider agreement. To the greatest extent possible, State officials seek to achieve consistency between the provider agreement and three-way contract; in any areas of inconsistency with regard to demonstration operations, provisions of the three-way contract apply.

Geographic coverage. As shown in ***Table 1***, the demonstration operates in 29 of Ohio's 88 counties (seven regions of three to five counties each). Two plans are available in each region, except for the Northeast region, which has three plans.

Care coordination. Care coordination is a central function of MyCare Ohio, and plans are required to provide care coordination services to all enrollees through transdisciplinary care teams (see ***Section 4.1, Care Coordination Model***). The three-way contract (2016, p. 42) states that the care team's composition will vary based on enrollees' needs and preferences, but at a minimum will include the enrollee, primary care provider, care manager, waiver service coordinator as appropriate, specialists, family members, caregivers, and any other individuals

[7] The Ohio Department of Medicaid (ODM) considers MyCare Ohio to be two programs: a demonstration that includes dually eligible beneficiaries receiving Medicare and Medicaid benefits through a MyCare Ohio plan, and also a separate program that includes dually eligible beneficiaries who receive only Medicaid benefits from a MyCare Ohio plan. ODM refers to the latter beneficiaries as the "opt-out" population because they opted out of receiving Medicare benefits through a MyCare Ohio plan. Likewise, ODM refers to beneficiaries who are in the Financial Alignment Initiative capitated model demonstration as "opt-in" because they receive both Medicare and Medicaid benefits through a MyCare Ohio plan. For the purposes of this evaluation, we refer to the "opt-out" population as non-enrollees and the "opt-in" population as enrollees.

requested by the enrollee. The three-way contract was revised in October 2017 and the next evaluation report will cover updates to any modifications impacting care coordination.[8]

Table 1
Demonstration regions and MyCare Ohio plans

Demonstration region (counties in *italics*)	Managed Care plans available
Northwest: *Fulton, Lucas, Ottawa, Wood*	Aetna, Buckeye
Southwest: *Butler, Clermont, Clinton, Hamilton, Warren*	Aetna, Molina
West Central: *Clark, Greene, Montgomery*	Buckeye, Molina
Central: *Delaware, Franklin, Madison, Pickaway, Union*	Aetna, Molina
East Central: *Portage, Stark, Summit, Wayne*	CareSource, United
Northeast Central: *Columbiana, Mahoning, Trumbull*	CareSource, United
Northeast: *Cuyahoga, Geauga, Lake, Lorain, Medina*	Buckeye, CareSource, United

SOURCE: Ohio Department of Medicaid.

MyCare Ohio plans must contract with AAAs for waiver service coordination for enrollees age 60 or older.[9] For the under-60 population, plans have the option of contracting with other entities or providing services in-house, for overall care management and HCBS waiver service coordination (Ohio three-way contract, 2016, p. 50). As of December 2016, two of the five MyCare Ohio plans fully delegated responsibility for all care management (all services and all age groups) to AAAs.

MyCare Ohio plans in demonstration counties with approved Community Behavioral Health Homes (hereafter referred to as behavioral health homes) have been required to contract with these entities to provide care management for Medicare-Medicaid beneficiaries with serious and persistent mental illness (SPMI). The MyCare Ohio plan retains responsibility for coordinating waiver services for these beneficiaries. Individuals with SPMI can choose to have all services coordinated by either a MyCare Ohio plan or a health home, if a health home is available in their area. As discussed in ***Section 1.3.2***, the Community Behavioral Health Home program will terminate in July 2018.

Benefits. In addition to benefits provided through the new, consolidated waiver, the demonstration provides (1) coordination of primary care, acute care, behavioral health services, and LTSS; (2) value-added, or flexible benefits, such as supplemental transportation, expanded dental coverage, and coverage of specified over-the-counter drug products up to a monthly dollar limit; and (3) the option to self-direct specified HCBS waiver services. ***Table 2*** includes a summary of standard benefits and an example of MyCare Ohio plans' value-added benefits.

[8] A summary of the revisions is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OHContractSummaryChanges10012017.pdf

[9] This requirement was modified in the October 2017 revisions to the three-way contract. Changes will be discussed in the next evaluation report.

Table 2
Summary of standard and value-added benefits under MyCare Ohio

Standard benefits—medical services

- Inpatient and outpatient medical and surgical care
- Skilled nursing facility, home health, and hospice services
- Diagnostic tests, laboratory, x-ray and imaging
- Urgent care
- Durable medical equipment and supplies
- Vision care
- Dental care
- Preventive care
- Renal dialysis
- Prescription drugs

Standard benefits—behavioral health

- Behavioral health assessment and therapy
- Crisis intervention
- Partial hospitalization
- Ambulatory detoxification services
- Targeted case management

Standard benefits—community-based services

- Respite care
- Adult day health care
- Transportation
- Home modification maintenance and repair
- Personal care, home care attendant, and homemaker services
- Nursing
- Home-delivered meals
- Pest control
- Assisted living

Sample of MyCare Ohio value-added benefits (benefits vary by plan)

- Enhanced dental services
- Enhanced vision services
- Zero copayments for generic drugs
- Zero copayments for Medicare Part D prescription drugs
- $20 monthly allowance for specified over-the-counter drug (OTC) products
- 30 round-trip rides with zero copayments
- Hearing exams and hearing aids
- $25 monthly OTC drug benefit
- Weight management

SOURCES (sample of value-added benefits from subgroup of plans):
http://www.molinahealthcare.com/members/oh/en-US/hp/mycare/duals/Pages/molinadiff.aspx,
https://www.caresource.com/oh/plans/mycare/benefits-services/,
https://mmp.buckeyehealthplan.com/2017/medicare-medicaid-plan.html,
https://www.aetnabetterhealth.com/ohio/members/premier/materials.

Stakeholder engagement. Ohio Medicaid officials have used a variety of methods to engage stakeholders, including meetings of the MyCare Ohio Implementation Team, regional forums, and meetings with enrollee and provider representatives. The State's Long-Term Care Ombudsman also engages with stakeholders on an ongoing basis (see ***Section 6, Stakeholder Engagement***).

1.3 Changes in Demonstration Design

1.3.1 Care Coordination Proposal

During the December 2016 site visit, State officials indicated that ODM had recently proposed an amendment to the three-way contract to give MyCare Ohio plans greater flexibility in the delivery of care management services and to promote a population health management approach. Key factors leading to the proposed change are discussed in ***Section 4.1.3, Change to the Care Coordination Model***. The proposed amendment was finalized and incorporated into the three-way contract as this report was being written. Additional discussion of the change will appear in future MyCare Ohio evaluation reports.

1.3.2 Termination of Community Behavioral Health Homes

ODM officials decided to terminate the Community Behavioral Health Home program in July 2016. State officials commented on the cost of behavioral health homes and indicated that this model of care had not led to reductions in preventable hospitalizations and emergency room use. ODM staff reported that in response to financial and employment concerns raised by health home providers, they postponed the termination of health homes until the start of the managed behavioral health care system in July 2018. At that time, Medicare-Medicaid enrollees with SPMI will have the option to transition to other behavioral health services rendered by the same or a different provider agency to replace the care coordination and health promotion aspects of the health home service. Enrollees who meet the eligibility criteria for Assertive Community Treatment (ACT) and have a medical need for that service may be transitioned into care from an ACT team which meets the ODM and OhioMHAS criteria.

1.4 Overview of State Context

As discussed below, the demonstration builds on Ohio's long history of Medicaid managed care and its efforts to rebalance LTSS. Moreover, it is consistent with ongoing planning for redesign of the State's behavioral health care delivery system. For a summary of predemonstration and demonstration design features for Medicare and Medicaid enrollees in Ohio, see ***Appendix E***.

1.4.1 Managed Care

Ohio first implemented Medicaid managed care in 1978 as an optional program in a limited number of counties. In 2006, the State implemented mandatory managed care enrollment for physical health care services for the Medicaid aged, blind, and disabled (ABD) populations but excluded Medicare-Medicaid enrollees, individuals living in institutions, individuals eligible through spending down their income, and individuals receiving services through Medicaid 1915(c) Home- and Community-Based Services waivers (proposal 2012, p. 3). As a result,

nearly 200,000 Medicare-Medicaid enrollees in the State were receiving benefits through the fee-for-service (FFS) system.

In January 2011, Governor John Kasich established the Office of Health Transformation (OHT) to modernize Medicaid and streamline health and human services (proposal, 2012, p. 3). The Kasich administration viewed the FFS system for Medicare-Medicaid enrollees as fragmented and ineffective. As noted in ***Section 1.2*** (***Model Description and Demonstration Goals***), State leadership decided to implement MyCare Ohio to promote more coordinated and effective care for Medicare-Medicaid enrollees, maximize enrollees' ability to function independently in community settings, and achieve cost savings for the State and Federal governments.

1.4.2 Rebalancing

Prior to implementation of MyCare Ohio, LTSS users comprised approximately 7 percent of the Medicaid population but accounted for about 41 percent of the program's annual expenditures (Ohio Governor's Office of Health Transformation, n.d.-a). The Kasich administration believed the traditional funding mechanism for Medicaid nursing facility care, a separate line item in the State's budget, led to an unbalanced LTSS system characterized by overuse of institutional care (Ohio Governor's Office of Health Transformation, n.d.-b; proposal, 2012, p. 4).

State leadership viewed the community-based LTSS system as complex and difficult to navigate, with five different Medicaid HCBS waiver service options and four Medicaid State Plan delivery models, each with different enrollment requirements, processes, and service packages (Ohio Governor's Office of Health Transformation, n.d.-b). Moreover, due to limitations in the number of HCBS waiver slots available, many Medicare-Medicaid enrollees who could have otherwise received community-based LTSS ended up receiving care in institutional settings.

To rebalance and streamline Medicaid LTSS, the State replaced the separate State budget line item for nursing facility care with a single LTSS line item encompassing both institutional and community-based care. This move was intended to enable LTSS spending decisions to be driven by individuals' choice of setting rather than specific appropriations in the budget process.

Additional State efforts to promote rebalancing include participation in the Balancing Incentive Program (BIP) and the Money Follows the Person demonstration. Ohio's proposal to participate in the BIP was approved by CMS in 2013. BIP provides enhanced Federal Medicaid matching payments to States in exchange for adopting three LTSS systems components: a single entry point for LTSS delivery systems, conflict-free case management systems, and a standardized assessment tool for determining eligibility for LTSS. The demonstration also sets targets for States for increasing the proportion of their Medicaid LTSS spending devoted to HCBS. Ohio received more than $169 million in Federal Medicaid funds for its commitment to direct half of all Medicaid long-term care funding to HCBS services by September 30, 2015. The State announced in September 2014 that it reached its 50 percent spending target a year earlier than planned (ODM, n.d.).

Ohio's Home Choice Program, a Money Follows the Person (MFP) demonstration established in 2008, likewise has supported the shift of Medicaid LTSS resources from institutional to community-based care. A report on the MFP demonstration cited Ohio as having the second-highest number of residents of any State who transitioned from institutions to community living under the initiative (ODM, 2013).

1.4.3 Behavioral Health Care System

Individuals with behavioral health needs compose 27 percent of the Medicaid population but account for 47 percent of Medicaid spending (Ohio Governor's Office of Health Transformation, 2015). In 2015, the State's Office of Health Transformation reported that about 50 percent of the Medicaid behavioral health population was being treated through Ohio's Mental Health and Addiction Services system. Individuals with SPMI who were not receiving services through this system often received care in nursing facilities, prisons, and psychiatric inpatient facilities. Many lacked connections to treatment due to homelessness, involvement in the criminal justice system, or social isolation (ODM, 2016).

To address funding challenges, increase service capacity, and promote integration of physical and behavioral health services, the Kasich administration launched a comprehensive redesign of the State's Medicaid behavioral health delivery system in 2015 (Ohio Governor's Office of Health Transformation, n.d.-b). The redesign was implemented in January 1, 2018, and was a complete overhaul of the behavioral health benefit package. On July 1, 2018, the existing FFS model will be carved into the State's traditional managed care system. The demonstration is proceeding at the same time as this transition, and the demonstration's goal of integrating physical, behavioral health, and LTSS services for Medicare-Medicaid enrollees is consistent with goals of the redesign. In some cases, elements of the redesign have implications for the demonstration. For example, according to some State officials, MyCare Ohio plans, and provider representatives, coding changes associated with behavioral health redesign may help address some of the delays and complexities in payment for behavioral health services, including those that have occurred under the demonstration (see ***Section 2.2.2, Provider Arrangements and Services***).

1.4.4 Federal Financial Support

Ohio was not among the 15 States that were awarded a demonstration design contract from CMS under the State Demonstrations to Integrate Care for Dual Eligible Individuals. As such, Ohio did not receive Federal funds to support the planning of the demonstration and was ineligible to receive CMS funding for implementation support.

The Ohio Office of the State Long-Term Care Ombudsman, housed within the Ohio Department of Aging, received a $272,354 grant from CMS, in collaboration with the Federal ACL, to support the first year of demonstration operations. Funding continued for the second and third years of the demonstration; the State reported that the grant for year 3, which ended in March 2017, was $479,927. In September 2016, CMS issued a new funding opportunity that was later awarded in January 2017. The State uses Federal funds to add staff who specialize in issues related to MyCare Ohio in the regional ombudsman offices serving the demonstration regions.

2. Integration of Medicare and Medicaid

Highlights

- Managed care plans, known as MyCare Ohio plans, provide the organizational and administrative structure to integrate the financing and delivery of medical care, behavioral health, and long-term supports and services (LTSS).
- Medicare-Medicaid Plans' (MMPs') lack of experience with LTSS and behavioral health care payment and delivery in Ohio, together with Ohio LTSS and behavioral health providers' lack of experience with managed care, led to significant payment challenges in the demonstration's first year.
- Through ongoing collaboration, plans and providers were able to resolve the systemic payment challenges, and they continue to meet regularly to address the remaining plan- and provider-specific payment issues.
- Primary care providers generally have not been engaged in demonstration activities, and MyCare Ohio plans are pursuing a variety of strategies to increase their engagement.

This section provides an overview of the management structure for the MyCare Ohio demonstration and describes the integrated delivery system, including the role and structure of MyCare Ohio plans and their provider arrangements.

2.1 Joint Management of the Demonstration

MyCare Ohio plans' operations are governed by a three-way contract with the State and CMS. The ODM also has two-way contracts, called the MyCare Ohio Provider Agreements, with the five MyCare Ohio plans. Provider agreements include provisions related to coverage of the MyCare Ohio opt-out population (see ***Section 1.2, Model Description and Demonstration Goals***). Each of the five MyCare Ohio plans is monitored by an ODM contract administrator who is also responsible for monitoring compliance of plans participating in Medicaid.

The joint CMS-State Contract Management Team (CMT) oversees MyCare Ohio plans and addresses issues related to integration of Medicare and Medicaid policies and processes. The CMT is responsible for day-to-day monitoring of MyCare Ohio plans, including monitoring plans' compliance with the three-way contract; implementing compliance actions when necessary; reviewing performance and enrollment data; reviewing and responding to beneficiary complaints; responding to stakeholder concerns; reviewing reports from the ombudsman; reviewing marketing materials; and reviewing grievance and appeal data.

The Ohio CMT includes representatives from the State Medicaid agency, CMS staff from the Chicago Regional Office, and the MMCO State Leads, who are authorized to represent their respective agencies in administering the three-way contract. The CMT meets on a biweekly

basis. Ohio's Medicaid Director also had biweekly meetings with CMS officials during the implementation phase, and now monthly, and the State's demonstration team lead is in frequent communication with CMS staff. The CMT meets once a month with each MyCare Ohio plan, and ODM contract administrators meet weekly with MyCare Ohio plans to discuss ongoing issues related to plan performance.

In addition to the standard reporting requirements set forth in the three-way contract, the CMT requires plans to submit a series of performance monitoring reports on various measures at certain periods. For example, plans are required to submit call center performance reports that detail average answer speed, average hold times, and abandonment rates on a monthly basis. Care management staffing ratios are reported semi-annually.

State Medicaid and CMS officials reported that the CMT has been a vehicle to address issues that arise when Medicare and Medicaid policies may not align, such as those related to grievances and appeals. In accordance with the 2016 Medicaid managed care rule, ODM made changes to align its grievance and appeals definitions and procedures with Medicare (e.g., by modifying the State's definition of a grievance and requiring enrollees to exhaust their internal plan appeals before exercising the State hearings option, see ***Section 5.2.9, Beneficiary Protections***).

The CMT also has served as a vehicle to address MyCare Ohio plans' performance in completing the health risk assessments (HRAs) required for care coordination. The CMT tracks this performance on a monthly basis, and as discussed in ***Section 4.1.1***, it established performance improvement plans in November 2014 to promote more timely HRA completion. Ohio Medicaid officials reported that no other performance improvement plans were implemented during the demonstration to address HRA completion.

According to State officials, pursuant to its monitoring and oversight role, the CMT took one compliance action early in the demonstration, when one MMP failed to meet requirements for sending enrollee ID cards in a timely manner. ODM staff commented that CMT meetings facilitated clear and efficient communication among the plan, the contract administrators, and other members of the CMT to address the issue. The CMT has not taken any additional compliance actions since that one incident.

2.2 Overview of Integrated Delivery System

2.2.1 MyCare Ohio Plans

Five competitively selected MyCare Ohio plans are charged with integrating financing and delivery of physical health, behavioral health, and LTSS for enrollees in the Ohio demonstration. Together, the five MyCare Ohio plans cover 29 counties grouped into seven regions. Each region has two plans, except for the Northeast region, which has three (see ***Table 1*** in ***Section 1.2***). All MyCare Ohio plans are part of managed care organizations that have Medicare Advantage plans, and four of the five have historically administered the State's large Medicaid managed care programs.

Additional coordinated care delivery systems for Medicare-Medicaid enrollees in Ohio include a Program of All-Inclusive Care for the Elderly (PACE program) with three locations in Cleveland,[10] as well as multiple Dual Eligible Special Needs Plans (D-SNPs) in each of the demonstration regions.[11]

Although all MyCare Ohio plans are subject to the same requirements pursuant to the three-way contract (see ***Section 2.1, Joint Management of the Demonstration***), there are significant operational variations with respect to organization and performance of required functions, such as care coordination and prior authorization .

A State official noted that although four of five MyCare Ohio plans are national plans with experience managing long-term care in other State Medicaid programs, their experience did not always transfer to the unique requirements of MyCare Ohio. The State's requirement for plans to contract with AAAs to coordinate HCBS waiver services for the over-60 population (see ***Section 1.2, Model Description and Demonstration Goals***) was, in part, an effort to improve plan capacity for managing LTSS.

2.2.2 Provider Arrangements and Services

LTSS and Behavioral Health Services

MyCare Ohio plans' lack of experience in handling LTSS and behavioral health claims in Ohio, combined with Ohio LTSS and behavioral health providers' lack of experience with health plan billing systems, led to lengthy payment delays for these providers in the demonstration's first year.

Nursing facilities. Plans and providers concurred that paying Medicaid nursing facility claims is considerably more complex than paying for Medicare skilled nursing facility benefits, which is what Medicare Advantage plans are accustomed to paying. Medicaid claims have multiple unique nuances, such as payment for bed holds and variable payment rates based on resident acuity levels. MyCare Ohio plans said that they did not expect to see the nuanced coding in nursing facility claims and, at the same time, nursing facilities were not submitting claims according to commercial insurance standards.

As a result, payment of claims at times was delayed for several months while the plans and the providers attempted to reconcile their differences over specific individual claims. Nursing facilities were accustomed to being paid by Medicaid within a week of submitting a claim; however, performance standards specified in the three-way contract give MMPs 30 days to pay 90 percent of all "clean" claims. And according to both plans and providers, some nursing facility claims would not have been considered "clean" because of coding disagreements. After several months of demonstration implementation, at least one MyCare Ohio plan provided cash advances to nursing facility providers while it was trying to fix its payment system. MyCare Ohio plans have made significant changes to their information technology (IT) systems to adjudicate LTSS claims.

[10] http://www.mcgregorpace.org

[11] https://q1medicare.com/PartD-SearchMA-Medicare-2017PlanFinder.php#results

HCBS/independent home care providers. A MyCare Ohio plan representative noted that prior to the demonstration, the plan also had not covered HCBS services; thus, it had to make significant modifications to its claims payment system to incorporate these services. Payments to independent, non-agency HCBS providers presented additional challenges.

At the start of the demonstration, Ohio had approximately 10,000 nonagency independent providers (IPs) who were delivering home care (mainly HCBS waiver services) as independent contractors paid by ODM. Many independent providers relied on a private billing company to submit claims on their behalf to Medicaid, but the company chose not to continue to provide that service under MyCare Ohio and ceased operations. This coincided with the implementation of MyCare Ohio. Independent providers were accustomed to submitting handwritten notices of work performed on behalf of Medicaid enrollees to the billing agent, who would turn the information into a legitimate claim that would be filed with ODM. Without their billing agent, the independent providers did not know how to get paid. And with the implementation of MyCare Ohio, these workers would no longer be paid by ODM but instead through MyCare Ohio plans.

At first, the inability of these low-income providers to bill MyCare Ohio for their services to beneficiaries went undetected and continued for almost a month before the problem reached a critical stage. When numerous press reports suddenly documented the plight of workers not being paid and of the low-income Medicaid beneficiaries who were not receiving vital services, the issue became tied to implementation of MyCare Ohio. All interviewees agreed that this incident had a very detrimental effect on the public's perception of MyCare Ohio in the early stages of the demonstration.

To address long-term care payment challenges, MyCare Ohio plans formed a long-term care collaborative for institutional LTSS providers and their associations, as well as a Home Care and Hospice Collaborative. According to ODM staff, the collaborative was an outgrowth of the MyCare Ohio Implementation Team led by the State. ODM representatives did not participate in the collaborative at the outset, but said they participated as needed; they became involved in Fall 2014 and participated periodically during subsequent months.

As a result of these efforts, State officials, stakeholders, and plan staff agreed that the early systemic problems associated with nursing facility and independent home care providers' claims payment eventually were resolved in 2015. According to a provider stakeholder, the LTSS collaborative meetings were discontinued in 2016, and now LTSS provider representatives meet regularly with individual MyCare Ohio plans to address remaining issues. For example, State officials, plan representatives, and providers reported continuing discrepancies between ODM and county data reported to MMPs on required enrollee contributions to nursing facility payments. ODM staff reported that the issue is not specific to the demonstration but rather is a broader Medicaid challenge that the State continues to address. The stakeholder reported that MyCare Ohio plans now generally are paying nursing facility claims within the required 30-day deadline for clean claims, but sometimes, individual plans miss the deadline in paying some or all providers.

Behavioral health care. Because behavioral health was not previously included in Medicaid managed care, behavioral health providers lacked experience billing health plans and

were using billing codes that were inconsistent with commonly accepted billing standards. Likewise, health plans did not have experience working with behavioral health providers serving the Medicaid populations, and their IT systems were not prepared to recognize the mix of services delivered by behavioral health providers. As a result, many behavioral health claims could not be processed electronically, and payments were delayed significantly.

To resolve numerous technical and payment-related challenges, MyCare Ohio plans and behavioral health providers used the same model that had been used effectively for LTSS: they formed a behavioral health collaborative in January 2015. As the State transitions Medicaid financing for all behavioral health services from FFS to managed care (see ***Section 1.4.3, Behavioral Health Care System***), State officials, plans, and providers commented that many of the policy and process barriers to integration of behavioral health service delivery and payment should be resolved by broader Medicaid policy.

As of December 2016, the behavioral health collaborative was continuing to meet and was focused largely on redesign of the Medicaid behavioral health care system and medication-assisted treatment for opioid addiction. A provider stakeholder reported that the collaborative also is addressing some remaining claims payment challenges associated with the demonstration.

Primary Care Providers

Although the three-way contract states that primary care physicians (PCPs) will be included in transdisciplinary care teams (see ***Section 4.1.2, Care Planning Process***), lack of engagement among PCPs has continued to be a challenge throughout the demonstration. When asked about PCPs' participation in care plan meetings, an ODM official reported that "It's not happening on a widespread basis." One plan representative commented that low PCP engagement is a broader issue affecting Ohio Medicaid, noting that "being actively engaged in the Medicaid member's care is still a new concept" for them.

ODM staff believed that PCPs are aware of the demonstration. However, State officials reported that PCPs often do not communicate with MyCare Ohio care managers or respond to their messages. State and CMS officials, MyCare Ohio plan staff, and enrollee representatives mentioned a variety of factors contributing to PCPs' lack of engagement: perceived administrative burden; lack of ongoing relationships with demonstration enrollees; perceived inadequacy of payment rates; payment delays; and reluctance to devote time to an initiative that affects a small portion of their patients. Additionally, one State official commented that Ohio Medicaid is participating in the Comprehensive Primary Care initiative, and PCPs view the expectation that they will engage in the health risk assessment process required under the demonstration as an added burden in light of the assessment process they undertake at the practice level as part of that initiative.

MyCare Ohio plans have pursued several strategies to increase PCP involvement. Staff of one plan said they try to increase the efficiency and effectiveness of PCP communications by providing phone updates on several patients at a time rather than individually, and by faxing rather than mailing requests for care plan review and approval. The plan's provider representatives make quarterly outreach visits to PCP offices with high volumes of MyCare Ohio members to explain the demonstration's care coordination services. Another plan sends provider engagement teams—comprised of the medical director and other providers, as well as quality

improvement and case management staff—to meet with large PCP practices. This plan also has conducted "learning breakfasts" for PCP office staff to discuss effective hypertension treatment.

Continuity-of-Care

MyCare Ohio plans must demonstrate that they have provider networks sufficient in number, mix, and geographic distribution to ensure adequate enrollee access to medical, behavioral health, pharmacy, and LTSS providers for all covered services (Ohio three-way contract, 2016, p. 64). Additionally, plans must allow Medicare-Medicaid beneficiaries to maintain their providers and service levels at the time of enrollment, through a specified transition period (Ohio three-way contract, 2016, p. 59). ODM officials reported that the transition period was 1 year for most services, and because of the challenges in payment for behavioral health services, the continuity-of-care period for behavioral health services was extended to 18 months.

State officials anticipated that they might see an increased number of grievances and appeals as the continuity-of-care provisions expired and enrollees lost access to their previous providers. However, MMP representatives interviewed in 2016 indicated that they have not observed such a trend. They said they had maintained the broad networks used at the outset of the demonstration and generally have not engaged in selective contracting with providers; thus, the vast majority of enrollees have continued to receive care from the providers they had prior to the demonstration. As noted below, some MMPs are planning to begin selective contracting arrangements in 2017.

A plan representative commented that terminating contracts with providers who have formed personal relationships with enrollees leads to member dissatisfaction. Therefore, rather than seeking efficiencies through selective provider contracting, the plan has looked for ways to contract selectively for items and services that do not affect members personally:

> An emergency response system (ERS) provider is not something quite as personal a relation as a nurse, so a person on a waiver, they've had the same nurse for 10 years maybe. [If you tell the enrollee that] "Susie can't come. We're going to provide you another provider," that's a big deal. But to say we're going to switch out this box for another box, we're going to choose some savings, they get the same service level, we're all good.

The plan reported that by switching to a single preferred provider for ERS services, it had achieved more than $500,000 in savings in 2016.

Selective Contracting

During the December 2016 site visit, staff of two MyCare Ohio plans said they had begun preliminary planning for selective contracting with some types of providers. One plan was beginning to evaluate the performance of nursing facilities, post-acute care providers, and home health agencies, for the purpose of selectively contracting with those identified as delivering high-quality care. Another MMP was planning to evaluate home care agencies' performance in reducing preventable emergency room use and enter into selective, value-based contracting arrangements with high-performing entities.

Value-Based Purchasing

MyCare Ohio plans indicated that they continue to pay the vast majority of network providers (for medical care, LTSS, and behavioral health services) on a FFS basis. ODM staff said that expanding use of value-based payments for LTSS was an important goal for the remainder of the demonstration. Two MyCare Ohio plans reported limited use of value-based payment models for LTSS and primary care, and a third described more extensive use of innovative payment systems. One plan has a pay-for-performance program that rewards AAAs for meeting contract requirements for care management (e.g., conducting an HRA, developing a comprehensive waiver service plan, following the required enrollee contact schedule, following up in a timely manner after significant health events). Two plans have a pay-for-performance initiative that rewards PCPs for achieving Healthcare Effectiveness Data and Information Set (HEDIS) benchmarks (e.g., for breast and colon cancer screening and diabetes care).

Staff of another MyCare Ohio plan reported that value-based arrangements now account for more than 25 percent of claims payments across all lines of business. In Fall 2016, the plan implemented value-based payment arrangements with several nursing facilities that use capitated payments with a quality withhold associated with clinical quality measures (e.g., for falls, catheter use, skin integrity). In 2017, the plan intends to launch three additional initiatives affecting MyCare Ohio enrollees: two will be implemented in nursing facilities; the third will provide value-based payments to patient-centered medical home (PCMH) providers delivering care in a community residential setting that provides support services such as therapeutic recreation and social network opportunities.

2.2.3 Training and Support for Providers

MyCare Ohio plans have provided training and support in a variety of ways to educate providers, particularly independent HCBS providers, about billing and other aspects of the demonstration's operations. During the demonstration's first year, plan representatives provided training to independent providers on evenings, weekends, online, through teleconferences, on videos, as well as in-person in MyCare Ohio plan offices and hotels. One plan set up a "MyCare Concierge" within its provider services team to answer MyCare Ohio providers' questions (particularly questions from independent providers) and to resolve claims payment challenges.

One plan reported that it provided open office hours in all regions during the demonstration's first year, to help educate representatives of hospitals, nursing facilities, independent providers, smaller home care providers, and assisted living providers. The meetings provided an opportunity for providers to connect with provider relations and claims payment staff, and others who could help providers resolve challenges.

2.3 Major Areas of Integration

2.3.1 Integrated Benefits and Enrollment

As discussed in ***Section 1.2, Model Description and Demonstration Goals***, demonstration enrollees receive the same Medicare and Medicaid benefits they received before the demonstration, with the addition of care coordination, a broader array of Medicaid HCBS

services than were previously available through any single HCBS waiver, and a variety of value-added benefits such as enhanced transportation, dental, and vision care.

Enrollment in MyCare Ohio was conducted in two phases. Phase 1, which began May 1, 2014, was limited to opt-in enrollment and rolled out across demonstration counties over a 3-month period. In Phase 2, which began in January 1, 2015, beneficiaries were passively enrolled (Ohio three-way contract, 2014, p. 22). Passive enrollment has continued on a monthly basis thereafter. As of December 2016, approximately 69,331 beneficiaries were enrolled in the demonstration (RTI, SDRS, 2016) out of an estimated total of 100,816 who were eligible (see ***Section 3, Eligibility and Enrollment***).

2.3.2 Integrated Care Coordination and Care Planning

Care management is a central function of MyCare Ohio, and plans are required to provide care management services to all enrollees through transdisciplinary care teams, led by a care manager. Care teams are charged with developing, managing, and coordinating enrollees' individualized care plans, which must address the entirety of enrollees' clinical and nonclinical needs (see ***Section 4, Care Coordination***).

2.3.3 Integrated Quality Management

The MyCare Ohio quality management framework includes four primary activities: joint monitoring and oversight by the State and CMS, external quality review activities conducted by the External Quality Review Organization and the Quality Improvement Organization, quality and performance improvement initiatives undertaken by the plans, and quality reporting and measurement. The CMT plays an integral role in each of these activities (see ***Section 9, Quality of Care***).

2.3.4 Integrated Financing

All services covered under the demonstration are paid for using prospective capitated payments to MyCare Ohio plans. The monthly capitated rates that plans receive for each beneficiary consist of three separate components: one that covers Medicare Parts A and B services, a second that covers Medicare Part D services, and a third that covers Medicaid services (Ohio three-way contract, 2014, pp. 125–41). Each component is risk-adjusted, and the Medicare Parts A and B and Medicaid payments reflect the application of savings percentages and quality withholds that increase in each demonstration year (see ***Section 7, Financing and Payment***).

3. Eligibility and Enrollment

Highlights

- Of the more than 100,000 Medicare-Medicaid beneficiaries eligible for MyCare Ohio, approximately 69,000, or 69 percent, had enrolled in the capitated model demonstration as of December 2016.
- During the demonstration's first year, the State reported significant challenges in the process of reconciling discrepancies among ODM, CMS, and county enrollment systems. ODM staff made system modifications and developed efficiencies in the reconciliation process, and subsequently, most enrollment systems challenges have been resolved.
- After finding a disproportionate rate of opt-outs among nursing facility residents and 100 percent opt-outs in some facilities, the State changed the required procedures for opting out, and it planned to re-enroll beneficiaries in facilities that had opted out all of their residents.

3.1 Introduction

This section provides an overview of enrollment issues associated with the MyCare Ohio demonstration. Eligibility, enrollment phases, and the passive enrollment process are described. We also present eligibility and enrollment data and discuss the passive enrollment experience, factors affecting enrollment decisions, and MyCare Ohio plan experiences with contacting and locating enrollees.

3.2 Enrollment Process

3.2.1 Eligibility

Individuals eligible for the demonstration are full-benefit Medicare-Medicaid beneficiaries age 18 and older. The following groups are not eligible to enroll: individuals with intellectual disabilities and other developmental disabilities (IDD) who are served through an IDD 1915(c) home and community-based services (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.

In August 2016, ODM implemented the State option to automatically enroll Supplemental Security Income (SSI) beneficiaries into Medicaid (Section 1634 of the Social Security Act), which raised the income and asset limits for Medicaid and increased enrollment in MyCare Ohio. Under the previous policy (Section 209(b)), Ohio had used more restrictive financial criteria than SSI. SSI beneficiaries had to apply for Medicaid at the county offices, and

some beneficiaries were required to use a spend-down to qualify for Medicaid. The long-term impact of this change on enrollment in the demonstration has yet to be determined.

3.2.2 Phases of Enrollment

Initial enrollment in MyCare Ohio was implemented in two phases (see ***Table 3*** for more detailed information on Ohio's phased approach). Phase 1, which began on May 1, 2014, was limited to opt-in enrollment and rolled out across demonstration counties over a 3-month period. Concurrently, and on the same schedule, Medicare-Medicaid enrollees who had not selected a plan for integrated Medicare and Medicaid benefits were passively enrolled in MyCare Ohio plans for Medicaid benefits only.

State officials initially planned to passively enroll Medicare-Medicaid beneficiaries into MyCare Ohio plans for both Medicare and Medicaid benefits simultaneously, following a 1-month opt-in period. However, the State chose to change course when it discovered that one of the plans selected through the procurement process had a Low Performing Icon (LPI) designation, prohibiting passive enrollment into the plan. Given the plan's corporate structure, its Medicare Advantage (MA) Star Rating reflected its performance in all States in which it operated, and Ohio was unaware of the plan's LPI status during the review of requests for proposals (RFPs). As a result, Ohio decided to delay passive enrollment into any Medicare-Medicaid Plan (MMP), because CMS rules require that to implement passive enrollment for Medicare benefits, at least two plans must be available to beneficiaries. The plan's LPI subsequently was removed, making it eligible to receive passive enrollments for Medicare benefits effective January 2015.

The State identified eligible beneficiaries by county of residence and sent the first of three enrollment letters approximately 90 days prior to the effective enrollment date. Ohio opted to send this letter to give beneficiaries early and additional notification of the upcoming passive enrollment and the beneficiary's opportunity to change plans. The State sent a second enrollment letter approximately 65 days before enrollment for Medicaid benefits. Approximately 60 days before each regional rollout date, beneficiaries in demonstration counties were able to submit requests to opt into the demonstration, with enrollments taking effect on the applicable regional rollout date. Beneficiaries who did not make a selection received a second notification roughly 30 days before mandatory passive enrollment into a plan for Medicaid benefits. The second notification included the name of the plan that the individual would be enrolled in if the individual did not choose otherwise.

Beneficiaries who had not previously opted into or out of the demonstration were passively enrolled in Phase 2. During Phase 2 and throughout the demonstration, beneficiaries are also able to opt out of passive enrollment before their effective enrollment date, and disenroll from the demonstration at any time, effective the first day of the following month. Those who opt out or disenroll return to Medicare FFS or MA plans for Medicare services, but they are required to be enrolled in MyCare Ohio plans to receive Medicaid benefits (see ***Section 1.2, Model Description and Demonstration Goals***).

Table 3
MyCare Ohio phased demonstration enrollment plan

Characteristic	Phase 1	Phase 2
Start date	May 1, 2014	January 1, 2015
Target population	All eligible beneficiaries	All beneficiaries eligible for passive enrollment
Geographic area	All demonstration counties	All demonstration counties
Demonstration enrollment method	Opt-in enrollment	Passive enrollment
Gradual rollout	Regional • May 1, 2014: Northeast • June 1, 2014: Northeast Central, Northwest, and Southwest • July 1, 2014: Central, East Central, and West Central	N/A

The passive enrollment methodology for the demonstration was similar to the process used to enroll beneficiaries into a MyCare Ohio plan for Medicaid benefits, including similar 60- and 30-day notice requirements (Ohio three-way contract, 2014, p. 22). Beneficiaries who did not select a plan were assigned to one, using a multi-step "intelligent assignment" algorithm with the following hierarchy:

- Historical MA enrollment (Part C and Part D)
- Historical Medicaid managed care enrollment
- Claims/utilization history matched to a MyCare provider network
- Random round-robin assignment (i.e., an ABABAB pattern in regions with two plans and an ABCABCABC pattern in the Northeast, where there are three plans)

State officials said that their intent in designing the methodology was to prioritize existing relationships to prevent—or at least minimize—disruption in care. Beneficiaries were placed in a plan at random only if no prior history could be established. The State expected the intelligent assignment process to result in beneficiaries being passively enrolled into the same MyCare Ohio plan that they were passively enrolled in for Medicaid benefits. The State also attempted to maintain existing provider relationships by matching historical provider utilization claims with the plans' provider networks.

Since completing Phase 2, Ohio has conducted passive enrollment on a monthly basis.[12] State officials said that conducting monthly passive enrollment has helped maintain total

[12] Monthly passive enrollment has continued throughout the demonstration, except that there are no passive enrollments with December effective dates. ODM indicated that this exception is intended to accommodate CMS's January enrollment process.

enrollment in the demonstration, which might have otherwise declined due to opt-outs, voluntary disenrollments, and disenrollments due to loss of Medicaid.

In April 2016, the State implemented retroactive re-enrollment into Medicaid managed care, to complement its policy of making Medicaid coverage retroactive for up to 3 months when beneficiaries lose and then regain Medicaid eligibility. Prior to April 2016, the State enrolled beneficiaries in FFS Medicaid during the months of eligibility gap. State officials commented that this practice "create[d] lots of havoc for the managed care enrollment." They said it was especially problematic to place MyCare Ohio HCBS waiver participants temporarily into FFS, because it was difficult to transition to them into one of the legacy HCBS waivers (see ***Section 1.2, Model Description and Demonstration Goals***) without interrupting their services and payments to their HCBS providers. By re-enrolling beneficiaries concurrently into both Medicaid managed care and their MyCare Ohio plan, those problems can be avoided.

3.2.3 Passive Enrollment Experience

More than 76,000 beneficiaries—primarily beneficiaries who were enrolled in MyCare Ohio plans for Medicaid benefits only—received passive enrollment notices in November 2014; 50,553 of them, or 66 percent, accepted enrollment into their assigned Medicare-Medicaid plans, effective January 1, 2015. The remaining 26,046, or 34 percent, chose to opt out of enrollment into Medicare-Medicaid plans and remain in Medicaid-only plans.

Some stakeholders said that the long opt-in enrollment period prior to passive enrollment was positive because it allowed State officials and plans to identify areas of improvement before full-scale implementation in January 2015. However, MMP staff reported that during the opt-in period, some beneficiaries were confused about which benefits their plans covered because they had received notices about Medicare-Medicaid integration, but they were passively enrolled into MyCare Ohio plans that covered their Medicaid benefits only, pursuant to the State's implementation of a mandatory Medicaid managed care delivery system for Medicare-Medicaid enrollees.

State officials, plans, and enrollee stakeholders reported additional confusion among beneficiaries in Fall 2014, when individuals scheduled for passive enrollment in January 2015 received disenrollment notices from their Part D prescription drug plans before they received MyCare Ohio passive enrollment notices from the State. Interviewees noted that the disenrollment letters included stock language indicating that the beneficiary had chosen to disenroll rather than explaining that they were being passively enrolled into a new plan. In 2015, State officials indicated that letters had been changed to assure enrollees that even though they were being disenrolled from their Medicare Part D plan, they were not going to lose their benefits.

State officials also discussed specific challenges created by the timing of the Medicare plan disenrollment letters. ODM had planned to stagger its passive enrollment notifications so as to stagger the number of calls to the consumer hotline expected as a result of the notices. However, all 60-day enrollment notifications had to be sent at the same time because they needed to reach beneficiaries before the MA and Medicare Part D disenrollment letters arrived. One State official expressed frustration that one combined letter was not sent to beneficiaries,

observing that an integrated system should not require separate letters from Medicare and Medicaid.

In 2015, ODM said that in response to concern that the many required notices were confusing to demonstration enrollees, CMS anticipated updating the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance to reduce the volume of notices for all capitated model demonstrations under the FAI (CMS did make these updates, effective January 1, 2017). State officials said they had tried to reduce the amount even further. CMS officials said they continue to review such requests from Ohio and other States. The large wave of passive enrollment that occurred in January 2015 presented operational challenges for MMPs. For example, one MMP representative commented that "…when you get 20,000 members [on] Day 1 and you have lots of assessment timeframes…that presents lots of challenges." See ***Section 4.1.1, Assessment,*** for additional discussion on this issue.

3.2.4 Integration of Medicare and Medicaid Enrollment Systems

Enrollment Broker

Ohio Medicaid modified the contract of its existing Medicaid managed care enrollment broker, Automated Health Systems (AHS), to administer enrollment for MyCare Ohio. AHS manages the enrollment process and the Ohio Medicaid Consumer Hotline. Any customer service representative can assist MyCare Ohio enrollees; however, dedicated enrollment staff were assigned for MyCare Ohio enrollees, and a MyCare Ohio-specific option was added to the consumer hotline's automated menu (i.e., "If you are calling about MyCare Ohio, press 1").

AHS is the only entity that can enroll beneficiaries in the demonstration; calls to 1-800-MEDICARE for enrollment in a MyCare Ohio plan are referred to AHS (Ohio three-way contract, 2014, p. 25). However, beneficiaries are able to initiate a disenrollment through either the Ohio Medicaid Consumer Hotline or 1-800-MEDICARE. State officials discussed challenges in building their system to handle transactions from both points of contact, comparing the process to that of putting together a puzzle. State officials discussed cases, although rare, in which beneficiaries have called both the Medicaid and Medicare hotlines (or even other consumer agencies, including the Ohio Senior Health Insurance Information Program [OSHIIP]) multiple times on the same day, which resulted in conflicting transactions.

AHS worked closely with Hewlett-Packard DXC, the information technology (IT) vendor charged with building and maintaining the State's enrollment system. State officials reported challenges in modifying the State's enrollment system to interface with CMS's systems. They described errors that resulted from miscommunications between the State and CMS and inadequate testing before launch. State staff indicated that significant time and cost were associated with integrating the State's enrollment system with CMS's system.

Enrollment Transactions

Beneficiaries enrolled in the demonstration can make enrollment changes at any time, effective at the end of the month. Although the three-way contract stipulates that only enrollments received 5 days or more before the end of a month are required to become effective on the first day of the following month (Ohio three-way contract, 2014, p. 21), the State is

processing any transaction up to the last day of the month (e.g., an October 31 transaction becomes effective November 1). Because an enrollment notice is not sent to the plans until the transaction is successfully processed in the CMS Daily Transaction Reply Report (DTRR), there may be a lag between an individual's effective enrollment date and notification to a plan of beneficiary coverage, which can create billing problems for plans and providers. Several plans discussed receiving enrollment files for beneficiaries who had already changed plans.

Although State officials praised the daily eligibility file transfers from CMS, the time it takes to process the DTRR files resulted in some misalignment between the State's enrollment system and the CMS enrollment system. State officials noted that enrollment requests pend until they are received and approved by CMS. However, beneficiaries are still able to call and initiate new transactions during that time, which are then queued behind the request that is already pending. According to the State, one beneficiary initiated as many as seven transactions (e.g., opted in, voluntarily disenrolled, opted back in) before enrollment was effective at the end of the month. Although such situations are rare, State officials said that early in the demonstration, MyCare Ohio was the most resource-intensive and time-consuming contract for the State's IT vendor (Hewlett-Packard) and the Medicaid consumer hotline. ODM staff reported that the number of demonstration-related calls declined significantly following the initial rollout.

Enrollment Discrepancies

ODM staff reported that early in the demonstration, there were hundreds of enrollment discrepancies each month due to misalignment between Medicare and Medicaid enrollment systems. State officials cited examples such as Medicare and Medicaid systems showing the same beneficiary enrolled in two different plans, as well as cases in which the Medicare system showed a beneficiary enrolled in Medicare and Medicaid, whereas the ODM system showed the individual as enrolled in Medicaid only.

According to State officials, some of the challenges with Medicare and Medicaid enrollment systems occurred because ODM did not have the opportunity to test interactions between Medicare and Medicaid systems prior to the demonstration's launch. ODM staff reported that early in the demonstration, they spent a lot of time analyzing enrollment discrepancies and developing manual workarounds. Subsequently they formed an enrollment reconciliation team, which worked to streamline and systematize the process. Additionally, ODM made system modifications to reduce errors. According to State officials, most problems were resolved during the demonstration's first year, and final cleanup was completed in the Summer of 2016. ODM representatives estimated in December 2016 that the number of enrollment discrepancies between CMS and State Medicaid systems had been reduced to between 20 and 30 per month.

According to ODM staff, enrollment system challenges have also occurred when erroneous or incomplete information is provided and/or entered during the Medicaid eligibility process, which is conducted at the county level. State officials reported that beginning in August 2016, Medicare-Medicaid enrollees were given access to Ohio Benefits, a statewide system allowing residents to check eligibility and apply for a variety of public program benefits through an online portal. County staff are responsible for checking the information for accuracy and completeness, and ODM representatives said the capacity of county eligibility workers varies.

ODM maintains a county compliance team to reconcile inconsistencies and facilitate enrollment of Medicare-Medicaid beneficiaries in the demonstration.

In addition to challenges in reconciling State, CMS, and county data, State officials reported an ongoing ODM systems challenge that has caused some beneficiaries to be identified as being simultaneously enrolled in both the MyCare Ohio waiver and one of the five legacy HCBS waivers. ODM staff said they have developed a manual workaround to correct the error each month.

3.2.5 Contacting and Locating Enrollees

As noted in ***Section 4.1.1***, MMPs are required to conduct HRAs for all enrollees within 15 to 75 days, depending on risk stratification level.[13] During each site visit, State officials and MMP staff discussed difficulties that plans face in physically locating enrollees to conduct initial assessments because of incomplete or erroneous contact information. One State official noted that this issue was not unusual for the Medicaid population. MMPs have experienced the greatest challenges in locating and conducting HRAs for enrollees in the community well category, who do not have ongoing contact with providers.

As indicated in ***Table 4***, the percent of enrollees whom plans were unable to locate has increased during the first demonstration period. In the last quarter of 2014, MMPs were unable to locate 5.3 percent of enrollees. In 2015, after passive enrollment began, plans were unable to reach between 5 and 15 percent of enrollees, and in 2016, this ranged from 14 to 21 percent. MMP strategies to find enrollees for the purpose of conducting HRAs are described in ***Section 4.1.1.***

Table 4
Percentage of enrollees that MyCare Ohio plans were unable to locate following three attempts, within 90 days of enrollment

Quarter	CY 2014	CY 2015	CY 2016
Q1	—	5.4%	14.2%
Q2	—	12.1%	17.5%
Q3	4.4%	9.2%	16.4%
Q4	5.3%	15.4%	21.1%

— = not available; CY = calendar year.

NOTES: The MyCare Ohio demonstration began May 1, 2014. The first available quarter of data for this measure was Quarter 3, 2014.

SOURCE: RTI analysis of MMP reported data for Core Measure 2.1, as of March 2017. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

[13] Under the revised three-way contract that became effective in October 2017, these requirements changed to allow different levels of assessment depending on beneficiaries' risk status. As noted in ***Section 1.2, Model Description and Demonstration Goals***, the next evaluation report will cover these and other changes to the care coordination model.

3.2.6 Factors Influencing Enrollment Decisions

Interviews with State officials and stakeholder groups provided insights into factors that may have influenced beneficiaries' decisions about demonstration enrollment and plan selection.

Factors Influencing Decisions about Demonstration Enrollment

State officials said beneficiaries were receptive to enrollment in the demonstration due to the State's long history with Medicaid managed care (see ***Section 1.4, Overview of State Context***). According to ODM staff, many beneficiaries believed that a health plan membership card does not carry the stigma associated with a Medicaid card.

When Ohio mailed passive enrollment notices for the demonstration in the Fall of 2014, the affected population was already enrolled in MyCare plans Ohio for Medicaid services, and typically received notices assigning them to a Medicare-Medicaid Plan operated by the same company as their Medicaid-only plan. A State official said that mandatory Medicaid managed care enrollment "greatly helped [the demonstration] and made it much more robust."

According to State officials and stakeholders, provider networks were probably not a significant factor affecting demonstration enrollment or plan selection, because MMPs tried to include all providers who served the Medicare-Medicaid beneficiaries in their networks (see ***Section 2.2.2, Provider Arrangements and Services***). A beneficiary stakeholder noted that most beneficiaries use physicians affiliated with major health systems, and all of the MyCare Ohio plans contracted with all of the major health systems.

Factors Influencing Selection of Plans

Beneficiaries' previous experiences with managed care may have influenced their choice of plans as well as decisions about enrolling in the demonstration, according to State officials. During the October 2014 site visit, State officials said that one MyCare plan with roots in Ohio and experience with Ohio Medicaid had attracted 44 percent of opt-in enrollments, although enrollment was more evenly distributed among plans after passive enrollment.

A beneficiary stakeholder group representative said that the group advised beneficiaries to consider plans' value-added benefits, such as supplemental transportation and coverage of over-the-counter drug products (see ***Section 1.2, Model Description and Demonstration Goals***) when choosing a plan. For example, the stakeholder noted that one MMP provides unlimited medical transportation, while other plans' value-added transportation benefits have limits.

Opt-outs among Nursing Facility Residents

Opt-outs by nursing facility residents have been a significant concern for ODM, CMS, and MMPs. During the December 2015 site visit, State officials and MyCare Ohio plan representatives reported that the opt-out rate among nursing facility residents was over 50 percent, compared to about 30 percent for all of MyCare. In some cases, all Medicare-Medicaid beneficiaries in a nursing facility opted out on the same day. A MyCare Ohio plan referred these cases to the ombudsman's office, which investigated the issue and filed complaints with the State Health Department. Subsequently, CMS and the State agreed that in January 2017, they would passively enroll all of the approximately 250 eligible residents of 13 facilities which had opted

out 100 percent of their eligible residents. While the nursing facility residents retain the right to opt-out again or disenroll, they will be required to contact the enrollment broker directly to do so, rather than opting out via fax or online.

3.3 Summary Data

When the opt-in phase of enrollment ended on December 31, 2014, there were 16,007 beneficiaries enrolled in the demonstration, or 17.2 percent of eligible beneficiaries, as shown below in ***Table 5***. In calendar year 2015, enrollment increased by over 44,000 beneficiaries, and the rate of demonstration enrollment increased to 66.4 percent. The enrollment rate increased slightly in the following calendar year and reached 68.8 percent in December 2016.

Table 5
Demonstration enrollment

Enrollment indicator	Number of beneficiaries		
	December 2014	December 2015	December 2016
Eligibility			
Beneficiaries eligible to participate in the demonstration as of the end of the month	92,994	90,811	100,816
Enrollment			
Beneficiaries currently enrolled in the demonstration at the end of the month	16,007	60,321	69,331
Percentage enrolled			
Percentage of eligible beneficiaries enrolled in the demonstration at the end of the month	17.2%	66.4%	68.8%

SOURCE: RTI International: State Data Reporting System (SDRS), 2015 and 2016.

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4. Care Coordination

Highlights

- Under MyCare Ohio, each enrollee has a care manager to coordinate all medical, long-term services and supports (LTSS), and behavioral health services.
- ODM, enrollee, and provider representatives believed that care management has improved during the demonstration, but that it has not reached its full potential. They identified needs for improvement in person-centered care planning, information sharing, and the performance of care managers.
- Ohio Medicaid officials believed that health risk assessment (HRA) requirements have led Medicare-Medicaid Plans (MMPs) to focus more on meeting compliance deadlines than on addressing enrollee needs. Therefore, the State proposed a change to the demonstration's care coordination model to streamline the HRA process.
- MyCare Ohio plans are conducting a variety of initiatives with hospitals to promote effective care transitions and reduce preventable readmissions.

4.1 Care Coordination Model

Care management is a central function of MyCare Ohio, and plans are required to provide care management services to all enrollees through transdisciplinary care teams. Generally, care management structures and processes are set forth in the three-way contract. Aside from ensuring that plans' care management models are person-centered, promote enrollees' ability to live independently, and coordinate the full set of Medicare and Medicaid benefits (including medical, behavioral health, LTSS, and social support services), State officials gave the plans considerable flexibility in designing their care management processes (Ohio three-way contract, 2014, p. 31).

This section provides an overview of the demonstration requirements related to the care coordination function, including assessment processes and HRA rates; use of transdisciplinary care teams and the development of care plans; and delivery of care coordination services at the plan level. The section also includes a discussion of health information exchange to promote care coordination.

4.1.1 Assessment

After a beneficiary enrolls in a MyCare Ohio plan, the plan is required to assign the enrollee to one of five risk tiers (see ***Section 4.1.2, Care Planning Process***) using predictive modeling, waiver enrollment status, nursing/assisted living facility placement, claims data, and other relevant information as available. The State provides plans with an enrollee's historical Medicaid claims data and legacy waiver service plans to facilitate this process. Some plans also receive historical Medicare data from CMS. There is no set time frame for when plans assign an enrollee to his or her care manager.

MyCare Ohio plan care managers are required to conduct comprehensive health risk assessments for all enrollees within time frames that vary depending on the individual's risk stratification level. The timing for HRAs ranges from 15 days for enrollees in the intensive tier to 75 days for enrollees assigned to the monitoring and low tiers (Ohio three-way contract, 2014, pp. 34–5). Assessments must be completed in-person for individuals assigned to the high and intensive tiers; plans may conduct assessments by telephone for individuals in the monitoring, low, and medium tiers (Ohio three-way contract, 2014, p. 35). Annual reassessments must be completed for all enrollees. ODM officials reported that plans can leverage information gathered from other organizations (e.g., Area Agencies on Aging [AAAs], nursing facilities, and patient-centered medical home practices [PCMH practices]) in completing HRAs. The CMT found early in the demonstration that plans were not meeting HRA requirements; therefore, in November 2014, it established performance improvement plans (see ***Section 2.1***) requiring MMPs to complete HRAs within 90 days of enrollment for at least 80 percent of beneficiaries who were not documented as unreachable or unwilling to participate. Some of the requirements noted above were amended in October of 2017, outside the period covered in this report. A future report will explore these changes in detail.

Plans have used a variety of strategies to meet the requirements for HRA completion. For example, two plans reported that they conduct unannounced "drive-by" visits to enrollees' homes. One plan created a member locator team composed of four full-time staff who search probate court records; review obituaries; and contact home health, durable medical equipment, pharmacy, and other providers. In another plan, outreach staff use Lexis/Nexis to search for updated enrollee phone numbers; seek contact information from the plan's call center; visit providers' and pharmacy offices; search for enrollees in homeless shelters; and review census lists of hospitals and emergency rooms.

ODM staff reported that after all plans met the 80 percent benchmark in late 2016, the improvement plans were discontinued in October 2016 (see ***Table 6***).

Table 6
Enrollees whose assessment was completed within 90 days of enrollment

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Assessment completed within 90 days of enrollment %	
		All enrollees	All enrollees not documented as unreachable or unwilling to participate
2014			
Q3	10,333	56.1%	59.1%
Q4	1,899	63.6%	67.7%
2015			
Q1	46,901	69.8%	74.8%
Q2	5,390	63.5%	73.4%
Q3	4,377	66.9%	75.0%
Q4	4,905	64.0%	77.9%

(continued)

Table 6 (continued)
Enrollees whose assessment was completed within 90 days of enrollment

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Assessment completed within 90 days of enrollment %	
		All enrollees	All enrollees not documented as unreachable or unwilling to participate
2016			
Q1	4,598	68.0%	82.1%
Q2	5,690	65.2%	82.0%
Q3	4,943	64.3%	79.9%
Q4	4,778	63.0%	82.9%

NOTES: The MyCare Ohio demonstration began May 1, 2014. The first available quarter of data for this measure was Quarter 3, 2014.

SOURCE: RTI analysis of MMP reported data for Core Measure 2.1, as of March 2017. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html

4.1.2 Care Planning Process

The Transdisciplinary Care Team

MyCare Ohio plans are required to provide each enrollee with a transdisciplinary care team, charged with developing, managing, and coordinating an enrollee's individualized care plan. Although the exact structure of the team varies based on an enrollee's specific needs and preferences, the three-way contract requires the team to include the following individuals: the enrollee, the enrollee's family and/or caregiver(s), a care manager, a waiver service coordinator (if the enrollee receives waiver services), the enrollee's primary care provider, and any specialists/other providers as necessary and appropriate (Ohio three-way contract, 2014, p. 11).

The care manager leads the transdisciplinary care team, is the central point of accountability, and is expected to ensure the integration of all of an enrollee's medical, behavioral health, substance use, and LTSS needs. The three-way contract (2016, pp. 33–4) states that primary care physicians (PCPs) must help coordinate enrollees' care and participate in development of individualized care plans. As discussed in ***Section 2.2.2, Provider Arrangements and Services,*** State officials as well as enrollee and provider representatives reported very limited PCP engagement in the demonstration.

The three-way contract stipulates several additional responsibilities of the care manager, including implementing and updating the individualized care plan as necessary, delineating and delegating roles and responsibilities across other members of the care team, and facilitating meetings and exchange of information across care team members (Ohio three-way contract, 2014, p. 38).

Enrollees have the right to request that the plan change their care manager. The three-way contract does not include specific education or credentialing requirements for the care managers,

and plans have used a mix of registered nurses, licensed certified social workers, social workers, and nonlicensed individuals.

The Individualized Care Plan

The central feature of MyCare Ohio's care management model is the enrollee's individualized, person-centered care plan. The care plan must address the entirety of an enrollee's clinical and nonclinical needs and include specific items enumerated in the three-way contract (e.g., lists of the enrollee's providers and medications, scheduled appointments, documented referral tracking/follow-up, integrated waiver service plan) (Ohio three-way contract, 2014, pp. 6, 36–7).

Table 7 shows the proportion of MMP members with care plans within 90 days of enrollment. The percent of enrollees with care plans completed during this time frame gradually increased over the course of the demonstration. Among all enrollees, the proportion with care plans completed ranged from 20 to 50 percent in 2014, 54 to 60 percent in 2015, and 58 to 61 percent in 2016. Among all enrollees not documented as unreachable or unwilling to participate, the percentage of enrollees with a care plan completed ranged from 22 to 53 percent in 2014, 63 to 67 percent in 2015, and 70 to 78 percent in 2016.

Table 7
Members with care plans within 90 days of enrollment

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Care plan completed within 90 days of enrollment %	
		All enrollees	All enrollees not documented as unwilling to complete a care plan or un-locatable
2014			
Q2	13,341	19.6%	22.3%
Q3	10,643	39.1%	43.3%
Q4	1,929	49.5%	52.6%
2015			
Q1	46,014	57.7%	62.5%
Q2	5,694	59.7%	66.7%
Q3	4,537	55.7%	63.0%
Q4	5,178	54.3%	63.1%
2016			
Q1	4,710	57.6%	70.4%
Q2	5,953	58.2%	71.7%
Q3	5,208	60.9%	76.0%
Q4	5,262	58.8%	77.9%

NOTES: The MyCare Ohio demonstration began May 1, 2014. Quarter 2, 2014 covers data for the period of May 2014 to June 2014. All subsequent quarters contain 3 months of data.

SOURCE: RTI analysis of MMP reported data for Ohio 1.1, as of March 2017. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Ohio-Specific Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html

Among MMP members with care plans completed, the proportion of those with at least one documented discussion of care goals remained at or above 89 percent for all but one quarter of the demonstration (Quarter 2 of 2015), when it was 83 percent. The proportion peaked in the first quarter of 2015, at 95 percent (see ***Table 8***).

Table 8
Members with care plans with at least one documented discussion of care goals

Quarter	Total number of members with a care plan completed	Members with at least one documented discussion of care goals in the care plan
2014		
Q3	3,667	92.3%
Q4	3,763	90.0%
2015		
Q1	15,372	94.9%
Q2	7,189	83.1%
Q3	9,328	91.8%
Q4	6,689	91.9%
2016		
Q1	4,817	90.4%
Q2	3,780	92.4%
Q3	3,234	93.3%
Q4	4,144	89.0%

NOTES: The MyCare Ohio demonstration began May 1, 2014. The first available quarter of data for this measure was Quarter 3, 2014.

SOURCE: RTI analysis of MMP reported data for Ohio 1.2, as of March 2017. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Ohio-Specific Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

Care Coordination at the Plan Level

Risk stratification and staffing requirements. MyCare Ohio plans are required to adopt an enrollee risk stratification framework to allocate care coordination resources and set time frames for interventions based on enrollees' acuity and needs. The three-way contract describes the demonstration's model risk stratification framework, which consists of five levels: monitoring, low, medium, high, and intensive. The plans develop the criteria and thresholds for each level, which are subject to CMS and ODM approval (Ohio three-way contract, 2014, p. 33).

The three-way contract also sets minimum staffing and contact requirements for each tier.[14] Plans are required to maintain staffing levels based on the number of enrollees in each risk tier, ranging from 1:25 to 1:50 for intensive to 1:25 to 1:350 for monitoring (Ohio three-way contract, 2014, pp. 38–9). Each risk tier also has its own minimum contact schedule that prescribes how often and by what method (i.e., in-person or telephonic) a plan must contact an

[14] These requirements were revised in the three-way contract effective on October 1, 2017. Changes will be described in the next evaluation report.

enrollee for both the first 6 months after assignment into the risk tier and then throughout the remaining duration of the demonstration (Ohio three-way contract, 2014, pp. 39–40). Every enrollee must have at least one in-person visit within the first 6 months of enrollment and then annually thereafter; plans are expected to conduct monthly in-person visits with the highest-need enrollees (two visits in the first month).

Caseloads and turnover. MMP staff reported that early in the demonstration, care managers and waiver service coordinators were overwhelmed with the influx of new members and struggled to meet requirements for enrollee contacts, assessments, and care planning. Representatives of one plan said that during this period, the pressure of completing assessments within the required time frames led to high turnover among care managers.

Over time, MyCare Ohio plans have increased their care management capacity in a variety of ways. One plan reported that it had doubled the size of its care management staff. Two plans have segmented their care management workforce, so that some care managers are devoted exclusively to conducting assessments, and the remainder focus on coordination of medical care, LTSS, and behavioral health services. Another plan contracts with a vendor to conduct HRAs if new enrollment exceeds 400 in a single month. One plan supplements care management staff with community-based "extenders," who live in enrollees' neighborhoods and are knowledgeable about community resources. Extenders might accompany enrollees to doctor visits and facilitate communication.

Plans are required to report to CMS' implementation contractor (NORC) on the ratio of care coordinators to enrollees. As shown in ***Table 9***, the average member load per care coordinator across all plans for calendar year 2014 was 22.4, and the average for calendar year 2015 was 65.1. The average reported turnover rate among care coordinators declined from 21 percent in 2014 to 17 percent in 2015.

Table 9
Care coordination staffing

Calendar year	Total number of care coordinators (FTE)	Percentage of care coordinators assigned to care management and conducting assessments	Member load per care coordinator assigned to care management and conducting assessments	Turnover rate
2014	867	82.7%	22.4	21.3%
2015	1,015	91.3%	65.1	16.9%

NOTES: The MyCare Ohio demonstration began May 1, 2014. Data for 2016 are not yet available.

SOURCE: RTI analysis of MMP reported data for Core Measure 5.1, as of March 2017. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html

Area agencies on aging. As discussed in ***Section 1.2, Model Description and Demonstration Goals***, plans are required to contract with AAAs to provide waiver service

coordination for individuals age 60 or older.[15] Since the inception of Ohio's HCBS waiver program for older adults more than 25 years ago, the AAAs have performed this function. To provide enrollees with a choice for waiver service coordination, plans are required to contract with one additional entity, although State officials noted that most enrollees choose AAAs. For waiver enrollees younger than age 60, plans can conduct waiver service coordination directly and/or contract with other entities. Two plans fully delegate care management to AAAs, for all services and all age groups.

Health plans and ODM officials reported that AAAs' performance in providing care coordination has varied. According to ODM staff, the greatest successes of care management in the demonstration have occurred when care managers are able to leverage their community connections to address enrollees' basic needs such as housing and nutrition.

During the demonstration's first year, MyCare Ohio plans found that AAAs' care teams did not have sufficient clinical expertise to address enrollees' complex needs. To improve the capacity of AAA staff, MyCare Ohio plans required AAAs to hire more registered nurses and provided clinical training to existing staff.

Representatives of plans that fully delegate care management to AAAs generally believed that it is the more effective model, as it provides a single point of contact for enrollees' care management services. Enrollee stakeholders concurred with this view. ODM staff suggested that when plans do not fully delegate care management to AAAs, enrollees sometimes may be confused about waiver service coordinators' and care managers' roles, and they may not know whom to contact for assistance (see ***Section 5.2.5, Care Coordination Services***). However, State officials noted that they have not conducted an evaluation to compare the performance of plans that fully delegate care management responsibilities to AAAs with those that contract with AAAs for waiver service coordination only.

MMP staff said they have made efforts to increase coordination and communication between waiver service coordinators and care managers. Two plans hold meet-and-greet sessions in conjunction with required training so that care managers and waiver service coordinators can get to know each other and discuss cases as needed. One plan has begun to reorganize care coordination assignments geographically, by zip code, so that each care manager works with a subset of three or four waiver service coordinators in a defined region rather than having to reach out to numerous coordinators throughout the service area. A provider representative believed that plans' efforts have led to improvements in communication between waiver service coordinators and care managers. ODM officials likewise believed that coordination between care managers and waiver service coordinators has increased.

Overall performance. ODM staff and enrollee stakeholders believed that care management has improved during the demonstration but that care management has not yet reached its full potential to improve enrollees' health and well-being. One enrollee representative commented that "the jury is still out" on whether MyCare Ohio has improved care coordination and is "fairly hopeful" that improvements can be achieved. State officials reported continuing enrollee challenges in reaching care managers, as well as concerns about the quality of care

[15] October 2017 changes will be described in the next evaluation report.

management services. One ODM representative said enrollees have complained about care managers' lack of knowledge about LTSS. The official noted that it is difficult to find care management staff with the knowledge and experience needed for effective coordination across delivery systems:

> I think…it's tough when we expect care managers to be a central point of integration. We have different care managers that bring different backgrounds and perspectives to the table… You talk about integrating the care for the member, but I think it's difficult to find the [care management] staff that can adequately convey and understand the different systems across the entire spectrum and understand LTC, and behavioral health and the medical care, and be able to work on behalf of the individual in all of those spaces. That feels like a disconnect that we continue to have, and I think it's going to be a struggle for a while.

Some State officials and enrollee stakeholder groups believed that MyCare Ohio plans' care managers generally are effective in addressing enrollees' medical needs but are not as effective in addressing nonmedical issues, due to a lack of specialized training.

4.1.3 Change to the Care Coordination Model

During the December 2016 site visit, a State official expressed the view that limitations in care managers' capacity to address enrollees' needs could be attributed at least in part to MyCare Ohio plans' intense focus and prioritization on meeting the demonstration's HRA requirements:

> Right out of the gate [since the start of the demonstration] …the plans' focus was…doing the [health risk] assessments, meeting our contact requirements, making sure our time frame requirements for other activities were met according to the contract. The downside…is that plans are not always responding to beneficiaries' needs.

Similarly, another State official believed that the focus on completing assessments limited care managers' ability to develop the personal relationships with enrollees that are important for effective care management:

> What we've heard from plans is that there are so many requirements that it's hard to create, in the home, this feeling that it's not just getting through the paperwork. There are a lot of required questions that a care manager needs to ask in those [health risk] assessments, and it doesn't feel like there is room for that personal relationship to be built. The relationship is really integral to ensuring that a person is able to receive excellent services.

An ODM representative said that the most important lesson learned from the demonstration is the importance of "allowing plans to have greater flexibility with how they design their programs." The official believed that the care management requirements "contributed to the plans' focus on compliance-oriented care management versus action-oriented care management."

In an attempt to refocus MyCare Ohio plans' efforts on care coordination activities to meet enrollees' needs and lessen the burden of meeting compliance deadlines for HRAs, the State recently proposed an amendment to the three-way contract. This amendment and several additional changes to the three-way contract were enacted in October 2017. These changes will be discussed in greater detail in future reports.

4.2 Information Exchange

4.2.1 MMPs' Care Management Information Systems

The three-way contract requires each plan to use an electronic care management system that includes a single, comprehensive enrollee record and enables sharing of enrollee assessment results, care plans, and notes across the multidisciplinary care team. The centralized enrollee record must include, at a minimum, demographic, enrollment, care management, assessment, and claims/pharmacy data, as well as the individualized care plan and service authorizations and referrals (Ohio three-way contract, 2014, pp. 41–2).

ODM staff said they have not evaluated plans' performance in creating centralized enrollee records. State officials acknowledged limitations in plans' capacity to meet this requirement, and AAAs reported difficulty accessing and navigating five different care management systems (one for each of the MMPs). A provider representative reported that most MyCare Ohio plans' care management systems do not enable AAAs to access claims data or to communicate online with care teams. Moreover, the provider stakeholder noted, AAA staff often cannot retrieve information that they have entered into MMPs' systems and are unable to determine whether services were provided in a timely manner. According to the stakeholder, this lack of access has made it difficult for AAAs to manage caseloads and monitor the performance of waiver service coordinators. AAAs have tried to use their own electronic systems for these tasks, with varying levels of success.

Staff of one MMP with a care management system that currently does not provide waiver service coordinators access to claims data said that the plan is modifying the system to enable this access. Plan staff hope to have the upgrades completed in 2017. MMP representatives said they have recommended additional upgrades to enable online communication across care teams, but changes have not yet been approved at the corporate level.

In contrast, staff of another MMP said that its care management system maintains centralized enrollee records that can be accessed by care managers, waiver service coordinators, and pharmacy technicians. Care managers and waiver service coordinators use the system to enter HRA data and update care plans, and send each other new tasks that need to be completed to address member needs. The system creates an alert once a new task has been created. Plan staff said that communication between care managers and waiver service coordinators has improved over the course of the demonstration, and they are now using the online care management system effectively to communicate and document enrollee information.

4.2.2 Post-Acute Care Transitions

The statewide health information exchange. The three-way contract requires MyCare Ohio plans to participate in a statewide health information exchange (HIE) (Ohio three-way

contract, 2014, p. 42). The Southwest region of the State is a Beacon Community (part of the Beacon Community Cooperative Agreement Program)[16] and developed a separate HIE, HealthBridge, in partnership with stakeholders in Indiana and Kentucky.

MMP staff reported that they have not relied on HIE data for discharge planning or management of care transitions. Plan representatives commented that HIE data are limited to admission, discharge, and transfer (ADT) notifications and do not include medical record information needed for discharge planning. Additionally, they noted that HIE data are not in a uniform format but rather, vary by hospital and are therefore difficult to use. Staff of another MMP commented that to receive HIE data, plans must seek approval from individual hospitals—an administrative burden that likewise has limited plans' use of HIE data. The plan has recommended changes to CliniSync that would facilitate greater use of HIE data, and, according to plan staff, CliniSync is addressing the issue.

Discharge planning and care transitions. The three-way contract does not provide many specifics on post-acute care transition requirements, but instead broadly requires plans to adopt an "aggressive" strategy to coordinate care across settings, obtain discharge/transition plans, conduct follow-up with the enrollee and his or her provider(s), and perform medication reconciliation (Ohio three-way contract, 2014, p. 37).

MMP staff reported that they track inpatient admissions through their utilization management (UM) systems, and they reach out to hospital staff to coordinate post-acute transitions. One plan indicated that it sends dedicated outreach staff and licensed practical nurse extenders to visit hospitals and review members' status. Care managers then follow up to plan next steps for the post-discharge transition. Plan representatives reported that they had difficulty coordinating with hospital teams early in the demonstration, but that coordination has improved as hospital staff have become more accustomed to care planning for Medicaid patients. Staff of another plan said that its care managers generally succeed in connecting with hospital discharge planners; however, sometimes care managers face barriers to conducting in-person hospital visits.

ODM staff reported that the level of contact between care managers and hospital discharge planners varies, depending on care managers' skills and level of effort. Additionally, an ODM official said that some health systems have been resistant to having MMPs' care managers enter hospitals to meet with their members. Moreover, the official commented that it can be difficult for hospitals to engage with care management staff from five different plans.

MyCare Ohio plans reported that they are pursuing initiatives with hospitals to improve transitions and reduce readmissions. For example, staff of one plan have collaborated on an *ad hoc* basis with hospital teams to reduce preventable inpatient admissions of enrollees receiving emergency department services. Hospital teams have notified the MMP when they believe that a plan member in the emergency department can be discharged safely to the community if the enrollee can immediately begin receiving HCBS services, and plan staff have expedited delivery

[16] The Beacon Community Cooperative Agreement Program is part of a U.S. Department of Health and Human Services initiative to show how health information technology investments and meaningful use of electronic records can promote patient-centered care, improve health care quality and patient health, and lower costs (U.S. Department of Health and Human Services, 2012).

of these services. As part of the initiative, the plan has provided expedited UM reviews and a dedicated on-call team to manage post-discharge transitions. Another plan will soon launch a program in which registered nurses work onsite in all network hospitals to monitor emergency room admissions and work with care managers to facilitate successful post-discharge transitions.

Exchange of behavioral health information. According to a provider representative, the lack of standardization in plan operations and systems has created challenges for sharing of behavioral health information, and Federal privacy regulations (42 CFR Part 2) have been a barrier to effective information-sharing about substance use disorder treatment. As Ohio Medicaid transitions to a managed behavioral health system, the stakeholder said, an important goal will be to improve the process of information-sharing between plans and behavioral health providers. MMP staff believed that plans have been able to coordinate behavioral health services effectively, and ODM staff said the agency has not received complaints about lack of member access to these services. Staff of one MyCare Ohio plan said it has provider relations staff focused on behavioral health, as part of its overall effort to "meet the provider wherever they need us." MMP representatives hold meetings with providers to answer questions and address concerns as needed.

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5. Beneficiary Experience

Highlights

- CAHPS results indicated that almost all respondents felt that their personal doctors understood how their health problems affected their everyday lives, and that most had the same doctor prior to enrolling in the demonstration. A majority of enrollees provided high ratings for their Medicare-Medicaid Plans (MMPs).
- MyCare Ohio plans' flexible transportation benefits are very popular, although enrollees reported many challenges in the timeliness and reliability of transportation services. In response, Ohio Department of Medicaid (ODM) modified provider agreements to improve service delivery.
- Focus group participants generally were aware of MyCare Ohio's beneficiary protections. They often showed familiarity with the ombudsman program, and a few had contacted the ombudsman's office.
- Early in the demonstration, many enrollees did not know who their care managers were or how to reach them. MyCare Ohio plans have conducted extensive outreach and education, and State officials and stakeholder reported that enrollee awareness of care managers has increased. Focus group participants' experience with care coordinators varied.

5.1 Introduction

Improving the experience of beneficiaries who access Medicare- and Medicaid-covered services is one of the main goals of the demonstrations under the Financial Alignment Initiative. Many aspects of MyCare Ohio are designed expressly with this goal in mind, including emphases on working closely with beneficiaries to develop person-centered care plans, delivering all Medicare and Medicaid services through a single plan, providing access to new and flexible services, and aligning Medicare and Medicaid processes.

This section highlights findings from various sources that indicate the levels of beneficiary satisfaction with MyCare Ohio overall; it also describes beneficiary experience with new or expanded MyCare Ohio benefits, medical and specialty services, access to care and quality of services, care coordination services, and person-centered care and patient engagement. For beneficiary experience, we draw on findings from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, as well as RTI focus groups and stakeholder interviews. Please see ***Section 1.1.3, Data Sources***, for details about each data source. This section also provides information on beneficiary protections, as well as data related to complaints and appeals. The section includes information, where available, on the experience of special populations.

5.2 Impact of the Demonstration on Beneficiaries

This section summarizes the findings of focus groups, beneficiary surveys, and stakeholder interviews reflecting beneficiary experiences with service delivery and quality of life under MyCare Ohio. Beneficiary experiences related to enrollment, including factors influencing enrollment decisions and plan selection, are discussed in ***Section 3, Eligibility and Enrollment***.

5.2.1 Overall Satisfaction with MyCare Ohio

Input from stakeholders and focus group participants suggested that overall satisfaction with MyCare Ohio has varied. Enrollee stakeholders described challenges due to early implementation issues and gradual improvement over time. One enrollee stakeholder described beneficiaries' early experiences with the demonstration as "chaotic" and attributed challenges to the large number of beneficiaries being passively enrolled at one time, many enrollees' lack of familiarity with managed care, and MMPs' limited experience serving the demonstration population. According to the stakeholder, enrollees and providers were not well informed about and did not understand the demonstration. Enrollee representatives believed that communication by ODM and MMPs has improved over time, and beneficiaries generally have adjusted to the demonstration.

Focus group participants' overall satisfaction with MyCare Ohio often was based on whether they felt that their coverage enabled them to meet their needs without difficulty. Experiences were mixed, with less satisfaction among those who faced limits due to health plans' prior authorization requirements.

Some participants expressed satisfaction with access to needed items and services:

> I needed a home aide, I got one. I need[ed] meals, I got them. I get my same doctor. Anything I ask for, I get it. I needed a wheelchair, I got one of them. I got a shower bench, [my care coordinator] got it. I have no trouble with her.

> I [have] [plan name], and I love [it]…Because when you bring something to them, like a prescription and all that stuff, you don't have to wait months and months before they do something. They get on it right away."

Other participants expressed frustration about limits in access to needed services or items:

> I can't get the [pain] patches [prescribed by my doctor] because I need preauthorization. The preauthorization has been stuck in somebody's computer or somebody's desk somewhere…I went through this with my nausea medication just a few months ago…

Some participants expressed a desire for improved communication and more effective care management:

> My biggest complaint [about MyCare Ohio] is that I would change the way that [the plan] informs you when they're changing these companies. Because I had run

out of a product, and then I had to go to the store to start purchasing that product because [plan name] dropped them as a provider.

I think [it would be helpful] if you had an advocate that you could go to, that could direct you to what you need, because a lot of times people have a need and they don't know who to call or where to go.

As shown in ***Table 10***, a majority of CAHPS survey respondents (between 56 and 59 percent) in all MMP plans in the MyCare Ohio demonstration rated their health plan as a 9 or 10 on a scale of 0 to 10 (with 10 being the best) in 2016. These results are similar to the national average for all Medicare Advantage (MA) contracts (61 percent) and for all MMP contracts (59 percent). We provide national benchmarks from MA plans, where available, understanding that there are differences in the populations served by the MyCare Ohio demonstration and the MA population. These include health and socioeconomic differences (e.g., lower level of need in the MA population overall) that must be considered in the comparison of the demonstration to the national MA contracts.

The percent of respondents giving plans this rating has improved since 2015, when it was given by less than half of respondents (47 to 48 percent) in three of the five MMPs. In 2015, an average of 62 percent of all national MA contract respondents rated their plans a 9 or 10, and an average of 51 percent of all MMP contract respondents gave their plans this rating.

The percent of enrollees rating their prescription drug plans as a 9 or a 10 ranged from 60 to 64 percent in all plans in 2016; this rating is similar to the ratings for national MA and MMP contract respondents, 61 percent. The percent of enrollees rating their prescription drug plans as a 9 or a 10 ranged from 49 to 67 percent in all plans in 2015. In 2015, on average, 62 percent of national MA contract respondents and 56 percent of national MMP contract respondents rated their drug plans as a 9 or 10.

Table 10
Beneficiary overall satisfaction, 2015 and 2016

CAHPS survey item	Year	National distribution—all MA contracts	National distribution—all MMP contracts	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	United (%)
Percent rating health plan 9 or 10 on scale of 0 (worst) to 10 (best)	2015	62 (N=148,335)	51 (N=5,141)	48 (N=178)	47 (N=177)	57 (N=251)	57 (N=168)	47 (N=175)
	2016	61 (N=142,984)	59 (N=9,765)	58 (N=222)	56 (N=197)	59 (N=217)	58 (N=461)	56 (N=182)
Percent rating drug plan 9 or 10 on scale of 0 (worst) to 10 (best)	2015	62 (N=136,044)	56 (N=5,042)	62 (N=181)	57 (N=172)	67 (N=246)	67 (N=164)	49 (N=171)
	2016	61 (N=132,613)	61 (N=9,617)	62 (N=219)	60 (N=204)	64 (N=217)	62 (N=453)	60 (N=186)

MA = Medicare Advantage; MMP = Medicare-Medicaid Plan.

SOURCE: CAHPS data for 2015 and 2016.

5.2.2 New or Expanded Benefits

As noted in ***Section 1.2, Model Description and Demonstration Goals***, MyCare Ohio plans offer a range of value-added benefits, such as supplemental transportation, expanded dental coverage, and coverage of over-the-counter drug products up to a monthly dollar limit.

Transportation

According to MMP, State, and beneficiary stakeholder representatives, supplemental transportation is very popular among enrollees and utilization has been high. One MyCare Ohio plan reported that 46 percent of demonstration enrollees use the plan's supplemental transportation benefit, while only about 5 to 6 percent of enrollees use the Medicaid State Plan and waiver transportation benefit, which is more limited.

During site visits and focus groups, participants' discussion of enrollee experience with value-added or expanded benefits focused mainly on transportation. In the demonstration's first year, enrollees and providers reported many transportation-related challenges. According to provider representatives, nursing facilities had difficulty arranging transportation because MyCare Ohio plans required prior authorization and were contracting with transportation companies not accustomed to serving nursing facility residents. A plan official commented that some nursing facilities were ordering transportation incorrectly, thus potentially affecting enrollees' experiences. Additionally, ODM received many complaints about lack of timeliness in transportation services.

Participants in several focus groups reported difficulties with transportation, but in some cases, they indicated that transportation challenges had been resolved:

> [The transportation service was] late. They just dropped me off. They were late picking me up. It got to the point that my daughter…would leave work to come to get me…It began to be a problem. So we just cut transportation out.

> The [transportation] company never calls you to let you know that everything's been confirmed. You're sitting there waiting to go to an appointment; they never show, they never call. I've complained about that considerably… [now] when I call in to set up some transportation services, a guy named [name] checks everything out. He sets everything up and he calls me back, gives me numbers to the company and confirms everything.

To improve enrollee experiences with transportation, ODM revised its provider agreement to stipulate that transportation vendors must pick up and drop off beneficiaries within 15 minutes of the scheduled times. Vendors and MyCare Ohio plans are required to follow up with enrollees to ensure transportation services are meeting their needs.

In recognition that some enrollees need help walking to and from vehicles, one plan modified its transportation vendor contract to replace the curb-to-curb model of service with a door-to-door model. According to an enrollee stakeholder, another plan required its transportation vendor to place cameras in vehicles to monitor drivers' behavior after receiving reports that they were not treating enrollees with respect.

Providers, MMP staff, and State officials indicated that as a result of ongoing State and plan efforts to improve transportation services, the systemic problems have been largely resolved. To address remaining issues, ODM added transportation-related provisions to its 2016 provider agreement. Effective in July 2016, MyCare Ohio plans are subject to a $1,000 fine if failure to provide timely transportation to a provider more than 30 miles from home causes an enrollee to miss an appointment (MyCare Ohio Provider Agreement, 2016, p. 205). The evaluation team will continue to monitor the effect of this provision and will note any changes in beneficiaries' transportation-related experiences in subsequent reports.

Over-the-Counter Drug Products

ODM staff reported that all plans offer over-the-counter drug coverage as a value-added benefit, and according to plan and enrollee representatives, it is popular among enrollees. One MMP representative explained that care managers help enrollees choose over-the-counter products, such as cough syrup and Tylenol, up to a $20 monthly limit, to treat minor conditions at home.

Supplemental Dental and Vision Care

ODM staff indicated that some plans offer supplemental dental and vision benefits. They noted that access to dental providers has been challenging in the Medicaid program, and to address the issue, ODM requires MyCare Ohio plans to provide enrollees with transportation to appointments with dental providers located more than 30 miles away. Plans are not allowed to count these rides against the monthly limits on Medicaid-covered transportation.

During the focus groups, some participants reported having better dental and vision coverage than they did prior to enrolling in MyCare Ohio:

> [Dental care is] better for me now…I'm getting partials, uppers and lowers. Never had them before.

> Since I've been in [the demonstration], I was able to get contacts for the first time, and that was something that was never, ever done…

Self-Direction

Under the three-way contract, enrollees who meet specified State criteria can choose to self-direct specified home and community-based services (HCBS) waiver services, an option that was previously available to enrollees in two of the five HCBS legacy waivers. The contract refers to self-direction as a means to give enrollees choice and authority over service delivery. In a self-directed care arrangement (an alternative to receiving personal care from agency-provided attendants or independent providers), enrollees recruit, hire, train and supervise their service providers. Self-directed care must include a person-centered planning process, a written care plan that includes specified information about the enrollee, physician, caregivers, services, and goals. Enrollees are required to keep track of all receipts, time sheets, and logs, which they must sign to verify that services were provided for the times indicated. Enrollees must designate individuals to provide them with information and support for managing the care plan (Centers for Medicare & Medicaid Services, 2015). MyCare Ohio plans are required to facilitate self-direction by training care managers and waiver service coordinators on self-direction; developing and

distributing a self-direction handbook for enrollees who express interest; providing an orientation to enrollees who choose the option; and contracting with the statewide Financial Management Services (FMS) to handle specified financial tasks in self-directed arrangements (Ohio three-way contract, 2016, p. 51).

ODM reported that throughout the demonstration, beneficiaries' use of the self-direction option has remained quite limited, at an estimated 0.4 to 0.5 percent of demonstration enrollees who were also in the MyCare Ohio HCBS waiver from 2014 through 2016. Enrollee stakeholder groups and ODM staff reported that many beneficiaries have used independent home care providers (see ***Section 2.2.2, Provider Arrangements and Services***) and believed that the independent provider (IP) model provides a similar level of flexibility and choice without the administrative responsibilities associated with self-direction. One stakeholder noted that ODM's enrollee guidance on self-direction is 100 pages, and enrollees are choosing IPs because they do not have the support and assistance needed to self-direct:

> …[Self-direction] takes a lot of hand-holding [of enrollees], and I think that's a stumbling block because there's not a ready source of hand holders, and there is the IP route [available to enrollees]. Therefore, you take the IP route.

CMS, ODM staff, and MyCare Ohio plans have provided training and education to increase awareness, education, and utilization of self-direction. In Spring 2016, CMS partnered with the State to arrange for an expert to conduct training on self-direction at a meeting of the MyCare Ohio Implementation Team which is comprised of enrollee stakeholders and representatives of MyCare Ohio plans, providers, Area Agencies on Aging (AAA) regional offices, CMS, other State agencies, and the State's Long-Term Care Ombudsman (see ***Section 6, Stakeholder Engagement***). Also in 2016, ODM partnered with CMS to provide expert training for AAA and MyCare Ohio plan care managers at plan offices, and it required plans to conduct regional outreach on self-direction.

5.2.3 Medical and Specialty Services

Nearly all focus group participants said they had been seeing their current PCPs regularly for at least a year, and many had the same PCP for many years. Participants described positive as well as negative perspectives on their experiences with providers.

> I like [my PCP] a lot…[and] so far everyone that she has recommended [is] very much like she is: concerned, questioning, very thorough in what she does to find out and make recommendations that just kind of fall in place with you and where you are…

> The office [was] small, and there were about 10 people with the same appointment time, so it's long sitting, waiting. Then when you get back there, it's hurry up, hurry up, hurry up.

CAHPS results also showed that the majority of demonstration enrollees had the same doctors that they had prior to enrolling in a MyCare Ohio plan (see ***Table 11***). However, in all plans, the percentage of enrollees reporting this continuity declined from 2015 to 2016.

Table 11
Beneficiary experience with medical services (including specialists), 2015 and 2016

CAHPS survey item	Year	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	United (%)
Percent reporting that they had the same doctor before enrolling in the health plan	2015	77 (N=187)	76 (N=174)	77 (N=237)	72 (N=164)	72 (N=174)
	2016	71 (N=87)	75 (N=79)	62 (N=69)	61 (N=181)	69 (N=64)

SOURCE: RTI Supplemental CAHPS data for 2015 and 2016.

Focus group findings suggested that participants' experiences with communication among care teams varied. A few participants shared differing perspectives:

> If I have a problem, when I ask [my doctors] for things for the house or for myself, they get together and all my doctors talk to each other.

> My specialist is at [provider group A], and then I have [provider group B]. So [my PCPs and specialists] …don't confer on anything.

5.2.4 Beneficiary Access to Care and Quality of Services

Access to Care

When discussing access issues associated with the demonstration, State officials and stakeholders often focused on access to durable medical equipment and home modifications. Enrollees reported difficulties with obtaining prior authorizations, as well as significant delays in delivery. After the issue of access to durable medical equipment (DME) and home modifications was raised during Medicaid Director's forums in May–October 2015 (see ***Section 6.2.1, State Role and Approach***), ODM required plans to follow-up to address identified needs. During the December 2016 site visit, a State official noted that the ombudsman's office had received many complaints about access to DME and home modifications. The official and an enrollee stakeholder suggested that these problems may be attributable to care managers' lack of knowledge. An enrollee stakeholder reported that plans have been making "a lot of effort collectively" to reduce the time frame for DME approvals.

Some focus group participants described access challenges caused by denials, reductions in services, and coverage limits for items such as nutrition supplements, bathroom safety supplies, and compression stockings:

> My father was getting nutrients. Ensure meals. Well, now he's not qualified for it. You have to go through all this red tape and the doctor has to be specific.

> The insurance wouldn't pay for [grab bars for the bathroom]... [and] they would not pay for [the shower chair].

I get [coverage for] four pairs of the compression stockings a year. Four pairs is not enough when you're wearing them every day.

Table 12 highlights findings from the CAHPS on beneficiary experience with access to behavioral health services. The two plans with sufficient data to report on this issue in both 2015 and 2016 had data specifically on enrollees indicating a need for personal or family counseling. In 2015, 16 percent of these two plans' enrollees indicated a need for these services. In 2016, the percent of plan enrollees indicating a need for these services ranged from 14 to 17 percent. One of five plans had sufficient data in both 2015 and 2016 to report on enrollees usually or always being able to obtain needed treatment or counseling for personal or family problems. The percent of the plan's members who gave this response increased from 67 percent in 2015 to 80 percent in 2016.

Table 12
Beneficiary experience with access to behavioral health services, 2015 and 2016

CAHPS survey item	Year	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	United (%)
Percent who needed any treatment or counseling for a personal or family problem	2015	13 (N=181)	15 (N=166)	16 (N=226)	16 (N=154)	15 (N=165)
	2016	#	#	17 (N=70)	14 (N=176)	#
Of those who reported needing it, percent who report it is "usually" or "always" easy to get the treatment or counseling they needed through their health plan	2015	90 (N=21)	67 (N=24)	89 (N=35)	67 (N=24)	87 (N=23)
	2016	#	#	#	80 (N=25)	#

= sample size too small (less than or equal to 10).

SOURCE: RTI Supplemental CAHPS data for 2015 and 2016.

Table 13 shows CAHPS findings on beneficiary access to LTSS and medical equipment. In 2016, between 40 and 45 percent of respondents said they needed someone to provide home health care or other assistance in their homes. These percentages represent an increase over 2015 levels for all but one of the MMPs. The percent of respondents indicating that it was usually or always easy to get personal care or aides at home varied among plans, ranging from 72 to 92 percent in 2016. The percent of respondents needing special medical equipment in 2016 ranged from 36 to 52 percent, in 2016, and ratings for access to medical equipment improved from 2015–2016 in most MMPs.

Table 13
Long-term services and supports and medical equipment, 2015 and 2016

CAHPS survey item	Year	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	United (%)
Percent who needed someone to come into their home to give them home health care or assistance	2015	45 (N=186)	38 (N=168)	34 (N=236)	35 (N=157)	35 (N=171)
	2016	43 (N=87)	45 (N=76)	44 (N=69)	40 (N=181)	44 (N=63)
Percent who reported it is "usually" or "always" easy to get personal care or aide assistance at home through their care plan	2015	93 (N=82)	88 (N=60)	78 (N=77)	71 (N=51)	80 (N=56)
	2016	92 (N=36)	79 (N=34)	72 (N=29)	90 (N=69)	85 (N=26)
Percent who had a health problem for which they needed special medical equipment, such as a cane, wheelchair or oxygen equipment	2015	50 (N=185)	47 (N=169)	42 (N=233)	34 (N=155)	32 (N=174)
	2016	43 (N=86)	46 (N=80)	52 (N=69)	43 (N=180)	36 (N=61)
Of those who report needing it, percent who report it is "usually" or "always" easy to get or replace the medical equipment they needed through their health plan	2015	58 (N=80)	66 (N=71)	60 (N=89)	65 (N=49)	57 (N=49)
	2016	74 (N=34)	72 (N=36)	77 (N=35)	58 (N=72)	89 (N=19)

SOURCE: RTI Supplemental CAHPS data for 2015 and 2016.

Quality of Services

As noted in ***Section 4.1.2 (Care Planning Process***), ODM officials, enrollee stakeholders, and health plan staff reported that the quality of care management has varied. MMPs have taken action to address the issue; ODM staff and enrollee stakeholders believe that quality has improved in this area but has not reached its full potential.

As discussed in ***Section 5.2.2***, enrollees, provider representatives and State officials have expressed concern about the quality of transportation services. ODM has revised provider agreements to improve timeliness.

5.2.5 Care Coordination Services

Early in the demonstration, many enrollees reported that they did not know who their care managers were or how to reach them. One stakeholder group that had gathered comments on enrollees' experiences reported that about half of respondents did not know their care managers' names, and many enrollees said they could "never" reach care managers when needed. The most common complaint that the State Ombudsman's office received in the first year was that beneficiaries were unable to connect with their care managers. A State official said that a priority for 2016 was to provide guidance to MyCare Ohio plans on strategies to increase enrollee awareness of care managers. Plans have conducted a variety of outreach and education efforts to achieve this goal. For example, some have provided care managers with scripts for introducing themselves, explaining their roles, and providing contact information each time they speak with enrollees. Plans have distributed refrigerator magnets and door hangers with care managers' contact information, as well as business cards with care managers' photos.

State officials and enrollee stakeholders believed that awareness of care managers has improved. During the December 2016 site visit, ODM staff said they no longer receive reports that enrollees do not know their care managers. However, a State official said that the ombudsman's office still receives reports of enrollee confusion about whom to contact for help with care coordination and that this confusion is sometimes associated with having both a care manager and a waiver service coordinator. In particular, the ombudsman's office noted that nursing facility residents and staff often are confused when they are contacted by several different care managers. Additionally, the ombudsman's office has reported complaints about lack of timely responses from care managers. The ombudsman's office has discussed care management challenges with MMPs and ODM staff.

The percent of MyCare Ohio enrollees who indicated that someone from their health plan, doctor's office, or clinic was helping coordinate their care ranged from 26 percent to 43 percent in 2016 (see ***Table 14***). This proportion increased from 2015 to 2016 in all but one MMP. Two plans had sample sizes too small in 2016 to report the percent of respondents who were very satisfied with the help they received in coordinating care. In the three other plans, the percent of enrollees who said they were very satisfied with this help rose from 2015 to 2016, when it ranged from 49 to 57 percent.

In 2016, between 78 and 82 percent of respondents enrolled in the four MMPs with data to report said they usually or always received needed information from their health plans. For one plan, this result represented a 17-percentage point increase over 2015. The 2016 national average for MMP contracts on this measure was 79 percent, and the national average for MA contracts was 81 percent.

Focus group participants generally indicated that they knew their care managers, and many had their care managers' contact information. Nearly half of the participants in the Cleveland group said they had refrigerator magnets distributed by MyCare Ohio plans. Participants expressed satisfaction with care managers' responsiveness and help with accessing items and services:

> She [the care manager] gets the job done…. And she helps you. That's the one I called [about a problem with transportation services] … And she said, "Oh, no. We can't have that…I'll get right back on it." Next thing I know, a day and half later CTS [transportation service] called me….

> I've had the same case manager since I have been on [this insurance]. And anything I present to them, less than a month I get it.

Among participants who expressed dissatisfaction with care coordinators, high turnover was a commonly cited reason.

> Well, I have had three case managers in 6 months, so it's a revolving door…

> Every time I look around, we have a new [case manager], a different one.

Table 14
Beneficiary experience with care coordination, 2015 and 2016

CAHPS survey item	Year	National distribution—all MA contracts	National distribution—all MMP contracts	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	United (%)
Percent who had anyone from their health plan, doctor's office, or clinic help them coordinate their care among doctors or other health providers	2015	N/A	N/A	39 (N=177)	38 (N=165)	32 (N=225)	30 (N=151)	25 (N=155)
	2016	N/A	N/A	36 (N=81)	40 (N=77)	36 (N=67)	43 (N=174)	26 (N=57)
Of those who used care coordination, the percent who were "somewhat satisfied" or "very satisfied" with the help from the health plan or doctor's office in coordinating their care	2015	N/A	N/A	81 (N=67)	89 (N=61)	89 (N=71)	91 (N=43)	74 (N=38)
	2016	N/A	N/A	79 (N=28)	83 (N=30)	100 (N=23)	85 (N=74)	73 (N=15)
Percent reporting that health plan "usually" or "always" gave them information they needed	2015	80 (N=45,457)	73 (N=2,058)	80 (N=72)	65 (N=71)	81 (N=104)	81 (N=73)	61 (N=61)
	2016	81 (N=42,677)	79 (N=3,669)	80 (N=84)	82 (N=78)	78 (N=71)	80 (N=177)	#

= sample size too small (greater than or equal to 10); N/A = not applicable.

SOURCE: RTI Supplemental CAHPS data for 2015 and 2016 and CAHPS data for 2015 and 2016.

Participants provided mixed reports on whether their providers were working as a team and knew whether the participants had been hospitalized or in the emergency room:

> My mother's nurse practitioner went and visited her while she was in the hospital.

> I just switched about 4 or 5 months [ago] from [a public health system to a private health system]. So I fell a couple of times when I was at [the public health system] and I'd go to the emergency room… And I don't think [either provider] knew anything.

5.2.6 Person-centered Care and Patient Engagement

A State official commented that plans' performance in providing person-centered care varies. According to the official, plans typically use standardized care management software with drop-down menus, and the potential for customization is limited. Another State official believed that MyCare Ohio plans are making progress in promoting person-centered care, but that progress is occurring slowly. An enrollee stakeholder commented that "[MyCare Ohio] care plans are cookie cutter sometimes, and you have to advocate for yourself to make sure your care plan looks like you and what you need."

Focus group participants expressed mixed views on whether doctors were listening to their concerns. Some felt that their providers had patience and answered their questions, while others felt that doctors were not sufficiently responsive to their input:

> [My PCP] listens to you. He wants to know what you're feeling, how you're feeling…If I have a question, I can even call him just on the phone and say, "This is my problem."

> [My doctor] doesn't listen to me…I told them before, "I prefer a holistic method. Why do we have to keep taking these pharmaceuticals and deal with these pharmaceutical-based doctors that want to write these prescriptions?" ...Dr. [name] told me, "I agree. But they're [the insurance is] not going to pay me to let you go to the health food store."

5.2.7 Personal Health Outcomes and Quality of Life

Focus group participants often reported that their health or quality of life was the same or better since enrolling in MyCare Ohio plans. A few participants said that individuals associated with MyCare Ohio, such as primary care providers and other care team members, had contributed to improvements in their well-being:

> I wasn't able to go walk the mall all day long, but I can do it now. I had 50, 60 more pounds on me extra. That was hard. I was short of breath all the time, but I'm not any of that [now]… I don't pass out anymore.

> [Plan name] makes sure I'm not cooped up at home…He [professional associated with the health plan] gave me the idea of going online for college. Kahn Academy has an audited class where I can take the class [in] entrepreneurship and learn from that.

Table 15 highlights CAHPS findings on beneficiary experience with personal health outcomes. In 2016, between 85 and 91 percent of respondents across the four MMPs with sufficient data, reported that their personal doctors understood how their health problems affected their everyday lives. These results were similar to those of 2015, when 85 to 94 percent of respondents reported this view.

Table 15
Beneficiary experience with personal health outcomes, 2015 and 2016

CAHPS survey item	Year	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	United (%)
Percent reporting that their personal doctor understands how any health problems you have affect your day-to-day life?	2015	90 (N=185)	85 (N=169)	94 (N=231)	90 (N=162)	92 (N=169)
	2016	90 (N=88)	90 (N=78)	91 (N=69)	85 (N=181)	#

= sample size too small (less than or equal to 10).

SOURCE: RTI Supplemental CAHPS data for 2015 and 2016.

5.2.8 Experience of Special Populations

ODM officials reported that since the beginning of the demonstration, a lack of data on enrollees' racial and ethnic backgrounds has prevented them from analyzing differences in the experiences of subpopulations. ODM staff noted that enrollees are not required to provide data on race or ethnicity as a condition of Medicaid eligibility; therefore, the State has data only on the subset of enrollees who provided it voluntarily.

An enrollee stakeholder expressed frustration about the continued lack of data available to identify and reduce disparities among racial and ethnic groups. ODM is seeking to address disparities in the broader Medicaid population by forming a Health Equity Work Group. According to State officials, the effort was delayed after the staff person hired to lead the effort left the agency. The State hired a replacement in 2016, and ODM staff reported during the December 2016 site visit that health equity activities are "still ramping up." ODM staff anticipated that the Health Equity Work Group's first meeting would be held in the first quarter of 2017. An update on ODM's approach to health equity will be included in the next evaluation report.

Tables 12 and ***13*** highlight CAHPS findings on beneficiary experience with access to behavioral health services and LTSS, and those data are discussed above (see ***Section 5.2.4 Beneficiary Access to Care and Quality of Services***).

5.2.9 Beneficiary Protections

MyCare Ohio provides formal beneficiary protections through an integrated Medicare-Medicaid grievance and appeals process and through the services of specialized staff at the State's Long-Term Care Ombudsman (see below), which are funded by a Federal grant (see ***Section 1.4.4***). This section describes the numbers and types of beneficiary complaints and appeals received about the demonstration. Because MyCare Ohio integrates Medicare and Medicaid services, these data have been compiled from a number of sources, including focus groups, the State's Long-Term Care Ombudsman, MyCare Ohio plans, ODM, and Medicare (Complaints Tracking Module [CTM] and Independent Review Entity [IRE]).

Focus group participants generally were aware of key rights and protections provided by MyCare Ohio. They often showed familiarity with the ombudsman program, and a few said they had contacted the ombudsman's office to resolve problems. Participants knew they could change MyCare Ohio health plans, but the vast majority did not know that they could change at any time:

> If I had called the case manager and they hadn't responded in time, then I would call the ombudsman. If you're not getting what you are supposed to get, call your ombudsman.

> Yeah [you can change health plans], but it's like every 6 months or something.

Complaints

Enrollees may file grievances at any time by calling or writing to an MMP, CMS, or ODM. Grievances for which remedial action is requested must be filed within 90 days of the precipitating event. MMPs are required to provide enrollees with "all reasonable assistance" needed to complete forms and procedures necessary for filing grievances (Ohio three-way contract, 2016, p. 86). Plans are required to report to CMS and the State any grievances filed by an enrollee and how the plan addressed them.

MMP staff commented that early in the demonstration, the volume of grievances was highest, due largely to enrollees' confusion and lack of understanding of health plan operations and the demonstration. Plan staff noted that as enrollees became more accustomed to the demonstration, the number of grievances declined. According to plan staff, common topics for grievances include: billing issues (e.g., erroneous balance billing by providers and misunderstanding of Explanation of Benefits statements); dissatisfaction that a provider is not in the plan's network; and prior authorization issues.

An enrollee stakeholder believed that beneficiaries are reluctant to file grievances because they do not understand the process and because they fear that MMPs will retaliate by becoming less responsive to their needs. Therefore, the stakeholder reported, enrollees generally try to resolve problems through their case managers or other channels.

The following is a summary of complaint data received from each of the three previously discussed sources: (1) data reported by MyCare Ohio plans on complaints made directly to them; (2) data reported on the CTM for complaints received by ODM and 1-800-Medicare; and (3) data reported by the State Long-Term Care Ombudsman's office on complaints and inquiries made directly to its office. Reporting periods vary across these sources. Some, but not all, sources report complaint data per 1,000 beneficiaries, thereby accounting for changes in enrollment. Also, the rates of complaints in some areas are extremely small (e.g., less than one complaint per 1,000 beneficiaries) and are therefore not included in this summary.

Complaints Received by MyCare Ohio Plans

Data in ***Table 16*** cover the period from May 2014 through December 2016. At the beginning of the demonstration, the number of complaints per 1,000 beneficiaries increased from 90.5 in the first quarter of implementation to 188.8 in the third quarter. As described in ***Section 3.2.3, Passive Enrollment Experience***, beneficiaries received passive enrollment notices, as well as disenrollment notices from their Part D prescription drug plans, during this time; State officials, plans, and stakeholders noted that the timing and language of the two mailings led to confusion among beneficiaries. Subsequently, the number of grievances declined and reached a low of 28.3 in Quarter 2 of 2015. In 2016, the number of complaints per 1,000 beneficiaries fluctuated between 48.8 and 75.3.

Categories of complaints to MyCare Ohio plans included: inability to get a PCP appointment; inability to get a specialist appointment; excessive wait time to get a PCP appointment; and excessive wait times to get a specialist appointment. Complaints that do not fall within one of those categories areas are grouped in a category called "other grievances

related to areas not mentioned." For each quarter presented in ***Table 16***, the vast majority of complaints (96.3 to 99.8 percent) fell into the "other" category.

Table 16
Total number of complaints by MyCare Ohio plans, by quarter

Quarter	Enrollment	Total grievances per 1,000 enrollees	Total appeals per 1,000 enrollees
2014			
Q2	8,953	90.472	0.558
Q3	14,760	170.461	5.420
Q4	16,069	188.811	9.397
2015			
Q1	65,123	104.510	0.952
Q2	63,013	55.687	2.999
Q3	62,353	38.699	4.667
Q4	60,326	28.280	4.111
2016			
Q1	62,179	52.461	2.943
Q2	62,471	57.851	3.458
Q3	63,379	48.770	3.345
Q4	69,365	75.297	2.941

NOTES: The MyCare Ohio demonstration began May 1, 2014. Q2 2014 covers data for the period of May 2014 to June 2014. All subsequent quarters contain 3 months of complaints.

SOURCE: RTI analysis of MMP reported data for Core Measure 4.2, as of March 2017. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html

Complaints Received by Ohio's Office of the State Long-Term Care Ombudsman

Ohio has established a formal role for the State Long-Term Care Ombudsman Program to handle complaints about MyCare Ohio. State officials reported that the ombudsman educates enrollees about their appeal rights and can provide help at all stages of grievance and appeals processes. Additionally, the ombudsman conducts conference calls with MyCare Ohio plan representatives and enrollees as needed to address concerns, and in some cases, can help enrollees resolve problems without filing grievances. Complaints filed directly with Ohio's Office of the State Long-Term Care Ombudsman are reported to ODM and the ACL as part of the demonstration's efforts to monitor plan complaints.

The ombudsman's office reported that from April 2014 through December 2016, it received a total of 2,116 enrollee contacts (see ***Table 17***), which include inquiries and complaints from demonstration enrollees as well as Medicare-Medicaid enrollees in managed care for Medicaid only.

The ombudsman's office categorizes enrollee contacts broadly, with more than a third falling into the category of "Other Benefits/Access Issues." The office has not conducted analyses to identify trends within this topic. Customer service, payment, and enrollment/ disenrollment each accounted for between 8 and 12 percent of contacts. Approximately one-third related to other issues such as Medicaid eligibility, care coordination, quality of care, transition coverage, and pharmacy availability. CMS, the ACL, and ODM have adopted new reporting categories for 2017. These changes will be discussed in greater detail in future reports.

Table 17
Ombudsman contacts by calendar year

Enrollee contacts	CY 2014	CY 2015	CY 2016	Total
Complaints and inquiries	475	884	757	2,116

SOURCE: Ohio Office of Long-Term Care Ombudsman.

Data on Complaints Received by ODM and 1-800-Medicare

As described above, beneficiaries may file complaints directly with ODM or 1-800-Medicare. The most current data available at the time of this report on the number and nature of those complaints cover the period May 2014–December 2016 and are shown in ***Table 18***.

Table 18
Number and category of beneficiary complaints filed with Ohio and 1-800-Medicare May 2014–December 2016

Category	Demonstration year 1	Demonstration year 2
Access and availability	0	0
Benefits/access	33	11
Confidentiality/privacy	0	0
Contractor/partner performance	0	0
Customer service	14	4
Enrollment/disenrollment	79	18
Equitable relief/good cause requests	0	0
Exceptions/appeals	0	0
Exceptions/appeals/ grievances	3	0
Marketing	1	0
Payment/claims	5	15
Plan administration	10	1
Pricing/premium/co-insurance	2	3
Program integrity issues/potential fraud, waste and abuse	0	0
Quality of care/clinical issues	0	0
Total	147	52

SOURCE: CMS, Complaint Tracking Module, Report covering May 2014–December 2016, Information Current as of February 15, 2017.

The number of complaints in year 1 was nearly three times that in year 2. As noted above, MMP staff attributed this trend to enrollees' confusion and lack of understanding of health plan operations and MyCare Ohio early in the demonstration. However, the volume of complaints was very low in both years. The highest number of complaints were in the enrollment/disenrollment categories. While no further details are available in the data on enrollment/disenrollment complaints, input from ODM staff suggests that some may not have been in reference to the enrollment/disenrollment process but rather, may represent contacts to ODM and CMS for the purpose of opting out. Additionally, some complaints may have related to enrollment discrepancies early in the demonstration (see ***Section 3.2.4, Integration of Medicare and Medicaid Enrollment Systems***) that led to confusion at the point of service.

The relatively low volume of complaints may reflect enrollee decisions to disenroll when they experienced difficulties in the demonstration, rather than undergo the formal grievance process. The low volume also may reflect instances in which enrollees worked with the ombudsman and care managers to resolve problems rather than submitting grievances (see above).

Appeals

The State and CMS developed joint policy on how appeals and grievances would be handled in the demonstration. Enrollee appeals related to Medicare services are first directed to plans for resolution or response. If the plan affirms its original decision, it must forward the case to Medicare's Independent Review Entity for a new review. Appeals related to Medicaid services can be directed by beneficiaries to either the plan or the State hearing officer. Each entity can be requested to review an appeal simultaneously or individually. If a plan's decision affirms its original action, enrollees are informed of their rights to access the State hearing officer and/or the next steps to seek a resolution of their appeal. The Medicaid appeal process will change to align with Medicare starting in 2018, in accordance with the 2016 Medicaid managed care rule and amended three-way contract. Future reports will provide further analysis of this process change.

Because beneficiaries have different appeals processes available to them depending on whether the service is covered by Medicare or Medicaid or both, three distinct notices are sent to enrollees for appeals related to Medicare services, Medicaid services, and crossover services that could be funded by either program, such as nursing facility services, home health, therapies, and durable medical equipment. The State has provided plans with a grid that outlines the program likely to apply for each plan benefit and has instructed plans to follow the payer sequence to determine which notice an enrollee will be sent to communicate the plan's decision.

As with complaints and grievances, MyCare Ohio plans are required to report the number and types of appeals as part of core reporting measures. These reports identify the number of appeals in six specific areas of interest to CMS: specialty services, LTSS, HCBS, institution-based LTSS, mental health, and substance use disorder. Appeals that do not fall within one of those six areas are grouped in a category called "other areas not mentioned."

Table 19 shows the number of appeals made to MyCare Ohio plans from April 2014 through September 2016, by outcome. In most quarters, less than ½ of all appeals resulted in a fully favorable or partially favorable outcome for beneficiaries. The appeals are categorized as denial or limited authorization of one of the following: specialty services; home and community-

based LTSS, institutional LTSS, mental health services, substance abuse treatment services, and "other." The majority of appeals were for denial or limited authorization of specialty care and in the "other" category.

Table 19
Total number of appeals by outcome across MyCare Ohio plans, by quarter

Calendar quarter	Enrollment	Total appeals	Fully favorable outcomes	Partially favorable outcomes	Adverse outcomes
2014					
Q2	8,953	5	100.0%	0.0%	0.0%
Q3	14,760	80	47.5%	1.3%	51.3%
Q4	16,069	151	50.3%	11.9%	37.7%
2015					
Q1	65,123	62	59.7%	0.0%	40.3%
Q2	63,013	189	68.8%	1.1%	30.2%
Q3	62,353	291	37.5%	1.0%	61.5%
Q4	60,326	248	41.9%	0.4%	57.7%
2016					
Q1	62,179	183	47.0%	0.0%	53.0%
Q2	62,471	216	45.8%	0.0%	54.2%
Q3	63,379	212	46.7%	0.5%	52.8%
Q4	69,365	204	43.6%	0.0%	56.4%

NOTES: The MyCare Ohio demonstration began May 1, 2014. Q2 2014 covers data for the period of May 2014 to June 2014. All subsequent quarters contain 3 months of complaints.

SOURCE: RTI analysis of MMP reported data for Core Measure 4.2, as of March 2017. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

Appeals Referred to IRE

As described earlier, initial appeals that result in an adverse outcome related to Medicare services are automatically referred to the IRE for further review. Data are available from May 2014–December 2015 on the number of appeals sent to the IRE. During this time period, the IRE received 270 appeals. Of these appeals, the determination made by the MyCare Ohio plan was upheld in 189 cases (70 percent); 31 (11.5 percent) were overturned; and 2 (0.7 percent) were partially overturned. The remaining appeals were dismissed, withdrawn, or pending as of the May 2016 report. The majority of appeals were related to clinical and laboratory services, home health, practitioner services, and durable medical equipment. Appeals relating to clinical and laboratory services and practitioner services represent the areas where the highest percent of appeals were overturned in favor of the beneficiary.

6. Stakeholder Engagement

Highlights

- Ohio Medicaid officials have engaged stakeholders through a variety of venues, including meetings of the MyCare Ohio Implementation team, regional forums, and meetings with enrollee and provider representatives.
- The State's Long-Term Care Ombudsman conducts enrollee outreach in community locations and meets with plan and stakeholder representatives to address implementation issues.
- The structure and function of MyCare Ohio plans' beneficiary advisory committees vary significantly. Enrollee stakeholders reported that some beneficiary advisory committees focus mainly on enrollee education and individual problem-solving, whereas others address broader issues such as the benefit package and models of transportation service.

6.1 Overview

The State has engaged stakeholders in a variety of ways. Just before the demonstration's launch, the ODM and the Department on Aging held a series of informational community forums across the demonstration regions to inform program design. Associations representing LTSS providers and facilities, hospitals, home care providers, and the AAAs met with Medicaid officials to learn more about the State's plans and provide feedback on the proposal (MyCare 2014 Annual Report, p. 6). MyCare Ohio plans held additional forums in 2014 to provide education and outreach to providers (MyCare 2014 Annual Report, p. 9).

To inform and help develop the demonstration's enrollment process, ODM established a multi-stakeholder Enrollment Advisory Workgroup. After enrollment began, ODM restructured the Enrollment Workgroup to become the MyCare Ohio Implementation Team, with a broader scope and membership. The MyCare Ohio Implementation Team, which meets quarterly, includes enrollee stakeholders and representatives of MyCare Ohio plans, providers, AAA regional offices, CMS, other State agencies, and the State's Long-Term Care Ombudsman.

Overall, health plan staff, as well as stakeholder groups that have been critical of the demonstration, believed that ODM has been effective in engaging most key stakeholders except primary care providers (see ***Section 2.2.2, Provider Arrangements and Services***). Stakeholders reported that the Medicaid Director and ODM staff have been responsive to their concerns.

6.2 Organization and Support

6.2.1 State Role and Approach

State officials said they have used MyCare Ohio Implementation Team meetings mainly to provide implementation updates (e.g., enrollment, grievance and appeals data), discuss special topics, and present key research findings. For example, during the November 2016 meeting, ODM staff presented CAHPS and HEDIS results.

Implementation Team meetings include time for open discussion, and if concerns about individual enrollees' experiences are raised, Medicaid officials follow up to provide assistance. ODM staff believed that the meetings are "a good venue for feedback," but said they are not intended as a forum to resolve implementation challenges affecting enrollees and providers broadly. Instead, State officials have addressed systemic implementation issues through issue-specific meetings and ongoing communication with MyCare Ohio plans, provider representatives, and enrollee stakeholders.

In response to implementation concerns expressed by enrollee representatives and other stakeholders, the ODM Director held forums from May to October 2015 in all seven demonstration regions. Issued raised during these forums included problems related to plan performance in providing home modifications, timeliness of provider payments and transportation, and knowledge of provider hotline staff. Based on input obtained during the forums, the State conducted research and follow-up. For example, MyCare Ohio plans were required to provide a listing of remaining payment problems and propose a timetable for resolution. For verification, the State's contract management staff compared the plan's list of payment issues with provider complaints to the State, and they provided monitoring and oversight to hold plans accountable.

According to ODM staff, the State did not implement significant new stakeholder engagement activities in 2016. State officials continued to meet with key stakeholders to discuss issues of concern, and they attended annual meetings of some provider groups (e.g., transportation vendors).

State officials and provider representatives reported that in response to input from the nursing facility community, ODM added new requirements to the provider agreement, which will become effective in 2017. These include changes to promote use of transportation vendors that are experienced in serving members with LTSS needs, as well as changes to improve the timeliness of nursing facility payment.

Activities of the Long-Term Care Ombudsman supplement ODM's stakeholder engagement efforts. The ombudsman's office has conducted outreach to enrollees at senior housing communities, county fairs, and houses of worship. The ombudsman's office also meets regularly with MyCare Ohio plan representatives and an enrollee stakeholder group to discuss implementation trends, challenges, and strategies to address them.

6.2.2 Beneficiary Advisory Committees

The three-way contract requires MyCare Ohio plans to obtain input from enrollees and community stakeholders on issues of demonstration management. The beneficiary advisory committees that every plan is required to establish in each region in which it participates constitute the primary vehicle by which plans receive such feedback (Ohio three-way contract, 2014, p. 80). These committees meet quarterly and provide input to their plans' governing boards. Plans are also required to demonstrate that participants reflect the diversity of their membership, including individuals with disabilities.

ODM and enrollee representatives reported that the function, structure, and composition of beneficiary advisory committees vary. Some plans use the committees mainly to provide member information and address enrollee-specific concerns, whereas others use the groups to seek input on plan policies and benefits and to address broader implementation challenges. Enrollee stakeholders said that a subset of the five MyCare Ohio plans' beneficiary advisory committees were functioning as collaborative entities for group problem-solving. Stakeholders reported that one plan allows drop-in participation, while others ask members to participate on an ongoing basis (e.g., for a year). One plan opens advisory committee meetings to members across all product lines, while other plans limit the group to Medicaid-only and demonstration enrollees.

Representatives of one MyCare Ohio plan said the plan has used beneficiary advisory committee meetings to provide education on topics such as access to behavioral health services, avoidance of scams, and fall prevention. According to plan staff, when advisory committee members raise an issue in multiple meetings, the plan does "a deeper dive" that may involve research or other follow-up. For example, after members reported difficulty locating behavioral health providers through the online directory, the plan conducted an audit to improve the directory's accuracy, made changes to clarify provider listings, and arranged for the plan's director of behavioral health services to attend an advisory group meeting to discuss how to access in-network services. Also, based on the committee's input on enrollee experiences with transportation services, the plan changed its transportation vendor to provide a door-to-door model of service delivery.

Another plan added supplemental transportation to its value-added benefits after hearing from its beneficiary advisory committee that lack of transportation was a significant barrier to care. Additionally, based on advisory committee members' comments about the length of the member handbook, the plan created a shorter, easy-to-read member "flip-book" with one-pagers on how to access member services, care management, transportation, and pharmacy benefits, as well as reminders for dental and vision care.

In Spring 2016, an enrollee stakeholder group provided training for beneficiary advisory committee members of two MyCare Ohio plans. Training covered issues such as group and committee dynamics and differentiation between personal issues and broader implementation issues that are appropriate for group discussion. ODM staff believed that the training was helpful to the plans for which it was conducted, whereas "the ones that [the stakeholder group] didn't work with are still having challenges" with enrollee engagement.

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7. Financing and Payment

Highlights

- MMP representatives reported mixed views about the adequacy of payment rates, and no plan has expressed intent to leave the demonstration.
- MMP and ODM staff reported continuing challenges with submission and processing of the encounter data needed for rate setting. State officials formed an encounter data team to address challenges and have gradually reduced backlogs in processing.
- MyCare Ohio plan representatives reported cost savings from reductions in hospital admissions, readmissions, and use of skilled nursing facility and emergency department services. However, State officials said they do not have data on cost savings.

7.1 Rate Methodology

All services covered under the demonstration are paid for using prospective capitated payments to MyCare Ohio plans. The monthly capitated rates that MyCare Ohio plans receive for each beneficiary consist of three separate components: one that covers Medicare Parts A and B services, a second that covers Medicare Part D services, and a third that covers Medicaid services (Ohio three-way contract, 2014, pp. 125–41). Each component, calculated using baseline spending trends, is risk-adjusted. The Medicare Parts A and B and Medicaid payments reflect the application of savings percentages and quality withholds that increase in each demonstration year (discussed below). This section describes the rate methodology of the demonstration and findings relevant to early implementation.

7.1.1 Rating Categories and Risk Adjustments

Risk-Adjusted Medicare Parts A and B Rates

The calculation of the Ohio Medicare capitation payments uses an approach developed by CMS for all capitated model demonstrations under the Financial Alignment Initiative. The Medicare spending baselines are calculated using a blend of standardized county Medicare fee-for-service (FFS) rates and projected Medicare Advantage (MA) payment rates based on the proportion of the population projected to participate in MA and FFS Medicare had the demonstration not been implemented. Separate baseline rates apply for beneficiaries with end-stage renal disease (ESRD) (Ohio three-way contract, 2014, pp. 129–30). The Medicare Parts A and B rates are risk-adjusted at the beneficiary-level using the CMS Hierarchical Condition Category (CMS-HCC) and CMS-HCC ESRD models. As in MA, MyCare Ohio plans do not receive the Medicare Parts A and B components of the capitated rate for beneficiaries receiving the Medicare hospice benefit.

Risk-Adjusted Medicare Part D Rates

The Medicare Part D component of the monthly capitation payment is calculated by multiplying the Part D national average monthly bid amount (NAMBA) by a beneficiary's prescription drug Hierarchical Condition Categories (RxHCC) risk score (Ohio three-way contract, 2014, p. 130). Average monthly low-income cost sharing subsidies and Federal reinsurance amounts are estimated by CMS, and the total is added to the risk-adjusted rates. The cost sharing subsidy and reinsurance payments are subject to the same annual reconciliation as other Medicare Part D sponsors. This approach is common across all States testing capitated model demonstrations.

Risk-Adjusted Medicaid Rates

Medicaid monthly rate cells vary by region and level of care (MyCare Ohio Provider Agreement, 2016, p. 94). Beneficiaries are categorized into one of two levels of care: (1) nursing facility level of care (NFLOC), which includes nursing facility residents meeting minimum-stay requirements as well as individuals eligible for or enrolled in a home and community-based waiver; or (2) community well, which includes beneficiaries not meeting NFLOC requirements. Payments for the community well population are further stratified by age group (18 to 44, 45 to 64, and 65 plus).

The Medicaid NFLOC rates are risk-adjusted using a retrospective member enrollment mix adjustment (MEMA) (Ohio three-way contract, 2014, p. 127). The MEMA is calculated using aggregate enrollment data in each region and is designed to provide higher rates to plans with a higher proportion of high-risk, high-cost beneficiaries (specifically, those that are institutionalized and individuals age 18 to 44 served by HCBS waivers). State officials noted that the MEMA was required because of the lack of an adequate grouper or comparable risk adjustment tool for the demonstration population.

Medical Loss Ratio

Consistent with Federal rules governing MA plans (CMS, 2013), MyCare Ohio plans are required to maintain a minimum medical loss ratio of 85 percent (Ohio three-way contract, 2014, pp. 131–3). For calculation purposes, plans are allowed to attribute select personnel costs, including the costs for care coordinators whose primary duty is direct beneficiary contact and the portion of the medical director's time attributable to MyCare Ohio. Quality withholds are included in the calculation of plans' revenue regardless of whether the plan actually receives the withhold payment. Plans with a medical loss ratio of less than 85 percent are required to proportionately refund the difference to ODM and CMS. Plans with a medical loss ratio between 85 and 90 percent may be required to submit a corrective action plan.

7.1.2 Encounter Data

ODM requires the plans to submit encounter data to the State's actuarial contractor. Throughout the demonstration, ODM and MyCare Ohio plan staff have reported challenges with collecting and processing encounter data. ODM and MyCare Ohio plan staff reported that plans must first submit Medicare encounters to CMS, and upon receiving the claim back from CMS, they submit the claim to ODM for Medicaid processing. According to health plan staff, problems have occurred due to misalignment between Medicare and Medicaid systems; ODM systems

sometimes have been unable to process the data returned from CMS. Many of the edits built into the Medicaid Information Technology System (MITS) under the FFS system have impeded the processing of encounter data. A State official noted that some of the encounter data from CMS includes enrollees' health insurance claim numbers (HICNs) and have been difficult to match with the corresponding enrollee data in the MITS.

Crossover claims have presented additional challenges. ODM staff noted that because the State and CMS did not develop a uniform policy on the attribution of Medicare and Medicaid costs on crossover claims, plans varied in the relative proportion of crossover claim costs attributed to each program.

To improve the submission and processing of encounter data, State officials formed an encounter data team that includes MyCare Ohio plan representatives. In the past year, plan and ODM staff worked on improving the accuracy and completeness of encounter data, and ODM has removed many automated edits to the MITS that previously delayed processing. State officials reported during the December 2016 site visit that most of the backlogs had been eliminated, and they expressed hope that within 6–8 months, they will have processed at least 95 percent of encounter data within the MITS.

7.1.3 Savings Percentage

Aggregate savings percentages are applied equally to the Medicare Parts A and B and Medicaid baseline spending components of the capitated rate (i.e., representing savings to the State and to CMS), based on the expectation that reasonable savings could be achieved while paying participating plans adequate rates (MOU, 2012, p. 39). As shown in ***Table 20***, the aggregate savings percentages are 1 percent in the first demonstration year, rising to 4 percent in the third (Ohio three-way contract, 2014, p. 130). These percentages were determined jointly by CMS and Ohio before the demonstration. Savings percentages are not applied to the Medicare Part D component of the capitation, although material changes in Part D spending may factor into modifying the savings rates applied to Medicare Parts A and B in future years (Ohio three-way contract, 2014, p. 134).

Table 20
Savings rates by demonstration year

Demonstration year	Period covered	Savings rate
Year 1	5/1/2014–12/31/2015	1%
Year 2	1/1/2016–12/31/2016	2%
Year 3	1/1/2017–12/31/2017	4%

7.1.4 Performance Incentives

Quality Withholds

A portion of the capitated rates is withheld to incentivize plans to meet quality thresholds established by CMS and ODM (Ohio three-way contract, 2014, pp. 134–9). Plans can earn back

the withheld amounts by meeting quality thresholds. As seen in ***Table 21***, the percentage of the rate that is withheld increases across the demonstration years, from 1 percent in the first year and up to 3 percent in the third. Medicare Part D rates are not subject to the quality withhold.

Table 21
Quality withhold percentages by demonstration year

Demonstration year	Period covered	Withhold
Year 1	5/1/2014–12/31/2015	1%
Year 2	1/1/2016–12/31/2016	2%
Year 3	1/1/2017–12/31/2017	3%

The quality withhold repayment is based on six measures in the demonstration year 1 and nine measures in the demonstration years 2 and 3. In addition to two beneficiary satisfaction measures and a nursing facility diversion measure, the demonstration year 1 measure set includes three process measures meant to ensure that the plans are meeting the demonstration's administrative requirements: timely and accurate encounter data submission; the percentage of assessments completed within 90 days; and creation of a beneficiary governance board (Ohio three-way contract, 2014, pp. 135–6). Note that due to timing constraints and other considerations, the encounter measure and beneficiary satisfaction measures did not apply for the first calendar year in demonstration year 1 (i.e., 2014). In demonstration years 2 and 3, all but two (the nursing facility diversion measure and encounter measure) are replaced with a mix of process and outcome measures tied to patient care (e.g., all-cause readmissions, follow-up after hospitalization for mental illness, blood pressure control). An overall long-term care balance measure also is included in demonstration years 2 and 3. Ohio selected quality and performance metrics that aligned with Ohio Medicaid's Quality Strategy.[17]

Rebalancing Incentives

MyCare Ohio plans are incentivized, as appropriate, to move beneficiaries from NFLOC status (which includes both long-term nursing facility residents and individuals eligible for or enrolled in an HCBS waiver) to the community, i.e., to either an HCBS waiver or community well status. Plans continue to receive the higher NFLOC capitation rate for beneficiaries moved to the community well level of care for a full 3 months after the change in categorization (Ohio three-way contract, 2014, p. 127). State officials indicated that MMPs supported this incentive.

ODM reported that none of the MMPs met the quality withhold benchmark and minimum performance standard for nursing facility diversion in 2014 or 2015. During the December 2016 site visit, State officials indicated that year 1 withhold funds had not yet been distributed to MMPs. As of December 2016, ODM was in the process of revising the methodology for the measures (see ***Section 9.1.1, Quality Measures***) and anticipated that withhold funds would be distributed to plans in early 2017.[18]

[17] A full list of quality withhold measures is included in ***Section 9.1.1***.
[18] The 2014 and 2015 quality withhold payments were distributed to MyCare Ohio plans in 2017.

7.2 Financial Impact

7.2.1 Adequacy of Rates

During the demonstration's first year, State officials identified sustainability as a top priority for developing the demonstration's payment rates. Acknowledging that they had not developed capitated rates for this population before—and that this demonstration had removed the plans' ability to negotiate nursing facility per diem rates—interviewees stressed that rates were developed to provide a budget-neutral payment that allowed the plans to operate in a fiscally sound manner. State officials reported that it took approximately 2 years to finalize the Medicaid rates, a much longer time frame than expected. One interviewee identified the primary challenge as having multiple actuaries (those at Mercer, CMS, and the plans) review the rates.

Effective January 2016, the State significantly reduced the Medicaid portion of the capitation rate , which is based on the Medicaid only (opt-out) rate. Plans expressed concern that the reduced rate—particularly the administrative portion—did not sufficiently account for MyCare Ohio's "high-touch" approach to care management or for the demonstration's extensive reporting requirements.

State officials said they had asked plans to submit cost data to support a need for a higher administrative component of the Medicaid rate, but that plans had not provided the data. Staff of one plan noted that the process of determining the 2016 Medicaid rate was delayed significantly. According to the plan's staff, the rate ultimately determined was not sufficient to cover the cost of waiver service coordination, particularly the cost for AAAs to hire registered nurses (RNs) to provide needed clinical expertise (see ***Section 4.1.2, Care Planning Process***). Therefore, the MMP reimbursed AAAs at a rate above the level covered by the State's capitation payments.

According to an ODM official, the State conducts actuarial analyses to examine plans' financial status on a quarterly basis and decided to increase the underlying Medicaid only (opt-out) rates in 2017. The rate for waiver service coordination also will increase by an average of 20 percent across demonstration regions; this change also increases the Medicaid portion of the MyCare rate.

MyCare Ohio plans submit encounter data to the State for both the demonstration and the Medicaid only (opt-out) portion of MyCare Ohio (see ***Executive Summary***). In addition to the encounter data, MyCare Ohio plans submit quarterly annual financial data summaries (cost reports). Under contract with the State, Milliman reviewed encounter data and cost reports in the rate development process. Encounter data has historically been incomplete when compared to the total expenses submitted in the cost reports, especially for the opt-in (i.e. demonstration) component of MyCare Ohio. Significant improvements in the encounter data quality have been noted for the opt-out Medicaid-only component; however, the opt-in encounter data continues to be less complete than the opt-out encounter data.

In ODM/Milliman's correspondence with CMS, CMS clarified that the MyCare Ohio demonstration capitation rates are to be developed absent the MyCare Ohio demonstration experience, and instead include only the opt-out Medicaid-only experience. For calendar year 2017 and calendar year 2018 capitation rates, Milliman developed the opt-out Medicaid-only

capitation rates first, then applied selection factors to develop the demonstration capitation rates. The base data for the calendar year 2017 MyCare Ohio rates represented a blend of opt-in and opt-out experience; however, CMS indicated a preference to use only opt-out experience. Therefore, for calendar year 2018, Milliman adjusted the rate setting process to develop the opt-out capitation rates solely from opt-out experience, and did not use the opt-in experience for the base data.

When asked about plans' financial status during the December 2016 site visit, a State official commented that "Some of the plans are losing money in MyCare. Some aren't…They will all tell you they could be paid more…I don't think we're concerned at all that the plans are going to leave [the demonstration]."

Plan staff reported mixed views about the adequacy of 2017 rates, but none expressed an intent to leave the demonstration. Staff of one plan said they are comfortable with the rate overall, but they believed that it does not adequately account for the costs of assessments, reassessments, and care planning. They said they would continue to seek an increase to cover care management costs.

Staff at another MMP said they have "started to get some heartburn" about increases in both the savings percentage and the withhold, which have "basically eliminated our margin." Representatives of a third plan did not express concern about 2017 rates. Plan staff reported that State actuaries had taken a "reasonable" and "fair" approach that incorporated plans' feedback during the rate setting process.

7.2.2 Cost Experience

During the 2014 and 2015 site visits, MyCare Ohio plans did not indicate that they had achieved cost savings, but during the December 2016 site visit, some MMPs reported that they had realized cost savings due to reductions in inpatient admissions and readmissions and in use of skilled nursing facilities and emergency department services. Plans expressed a desire to achieve additional savings from reduced utilization of skilled nursing facility services. Representatives of one plan said to increase savings in the future, they will pursue strategies that have been successful in their Medicaid managed care products to address emergency department, pharmacy, and behavioral health costs.

State officials said they did not have data to indicate cost savings by the plans, and one official commented that cost savings was not a primary goal of the demonstration. "Theoretically there could be some savings," he said, "but it's generally not why we went about the initiative. We had a whole host of other reasons to do it," such as improving care coordination and quality.

8. Service Utilization

Highlights

- As measured across all eligible beneficiaries, the demonstration resulted in a 21.3 percent reduction in inpatient admissions, a 14.3 percent reduction in the probability of ambulatory care sensitive condition (overall) admissions, a 13.2 percent reduction in the probability of ambulatory care sensitive condition (chronic) admissions, and a 15.3 percent reduction in skilled nursing facility admissions. Conversely, the demonstration resulted in a 10.3 percent increase in preventable emergency room visits.
- Although the results on the measures above for those with severe and persistent mental illness were in the same direction and to a different degree as for all eligible beneficiaries, results for those with any LTSS use were higher and in the opposite direction than for all eligible beneficiaries for both skilled nursing facility admissions and the probability of ambulatory care sensitive condition (chronic) admissions.

The purpose of the analyses in this section is to understand the effects of the MyCare Ohio demonstration through demonstration year 1 (ending calendar year 2015) using difference-in-differences (DID) regression analyses. In addition, descriptive statistics on service utilization are provided for selected Medicare services. As discussed in ***Section 1.2*** (***Model Description and Demonstration Goals***), five competitively selected health plans (called MyCare Ohio plans) provided integrated Medicare and Medicaid services, including primary, acute, behavioral health, and long-term services and supports (LTSS), to enrollees in the demonstration. Additionally, since the time of the demonstration's launch in May 2014, Medicare-Medicaid enrollees in the 29 demonstration counties have been required to receive Medicaid benefits from the same five plans, even if they opt out of the demonstration. The five participating MMPs are Aetna, Buckeye Health Plan (Centene), CareSource, Molina Healthcare of Ohio, and UnitedHealthcare.

We find evidence that the demonstration resulted in significant changes in utilization patterns, including changes in quality of care and care coordination. These include lower utilization on most of the institutional and community service measures, and higher use on only one institutional measure. ***Table 22*** presents an overview of the results from impact analyses using Medicare and Minimum Data Set (MDS) data through demonstration year 1. The relative direction of all statistically significant results at the $p < 0.10$ significance level (derived from 90 percent confidence intervals [CIs]) is shown.

Monthly inpatient admissions, physician evaluation and management (E&M) visits, and skilled nursing facility (SNF) admissions were lower, and the probability of any long-stay nursing facility (NF) use was lower for the Ohio demonstration group than for the comparison group. There was no statistically significant difference in monthly emergency room (ER) visits between the demonstration and comparison groups. For the RTI quality of care and care

coordination measures, the probability of overall and chronic ambulatory care-sensitive condition (ACSC) admissions was lower for the demonstration group than the comparison group, whereas the number of preventable ER visits was higher. As with ER visits overall, the demonstration had no impact on the probability of monthly follow-up after mental health discharges or the count of all-cause 30-day readmissions.

Table 22
Summary of MyCare demonstration impact estimates for demonstration period (May 1, 2014, to December 31, 2015)

Measure	All demonstration eligibles	Demonstration eligibles with LTSS use	Demonstration eligibles with SPMI
Inpatient admissions	Lower	Lower	Lower
Probability of ambulatory care-sensitive condition (ACSC) admissions, overall	Lower	NS	Lower
Probability of ACSC admissions, chronic	Lower	Higher	Lower
All-cause 30-day readmissions	NS	Lower	NS
Emergency room (ER) visits	NS	NS	NS
Preventable ER visits	Higher	Higher	Higher
Probability of monthly follow-up after mental health discharges	NS	NS	NS
Skilled nursing facility (SNF) admissions	Lower	Higher	Lower
Probability of any long-stay nursing facility (NF) use	Lower	N/A	N/A
Physician evaluation and management (E&M) visits	Lower	NS	Lower

LTSS = long-term services and supports; N/A = not applicable; NS = not statistically significant; SPMI = severe and persistent mental illness.

NOTES: The relative direction of all statistically significant results at the $p < 0.10$ significance level (derived from 90 percent confidence intervals) is shown.

SOURCE: RTI analysis of Medicare and Minimum Data Set data.

The relative directions of the impact estimates for demonstration eligibles who used LTSS were different from the findings for the overall demonstration eligible population in terms of most of the outcome measures, although the relative directions of the impact estimates for those with severe and persistent mental illness (SPMI) were similar to the overall demonstration eligible population.

8.1 Overview of Benefits and Services

In conjunction with implementing the demonstration, Ohio Medicaid created a 1915(c) waiver that consolidated features of five "legacy" home and community-based services (HCBS) waivers into a new MyCare Ohio waiver for enrollees who meet the State's criteria for receiving an NF level of care. Under the new waiver, homemaker and home attendant services—previously not offered under all the legacy HCBS waivers—are now available to all enrollees.

In addition to benefits provided through the new, consolidated waiver, the demonstration provides (1) coordination of primary, acute care, behavioral health (BH), and LTSS; (2) value-added, or flexible benefits, such as supplemental transportation, expanded dental coverage, and coverage of specified over-the-counter drug products up to a monthly dollar limit; and (3) the option to self-direct specified HCBS waiver services.

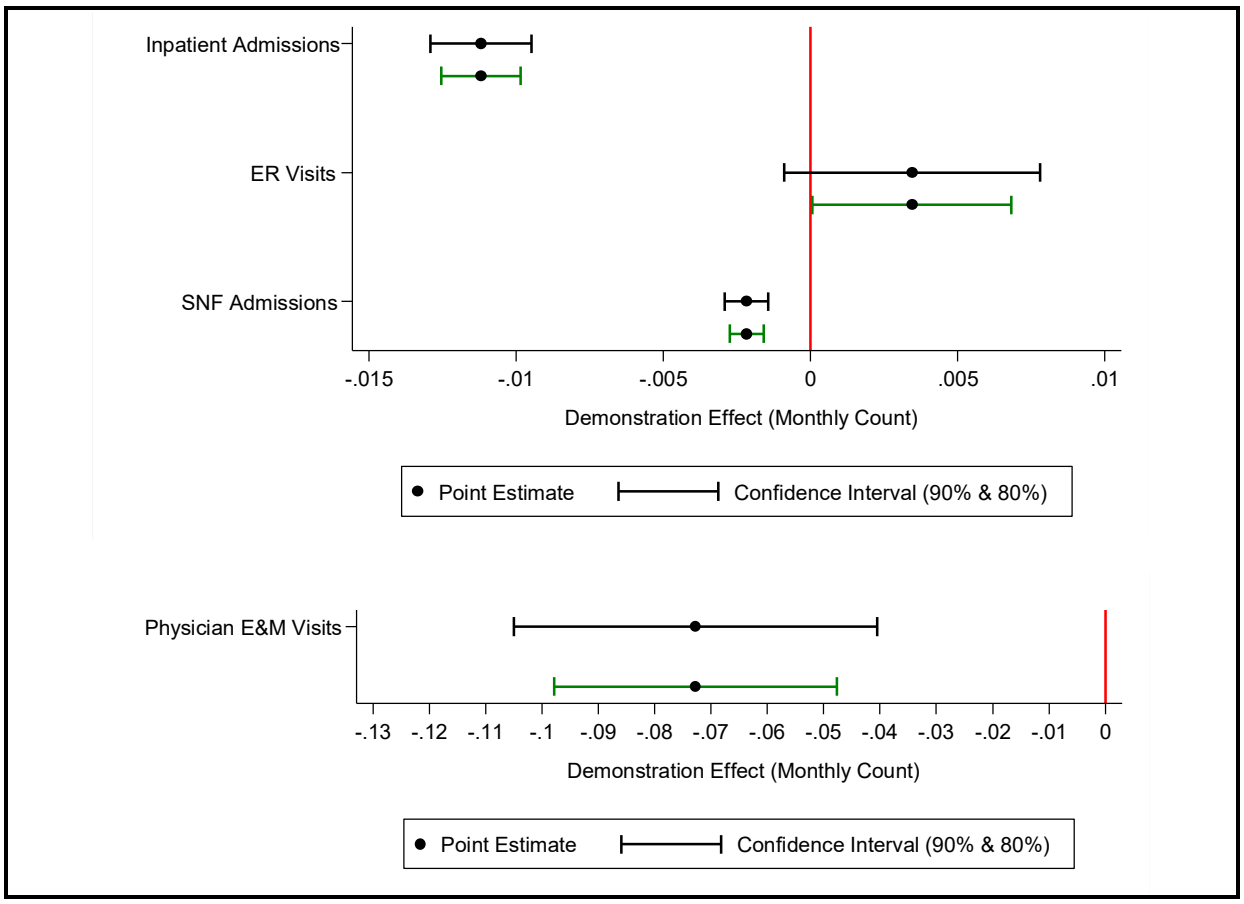
8.2 Impact Analyses on the Demonstration Eligible Population

The population analyzed in this section includes all beneficiaries who met demonstration eligibility criteria in Ohio or in the comparison areas for Ohio. For context, in Ohio, approximately 71 percent of eligible beneficiaries in demonstration year 1 whose utilization was analyzed were enrolled in MyCare Ohio. ***Appendix A*** provides a description of the comparison group for Ohio. Demonstration eligibility requirements are described in ***Section 3.2***. Subsections within this section present the results for demonstration eligible beneficiaries with any use of LTSS (defined as receipt of any institutional long-stay NF services or Medicaid HCBS encounters) and results for demonstration eligible beneficiaries with SPMI.

Appendix B contains a description of the evaluation design, the comparison group identification methodology, data used, measure definitions, and regression methodology used in estimating demonstration impacts using a DID approach. The regression methodology accounts for differences between the demonstration and comparison groups during the predemonstration period (May 1, 2012–April 30, 2014) and the first demonstration year (May 1, 2014–December 31, 2015) to provide estimates of demonstration impact.

Figures 1 and ***2*** display the Ohio demonstration's effect on key service utilization measures for the demonstration group relative to the comparison group through demonstration year 1. The demonstration decreased monthly inpatient admissions by 0.0112 admissions per month (90 percent CI: –0.0129, –0.0095). After multiplying the monthly estimate by 12, the annual estimate corresponds to 0.1343 fewer inpatient admissions per eligible beneficiary per year. The demonstration also decreased physician E&M visits by 0.0728 visits per month (90 percent CI: –0.1050, –0.0405) and SNF admissions by 0.0022 visits per month (90 percent CI: –0.0029, –0.0014). The demonstration also resulted in a 1.59 percentage point decrease (90 percent CI: –2.07, –1.11) in the probability of any long-stay NF use during demonstration year 1. This measure is defined as the number of individuals who stayed in a NF for 101 days or more, who were long-stay after the first month of demonstration eligibility, and it includes both new admissions from the community and those with a continuation of a stay in a NF. There was no statistically significant demonstration effect on ER visits.

Figure 1
Demonstration effects on service utilization for eligible beneficiaries in Ohio—Difference-in-differences regression results for the demonstration period, May 1, 2014–December 31, 2015

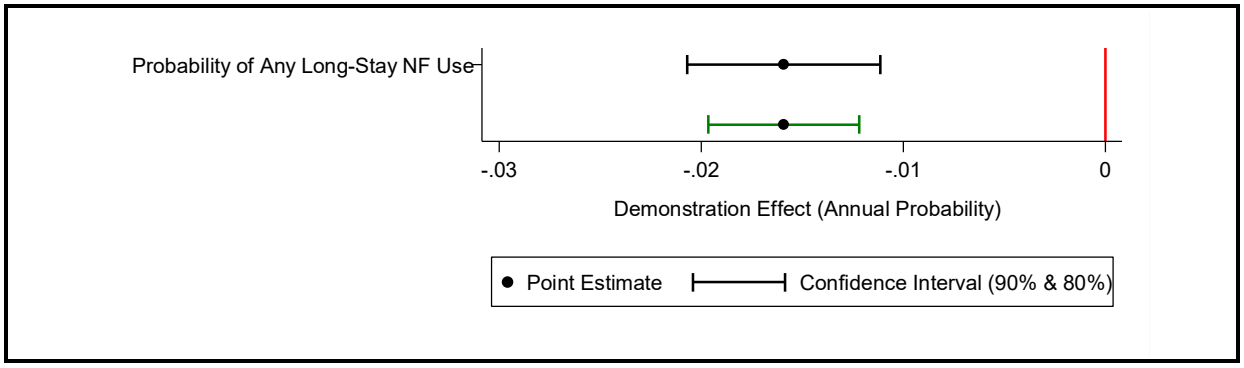


E&M = evaluation and management; ER = emergency room; SNF = skilled nursing facility.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. 80 percent confidence intervals are provided here for comparison purposes only. The 90 percent intervals are black, and the 80 percent intervals are green.

SOURCE: RTI International analysis of Medicare data.

Figure 2
Demonstration effects on long-stay nursing facility use for eligible beneficiaries in Ohio—Difference-in-differences regression results for the demonstration period, May 1, 2014–December 31, 2015



NF = nursing facility.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. 80 percent confidence intervals are provided here for comparison purposes only. The 90 percent intervals are black, and the 80 percent intervals are green.

SOURCE: RTI International analysis of Minimum Data Set data.

Tables 23 and ***24*** present the demonstration's effects on service utilization for the first demonstration year. The demonstration reduced average monthly inpatient admissions by 0.0112 admissions ($p < 0.0001$), reduced average monthly physician E&M visits by 0.0728 visits ($p = 0.0002$), and reduced average monthly SNF admissions by 0.0022 admissions ($p < 0.0001$). The reduction in the probability of any long-stay NF use is statistically significant, with a 1.59 percentage point decrease ($p < 0.0001$) in the first demonstration year. The demonstration effect on ER visits was not statistically significant.

Table 23
Annual demonstration effects on service utilization for eligible beneficiaries in Ohio

Utilization measure (per month)	Demonstration year 1 (5/14–12/15)
Inpatient admissions	−0.0112**
ER visits	0.0035
Physician E&M visits	−0.0728**
SNF admissions	−0.0022**

E&M = evaluation and management; ER = emergency room; SNF = skilled nursing facility.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. Significance based on 80 percent confidence intervals are provided here for comparison purposes only. * indicates significant at $p < 0.20$, ** indicates significant at $p < 0.10$.

SOURCE: RTI International analysis of Medicare data.

Table 24
Annual demonstration effects on probability of long-stay nursing facility use for eligible beneficiaries in Ohio

Utilization measure (per demonstration year)	Demonstration year 1 (5/14–12/15)
Probability of any long-stay NF use	−0.0159**

NF = nursing facility.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. Significance based on 80 percent confidence intervals are provided here for comparison purposes only. * indicates significant at $p < 0.20$, ** indicates significant at $p < 0.10$.

SOURCE: RTI International analysis of Minimum Data Set data.

Table 25 provides estimates of the regression-adjusted mean values of the utilization measures for the demonstration and comparison groups for the predemonstration and demonstration periods for each service. The purpose of this table is to understand the magnitude of the DID estimate relative to the adjusted mean outcome value in each period. The values in the third and fourth columns represent the post-regression, mean predicted value of the outcomes for each group in each period, based on the composition of a reference population (the comparison group in the demonstration period). These values show how different the two groups were in each period and the relative direction of any potential effect in each group over time. In addition to the graphic representation above, the DID estimate is also provided for reference, along with the *p*-value and the relative percent change of the DID estimate compared to an average mean use rate for the comparison group over the entire demonstration period.

As shown in the table, the adjusted mean for monthly inpatient admissions was higher in the demonstration group than in the comparison group in the predemonstration period and was lower in the demonstration period. The DID estimate, which was negative (−0.0112) and statistically significant ($p < 0.0001$), implies a lower annual relative percentage difference of −21.3 percent between the demonstration and comparison groups. In contrast, the adjusted mean for monthly physician E&M visits was higher for the demonstration group in both the predemonstration period and the demonstration period, but due to the smaller difference during the demonstration period, we observed a negative (−0.0728) and statistically significant ($p = 0.0002$) DID estimate reflecting a lower relative percentage difference of −6.3 percent between the demonstration and comparison groups. In addition, the adjusted mean for monthly SNF admissions had a similar pattern, yielding a negative (−0.0022) and statistically significant ($p < 0.0001$) DID estimate that implies a relative percentage difference of −15.3 percent between the demonstration and comparison groups. The DID estimate was −1.59 percent for the probability of any long-stay NF use during the demonstration period, which represents a relative percentage difference of –7.9 percent between the demonstration and comparison groups. The DID estimate for ER visits was not significant.

Table 25
Adjusted means and impact estimate for eligible beneficiaries in the demonstration and comparison groups in Ohio through December 31, 2015

Measure	Group	Adjusted mean for predemonstration period	Adjusted mean for demonstration period	Relative difference (%)	Regression-adjusted difference-in-differences (90% confidence interval)	*p*-value
Inpatient admissions	Demonstration group	0.0603	0.0450	−21.3	−0.0112 (–0.0129, –0.0095)	< 0.0001
	Comparison group	0.0572	0.0526			
ER visits	Demonstration group	0.0805	0.0871	NS	0.0035 (–0.0009, 0.0078)	0.1900
	Comparison group	0.1031	0.1077			
Physician E&M visits	Demonstration group	1.4087	1.2690	−6.3	−0.0728 (–0.1050, –0.0405)	0.0002
	Comparison group	1.2237	1.1643			
SNF admissions	Demonstration group	0.0219	0.0156	−15.3	−0.0022 (–0.0029, –0.0014)	< 0.0001
	Comparison group	0.0179	0.0144			
Probability of any long-stay NF use	Demonstration group	0.2845	0.2308	−7.9	−0.0159 (–0.0207, –0.0111)	< 0.0001
	Comparison group	0.2361	0.2005			

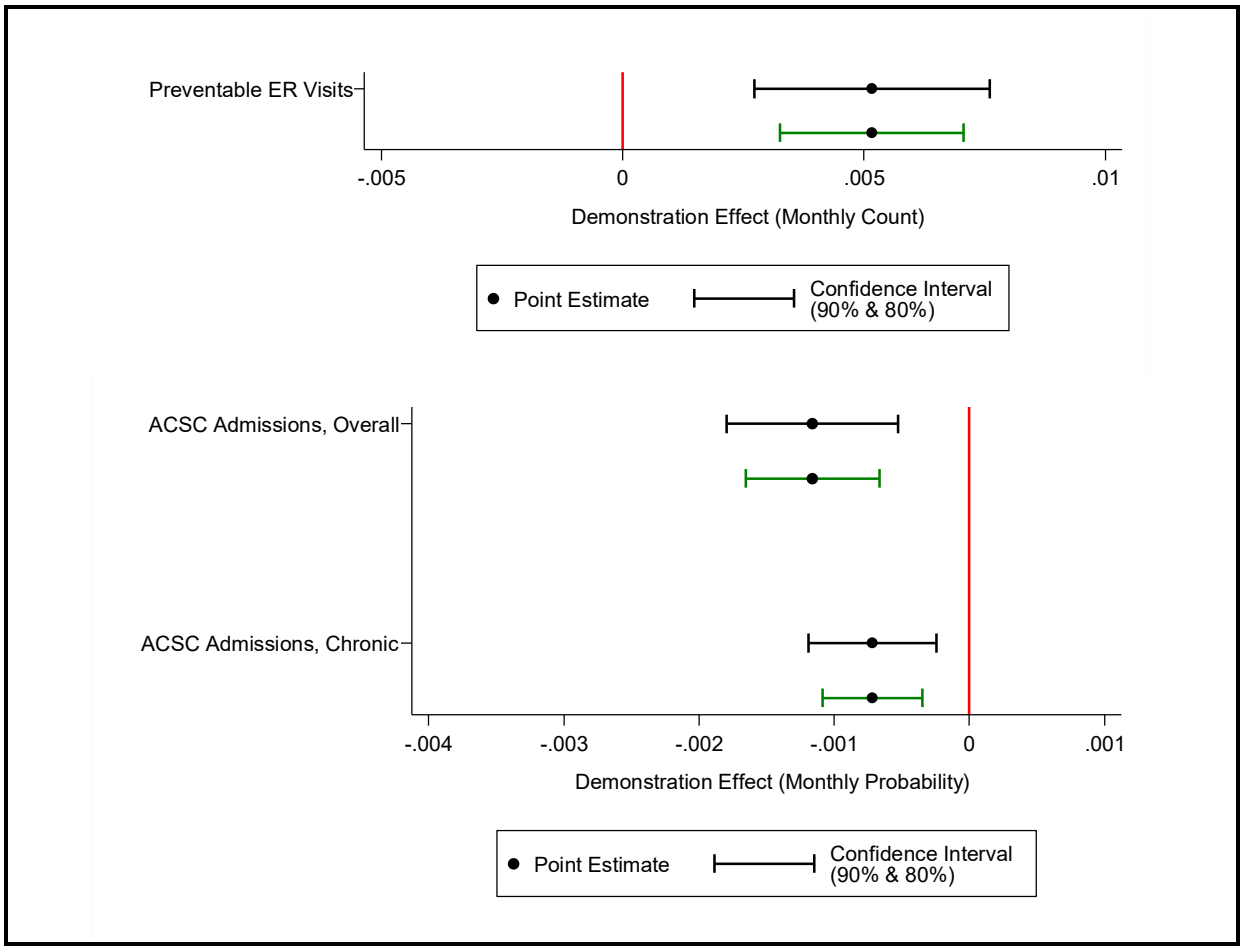
E&M = evaluation and management; ER = emergency room; NF = nursing facility; NS = not statistically significant; SNF = skilled nursing facility.

NOTE: Standard statistical practice is to use confidence intervals of 90 percent or higher.

SOURCE: RTI International analysis of Medicare and Minimum Data Set data.

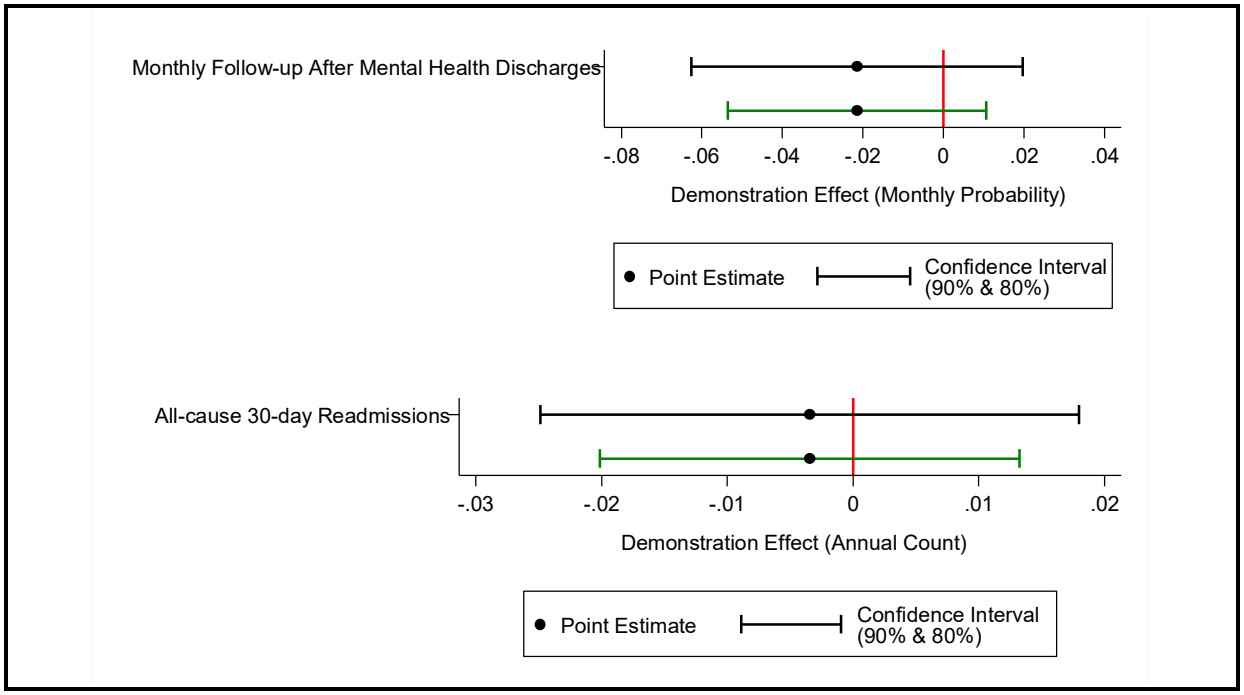
Figure 3 displays the Ohio demonstration's effects on RTI quality of care and care coordination measures for the demonstration group relative to the comparison group through demonstration year 1. The Ohio demonstration decreased the probability of monthly inpatient ACSC admissions both overall (lower by 0.12 percent per month; 90 percent CI: −0.0018, −0.0005) and for chronic conditions (lower by 0.07 percent per month; 90 percent CI: −0.0012, −0.0002). However, there was an increase in monthly preventable ER visits (higher by 0.0052 visits; 90 percent CI: 0.0027, 0.0076) during the demonstration period. There was no statistically significant demonstration effect on the probability of monthly follow-up after mental health discharge or the count of all-cause 30-day inpatient readmissions.

Figure 3
Demonstration effects on RTI quality of care measures for eligible beneficiaries in Ohio—Difference-in-differences regression results for the demonstration period, May 1, 2014–December 31, 2015



(continued)

Figure 3 (continued)
Demonstration effects on RTI quality of care measures for eligible beneficiaries in Ohio—Difference-in-differences regression results for the demonstration period, May 1, 2014–December 31, 2015



ACSC = ambulatory care-sensitive condition; ER = emergency room.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. 80 percent confidence intervals are provided here for comparison purposes only. The 90 percent intervals are black, and the 80 percent intervals are green.

SOURCE: RTI International analysis of Medicare data.

Table 26 presents the demonstration's effects on the RTI quality of care and care coordination measures for the first demonstration year. We indicate the previously reported point estimates with their associated significance levels.

Table 26
Annual demonstration effects on quality of care and care coordination for eligible beneficiaries in Ohio

Quality of care and care coordination measures	Demonstration year 1 (5/14–12/15)
Preventable ER visits	0.0052**
Probability of ACSC admissions, overall	−0.0012**
Probability of ACSC admissions, chronic	−0.0007**
Probability of monthly follow-up after mental health discharges	−0.0214
All-cause 30-day readmissions	−0.0034

ACSC = ambulatory care-sensitive conditions; ER = emergency room.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. Significance based on 80 percent confidence intervals are provided here for comparison purposes only. * indicates significant at $p < 0.20$, ** indicates significant at $p < 0.10$.

SOURCE: RTI International analysis of Medicare data.

Table 27 provides estimates for the regression-adjusted mean value for each of the demonstration and comparison groups for the predemonstration and demonstration periods for the RTI quality of care and care coordination measures. The purpose of this table is to understand the magnitude of the DID estimates for quality of care outcomes relative to the adjusted mean values in each period. The values in the third and fourth columns represent the post-regression, mean predicted value of the outcomes for each group in each period, based on the composition of a reference population (the comparison group in the demonstration period). These values show how different the two groups were in each period and the relative direction of any potential effect in each group over time. In addition to the graphic representation above, the DID estimate is also provided for reference, along with the *p*-value and the relative percent change of the DID estimate compared to an average mean use rate for the comparison group during the entire demonstration period.

The adjusted mean for the probability of overall ACSC admissions was higher for the demonstration group than for the comparison group in the predemonstration period and was lower in the demonstration period. The DID estimate, which was negative (−0.0012) and statistically significant ($p = 0.0026$), implies an annual relative percentage difference of −14.3 percent between the demonstration and comparison groups. The relative percentage difference was −13.2 percent for chronic ACSC admissions. In contrast, the adjusted means for preventable ER visits were lower for the demonstration group than the comparison group during both periods, but due to the larger increase in the demonstration group over time, we observed a positive and statistically significant relative difference of 10.3 percent. The DID estimates for the probability of monthly follow-up after mental health discharges and the count of all-cause 30-day readmissions were not significant.

Table 27
Adjusted means and impact estimate for eligible beneficiaries in the demonstration and comparison groups for Ohio through demonstration year 1

Measure	Group	Adjusted mean for predemonstration period	Adjusted mean for demonstration period	Relative difference (%)	Regression-adjusted difference-in-differences estimate (90% confidence interval)	*p*-value
Preventable ER visits	Demonstration group	0.0377	0.0434	10.3	0.0052 (0.0027, 0.0076)	0.0005
	Comparison group	0.0490	0.0506			
Probability of ACSC admission, overall	Demonstration group	0.0095	0.0076	−14.3	−0.0012 (−0.0018, −0.0005)	0.0026
	Comparison group	0.0091	0.0084			
Probability of ACSC admission, chronic	Demonstration group	0.0056	0.0046	−13.2	−0.0007 (−0.0012, −0.0002)	0.0130
	Comparison group	0.0057	0.0053			
Probability of monthly follow-up after mental health discharges	Demonstration group	0.3618	0.3725	NS	−0.0214 (−0.0626, 0.0198)	0.3924
	Comparison group	0.4301	0.4634			
All-cause 30-day readmissions	Demonstration group	0.3446	0.4935	NS	−0.0034 (−0.0249, 0.0180)	0.7919
	Comparison group	0.3382	0.4877			

ACSC = ambulatory care-sensitive conditions; ER = emergency room.

NOTE: Standard statistical practice is to use confidence intervals of 90 percent or higher.

SOURCE: RTI International analysis of Medicare data.

8.2.1 Descriptive Statistics on the Demonstration Eligible Population

In addition to the impact results presented for the demonstration eligible population in this section, ***Appendix C, Tables C-1*** through ***C-3,*** present descriptive statistics for the demonstration eligible population for each service for the predemonstration and demonstration years to help understand the utilization experience over time. We examine 12 Medicare service utilization measures, six RTI quality of care measures, and five NF-related measures derived from the MDS. No statistical testing was performed between groups or years. The results reflect the underlying experience of the two groups, and not the DID estimates presented earlier.

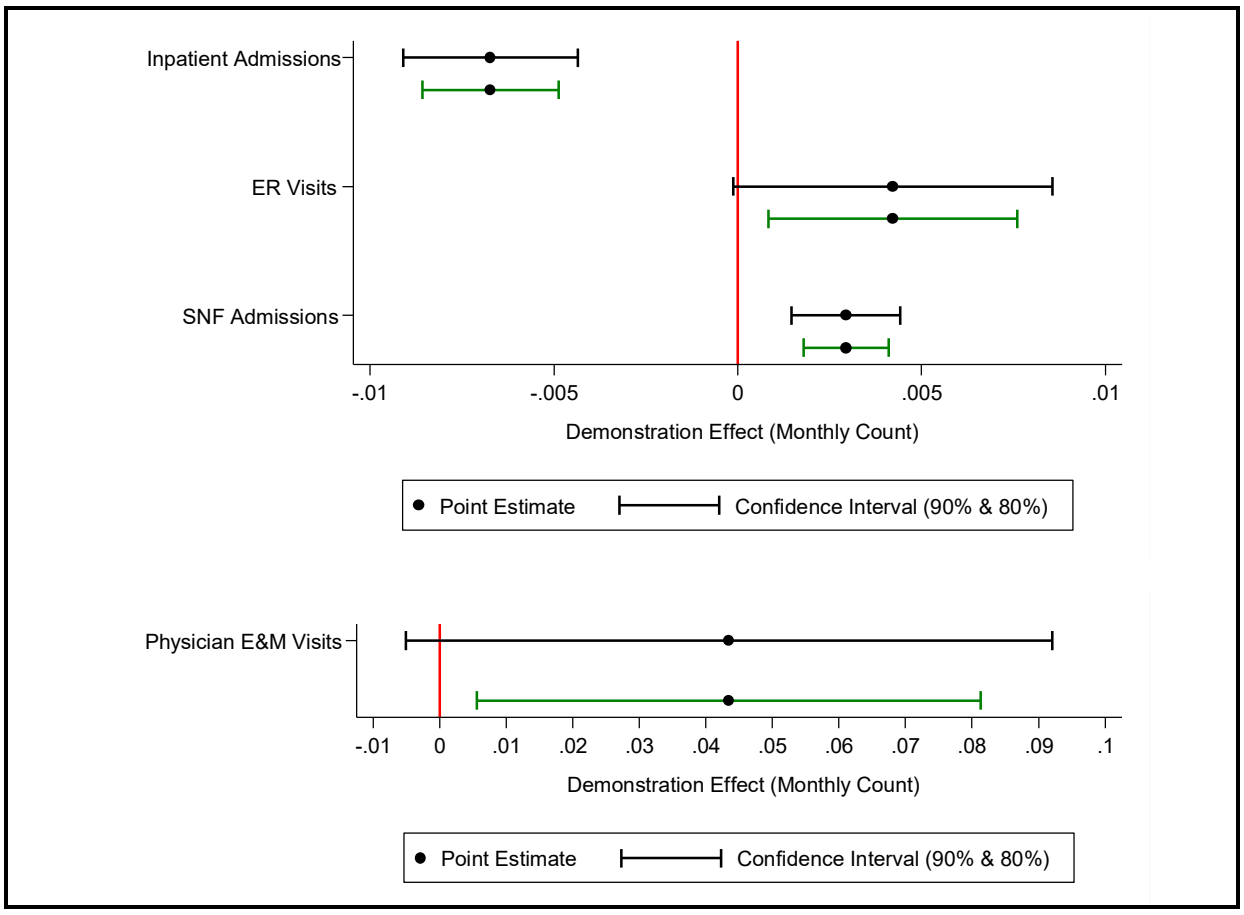
The demonstration and comparison groups were similar across many of the service utilization measures in each of the predemonstration (baseline) years and the demonstration years (***Table C-1***). However, there were a few outcomes where some differences were apparent. For example, ER use tended to be lower for the demonstration group than the comparison group, whereas SNF use tended to be higher. As with the service utilization measures, the Ohio demonstration eligible beneficiaries were similar to the comparison group on many, but not all, of the RTI quality of care and care coordination measures (***Table C-2***). Key differences included lower rates of preventable ER visits and 30-day follow-up after hospitalization for mental illness. Finally, there are more differences between the demonstration group and comparison group in long-stay NF utilization (***Table C-3***), including more new long-stay NF admissions and more long-stay NF users in the demonstration group. There were also differences in some characteristics of long-stay NF residents: MyCare demonstration eligible beneficiaries had a lower percentage with severe cognitive impairment, better functional status, and relative to the comparison group, more beneficiaries with a low level of care needed during the demonstration period.

8.2.2 Impact Analysis on the Demonstration Eligible Beneficiaries with LTSS Use

Demonstration eligible beneficiaries were defined as using LTSS in a demonstration year if they received any institutional services or HCBS. Approximately 49 percent of all eligible beneficiaries in demonstration year 1 were LTSS users. The demonstration eligible beneficiaries with LTSS use had lower monthly inpatient admissions and lower annual all-cause 30-day readmissions, but they had a higher probability of chronic ACSC admissions, preventable ER use, and SNF admissions. The demonstration had no impact on ER use, physician E&M visits, the probability of overall ACSC admissions, and the probability of monthly follow-up after mental health discharges for beneficiaries with LTSS use.

Figure 4 displays the demonstration effects on key service utilization measures among demonstration eligible beneficiaries who were LTSS users in the demonstration group relative to the comparison group through demonstration year 1. The demonstration decreased monthly inpatient admissions by 0.0067 admissions per month (90 percent CI: –0.0091, –0.0044). After multiplying the monthly estimate by 12, the annual estimate corresponds to 0.0807 fewer inpatient admissions per eligible beneficiary per year. The demonstration increased SNF admissions by 0.0029 visits per month (90 percent CI: 0.0015, 0.0044). There was no statistically significant demonstration effect on ER visits and physician E&M visits.

Figure 4
Demonstration effects on service utilization for eligible beneficiaries with LTSS use in Ohio—Difference-in-differences regression results for the demonstration period, May 1, 2014–December 31, 2015



E&M = evaluation and management; ER = emergency room; SNF = skilled nursing facility.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. 80 percent confidence intervals are provided here for comparison purposes only. The 90 percent intervals are black, and the 80 percent intervals are green. Beneficiaries who first met LTSS criteria during the demonstration period were removed from the regression model to address analytic issues in estimating results. Results should be interpreted with caution as there may be important observable and unobservable factors specific to the LTSS population that are not included in the propensity score model and weights.

SOURCE: RTI International analysis of Medicare data.

Table 28 presents the demonstration effects on key service utilization for the demonstration eligible population with LTSS use for the first demonstration year. We indicate the previously reported point estimates with their associated significance levels.

Table 28
Annual demonstration effects on service utilization for eligible beneficiaries with LTSS use in Ohio

Utilization measure (per month)	Demonstration year 1 (5/14–12/15)
Inpatient admissions	−0.0067**
ER visits	0.0042
Physician E&M visits	0.0434
SNF admissions	0.0029**

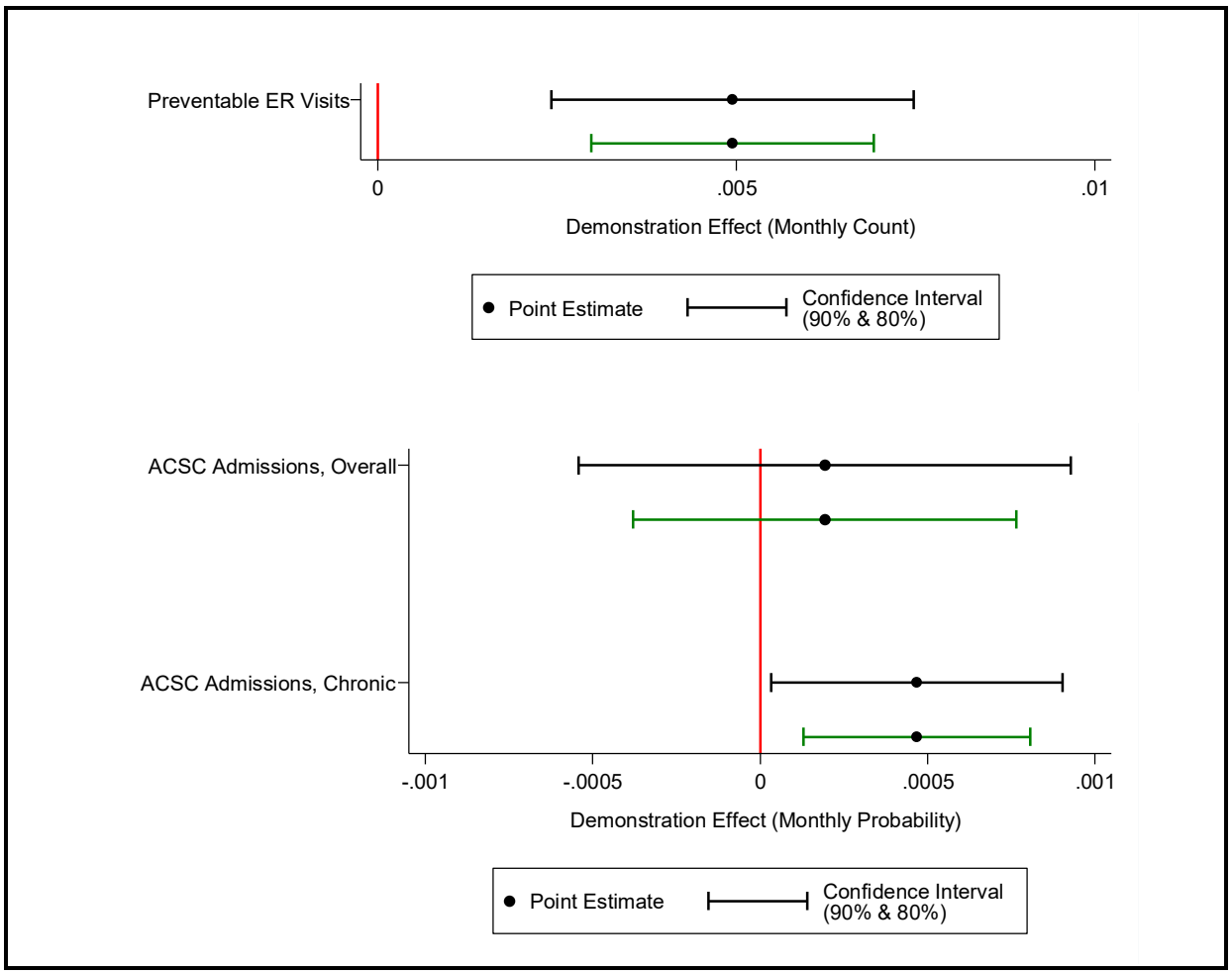
E&M = evaluation and management; ER = emergency room; SNF = skilled nursing facility.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. Significance based on 80 percent confidence intervals are provided here for comparison purposes only. * indicates significant at $p < 0.20$, ** indicates significant at $p < 0.10$. Beneficiaries who first met LTSS criteria during the demonstration period were removed from the regression model to address analytic issues in estimating results. Results should be interpreted with caution as there may be important observable and unobservable factors specific to the LTSS population that are not included in the propensity score model and weights.

SOURCE: RTI International analysis of Medicare data.

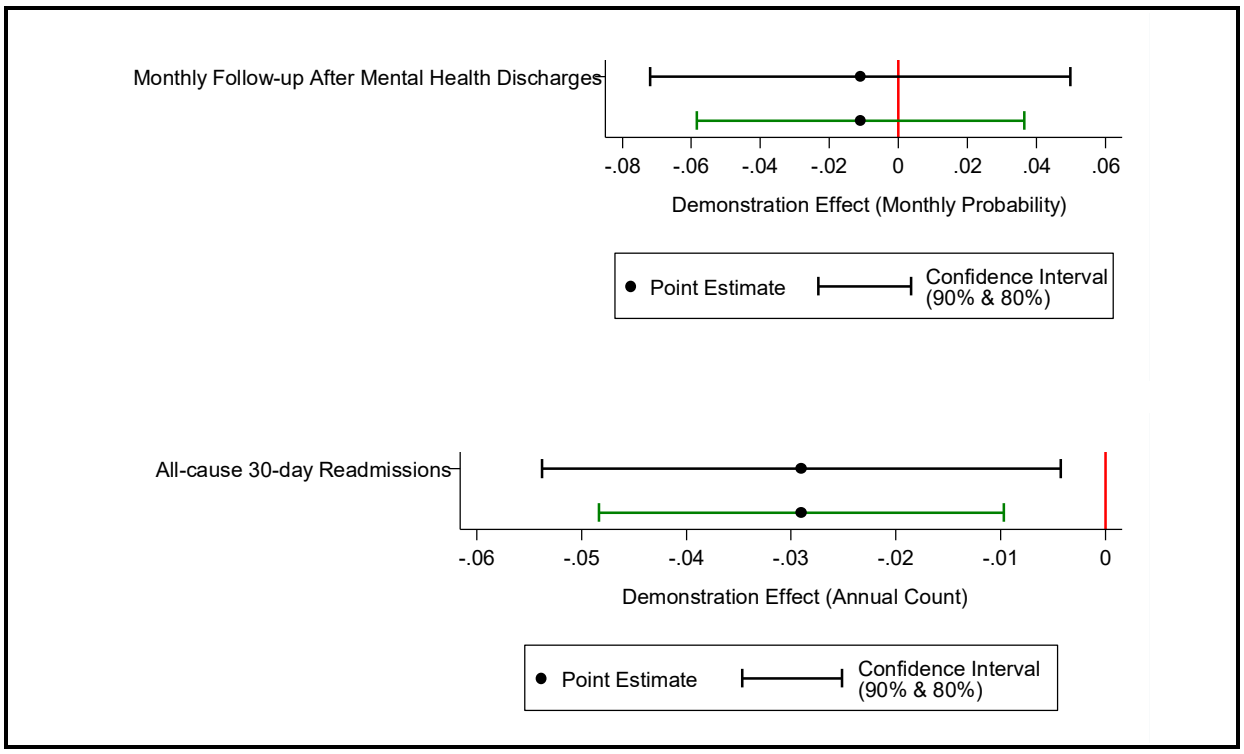
Figure 5 displays demonstration effects on RTI quality of care and care coordination measures for the demonstration eligible population who were LTSS users through demonstration year 1. The Ohio demonstration decreased the count of the all-cause 30-day readmissions by 0.0290 visits (90 percent CI: −0.0538, −0.0042). However, the demonstration increased the probability of chronic ACSC admissions by 0.05 percent per month (90 percent CI: 0.0000, 0.0009) and increased monthly preventable ER visits by 0.0050 visits (90 percent CI: 0.0024, 0.0075). There was no demonstration effect on the probability of overall ACSC admissions or the probability of monthly follow-up after mental health discharges by LTSS users.

Figure 5
Demonstration effects on RTI quality of care and care coordination for eligible beneficiaries with LTSS use in Ohio—Difference-in-differences regression results for the demonstration period, May 1, 2014–December 31, 2015



(continued)

Figure 5 (continued)
Demonstration effects on RTI quality of care and care coordination for eligible beneficiaries with LTSS use in Ohio—Difference-in-differences regression results for the demonstration period, May 1, 2014–December 31, 2015



ACSC = ambulatory care-sensitive conditions; ER = emergency room.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. 80 percent confidence intervals are provided here for comparison purposes only. The 90 percent intervals are black, and the 80 percent intervals are green. Beneficiaries who first met LTSS criteria during the demonstration period were removed from the regression model to address analytic issues in estimating results. Results should be interpreted with caution as there may be important observable and unobservable factors specific to the LTSS population that are not included in the propensity score model and weights.

SOURCE: RTI International analysis of Medicare data.

Table 29 displays the demonstration effects on RTI quality of care and care coordination measures for the demonstration eligible population with LTSS use for the first demonstration year. We indicate the previously reported point estimates with their associated significance levels.

Table 29
Annual demonstration effects on quality of care and care coordination for eligible beneficiaries with LTSS use in Ohio

Quality of care and care coordination measures	Demonstration year 1 (5/14–12/15)
Preventable ER visits	0.0050**
Probability of ACSC admissions, overall	0.0002
Probability of ACSC admissions, chronic	0.0005**
Probability of monthly follow-up after mental health discharges	−0.0110
All-cause 30-day readmissions	−0.0290**

ACSC = ambulatory care-sensitive conditions; ER = emergency room.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. Significance based on 80 percent confidence intervals are provided here for comparison purposes only. * indicates significant at $p < 0.20$, ** indicates significant at $p < 0.10$. Beneficiaries who first met LTSS criteria during the demonstration period were removed from the regression model to address analytic issues in estimating results. Results should be interpreted with caution as there may be important observable and unobservable factors specific to the LTSS population that are not included in the propensity score model and weights.

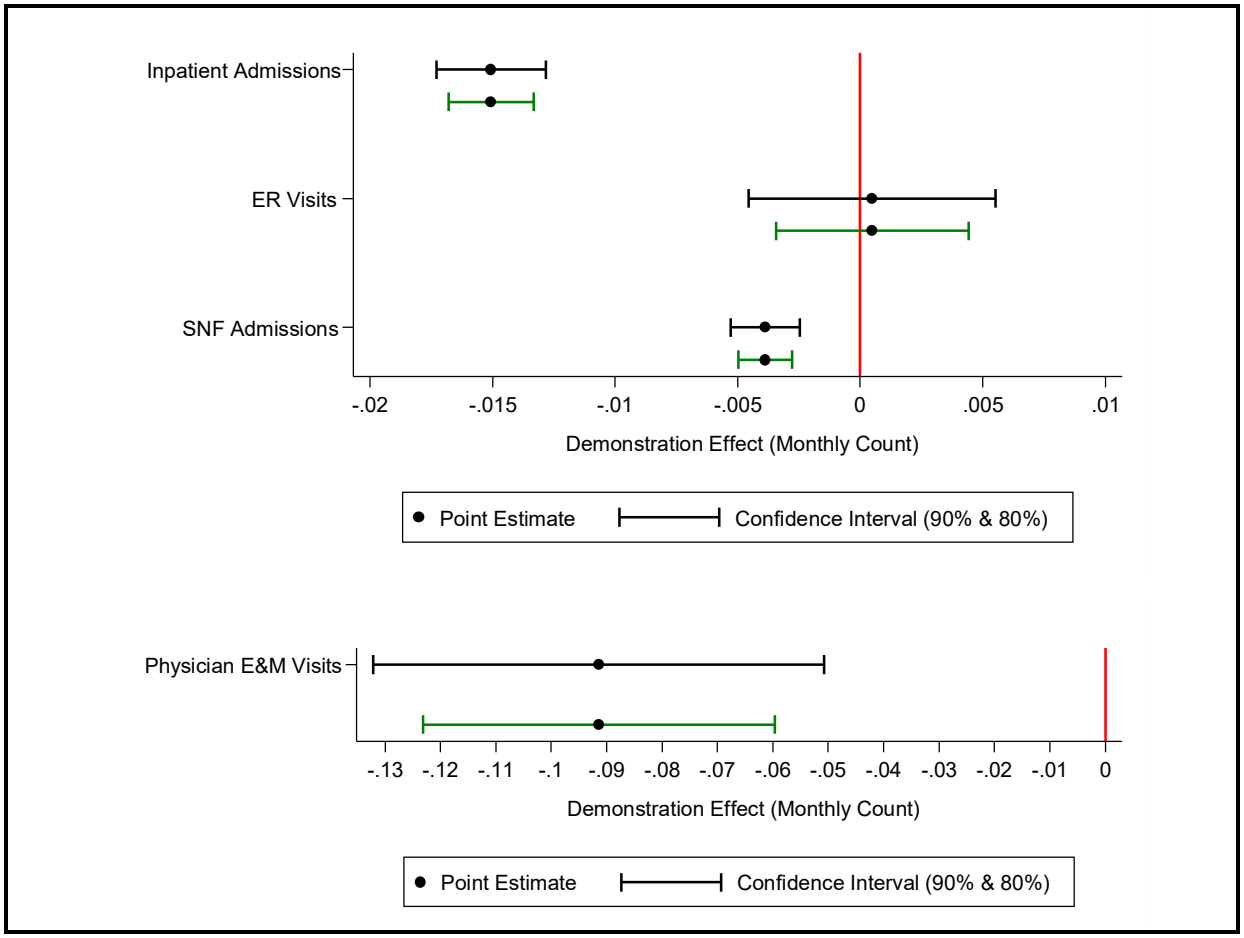
SOURCE: RTI International analysis of Medicare data.

8.2.3 Impact Analyses on the Demonstration Eligible Population with SPMI

Demonstration eligible beneficiaries were categorized as having SPMI if there were any inpatient or outpatient mental health visits for schizophrenia or bipolar disorders in the last 2 years. Approximately 43 percent of all eligible beneficiaries had SPMI in demonstration year 1. As was true for the overall demonstration eligible population, demonstration eligible beneficiaries with SPMI had reduced monthly inpatient admissions, SNF admissions, physician E&M visits, and a lower probability of ACSC admissions, but they had higher preventable ER use. As for all demonstration eligible beneficiaries, the demonstration had no impact on ER use, all-cause 30-day readmissions, and the probability of monthly follow-up after mental health discharges for beneficiaries with SPMI.

Figure 6 displays the demonstration effects on key service utilization measures for the demonstration eligible population with an SPMI. The demonstration decreased monthly inpatient admissions by 0.0151 admissions per month (90 percent CI: –0.0173, –0.0128). After multiplying the monthly estimate by 12, the annual estimate corresponds to 0.1808 fewer inpatient admissions per eligible beneficiary per year. The demonstration also decreased physician E&M visits by 0.0914 visits per month (90 percent CI: –0.1321, –0.0507) and SNF admissions by 0.0039 visits per month (90 percent CI: –0.0053, –0.0025). There was no statistically significant demonstration effect on ER visits.

Figure 6
Demonstration effects on service utilization for eligible beneficiaries with SPMI in Ohio—Difference-in-differences regression results for the demonstration period, May 1, 2014–December 31, 2015



E&M = evaluation and management; ER = emergency room; SNF = skilled nursing facility.

NOTE: Standard statistical practice is to use confidence intervals of 90 percent or higher. 80 percent confidence intervals are provided here for comparison purposes only. The 90 percent intervals are black, and the 80 percent intervals are green.

SOURCE: RTI International analysis of Medicare data.

Table 30 displays the demonstration effects on key service utilization measures among beneficiaries with SPMI for each demonstration year. We indicate the previously reported point estimates with their associated significance levels.

Table 30
Annual demonstration effects on service utilization for eligible beneficiaries with SPMI in Ohio

Utilization measure (per month)	Demonstration year 1 (5/14–12/15)
Inpatient admissions	−0.0151**
ER visits	0.0005
Physician E&M visits	−0.0914**
SNF admissions	−0.0039**

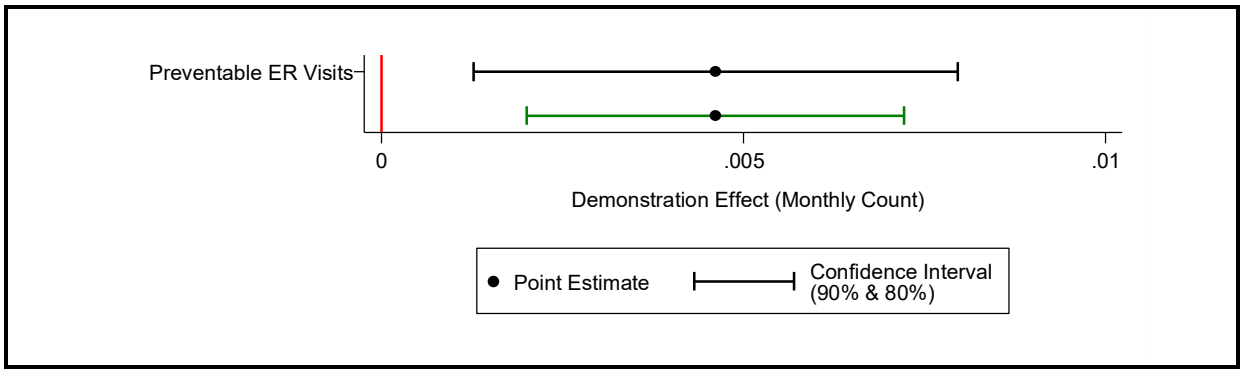
E&M = evaluation and management; ER = emergency room; SNF = skilled nursing facility.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. Significance based on 80 percent confidence intervals are provided here for comparison purposes only. * indicates significant at $p < 0.20$, ** indicates significant at $p < 0.10$.

SOURCE: RTI International analysis of Medicare data.

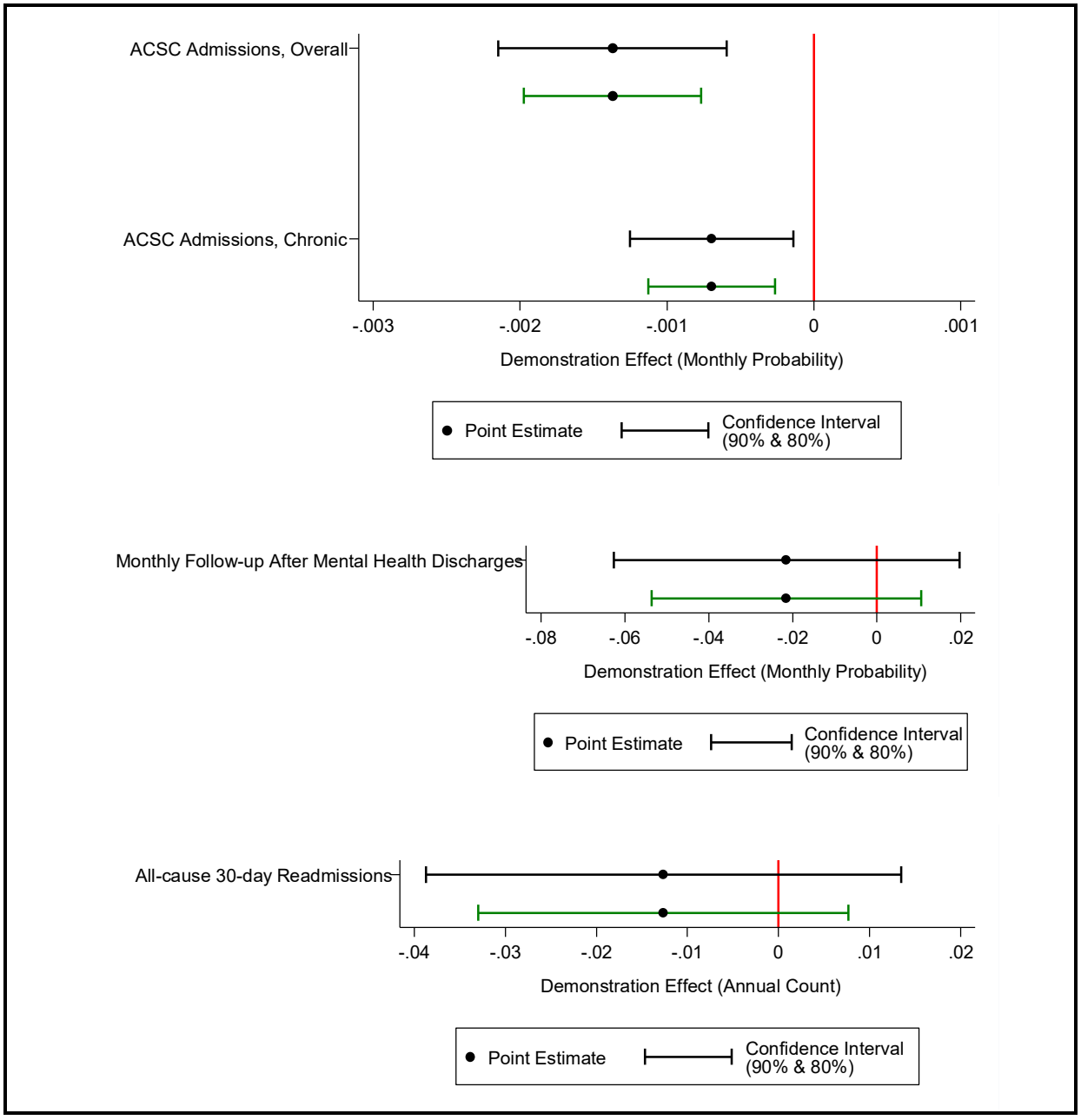
Figure 7 displays the demonstration effects on RTI quality of care and care coordination measures for the demonstration eligible population with an SPMI. The Ohio demonstration decreased the probability of overall and chronic ACSC admissions by 0.14 percent per month (90 percent CI: −0.0021, −0.0006) and 0.07 percent per month (90 percent CI: −0.0013, −0.0001), respectively. However, the demonstration increased monthly preventable ER visits by 0.0046 visits (90 percent CI: 0.0013, 0.0080). There was no demonstration effect on the probability of monthly follow-up after mental health discharges or the count of all-cause 30-day readmissions among the SPMI population.

Figure 7
Demonstration effects on quality of care and care coordination for eligible beneficiaries with SPMI in Ohio—Difference-in-differences regression results for the demonstration period, May 1, 2014–December 31, 2015



(continued)

Figure 7 (continued)
Demonstration effects on quality of care and care coordination for eligible beneficiaries with SPMI in Ohio—Difference-in-differences regression results for the demonstration period, May 1, 2014–December 31, 2015



ACSC = ambulatory care-sensitive conditions; ER = emergency room; SPMI = severe and persistent mental illness.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. 80 percent confidence intervals are provided here for comparison purposes only. The 90 percent intervals are black, and the 80 percent intervals are green.

SOURCE: RTI International analysis of Medicare data.

Table 31 displays the demonstration effects on RTI quality of care and care coordination measures for the demonstration eligible population with SPMI in the first demonstration year. We indicate the previously reported point estimates with their associated significance levels.

Table 31
Annual demonstration effects on quality of care and care coordination for eligible beneficiaries with SPMI in Ohio

Quality of care and care coordination measures	Demonstration year 1 (5/14–12/15)
Preventable ER visits	0.0046**
Probability of ACSC admissions, overall	−0.0014**
Probability of ACSC admissions, chronic	−0.0007**
Probability of monthly follow-up after mental health discharges	−0.0215
All-cause 30-day readmissions	−0.0126

ACSC = ambulatory care-sensitive conditions; ER = emergency room; SPMI = severe and persistent mental illness.

NOTES: Standard statistical practice is to use confidence intervals of 90 percent or higher. Significance based on 80 percent confidence intervals are provided here for comparison purposes only. * indicates significant at $p < 0.20$, ** indicates significant at $p < 0.10$.

SOURCE: RTI International analysis of Medicare data.

8.2.4 Service Use for Enrollee and Non-Enrollee Populations

Tables C-4 and ***C-5*** in ***Appendix C*** present descriptive statistics for the enrolled population, compared to those demonstration eligible beneficiaries who were not enrolled, for each service by demonstration year, to help understand the utilization experience over time.

Enrollees had higher utilization than non-enrollees across all service settings in the first demonstration year, except for hospice care and outpatient therapy use (***Table C-4***). For the quality of care and care coordination measures, enrollees and non-enrollees have a similar probability of ACSC admissions and rates of all-cause 30-day readmissions, while enrollees are more likely to have a higher number of preventable ER visits and a lower number of screenings for depression, as well as lower rates of 30-day follow-up for hospitalization for mental illness (***Table C-5***).

8.2.5 Service Use by Demographic Characteristics of Eligible Beneficiaries

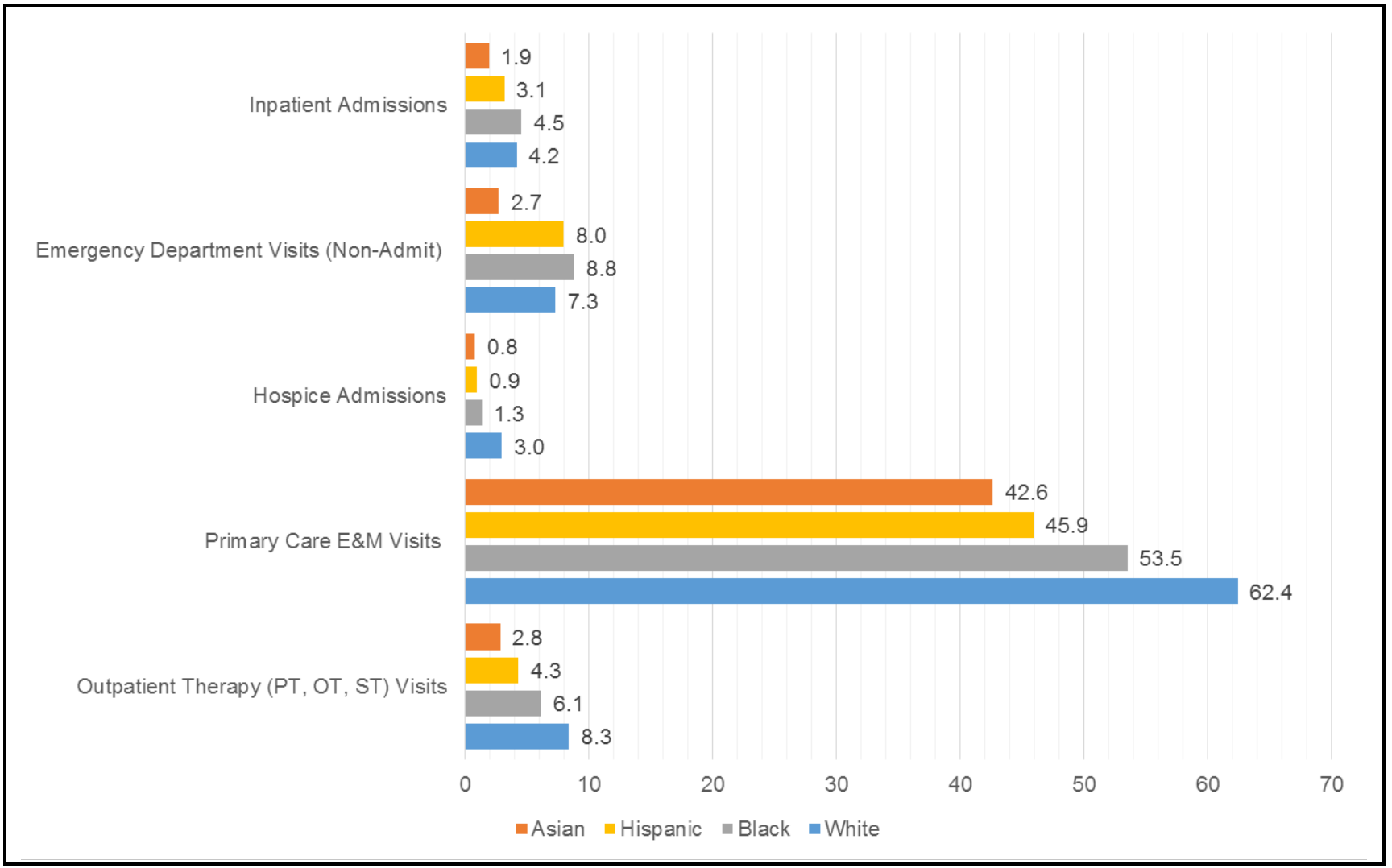
To examine any differences in racial and ethnic groups, ***Figures 8, 9,*** and ***10*** provide month-level results for five settings of interest: inpatient admissions, ER (non-admit), primary care E&M visits, outpatient therapy (physical therapy [PT], occupational therapy [OT], and speech therapy [ST]), and hospice. Results across these five settings are displayed using three measures: percentage with any use of the respective service, counts per 1,000 demonstration eligible beneficiaries, and counts per 1,000 eligible beneficiaries with any use of the respective service.

Figure 8 presents the percentage with use of selected Medicare services. Asians had the lowest use of all five service settings. Blacks had the highest percentage use for inpatient admissions and emergency department visits, whereas whites had the highest use for hospice admissions, primary care E&M visits, and outpatient therapy visits.

Regarding counts of services used among users of each respective service, as presented in ***Figure 9***, the counts of inpatient admissions, emergency department visits, and hospice admissions were very similar across different racial and ethnic groups. Whites had the most primary care E&M visits, followed by blacks, Hispanics, and then Asians, respectively. The same pattern could be observed in outpatient therapy visits.

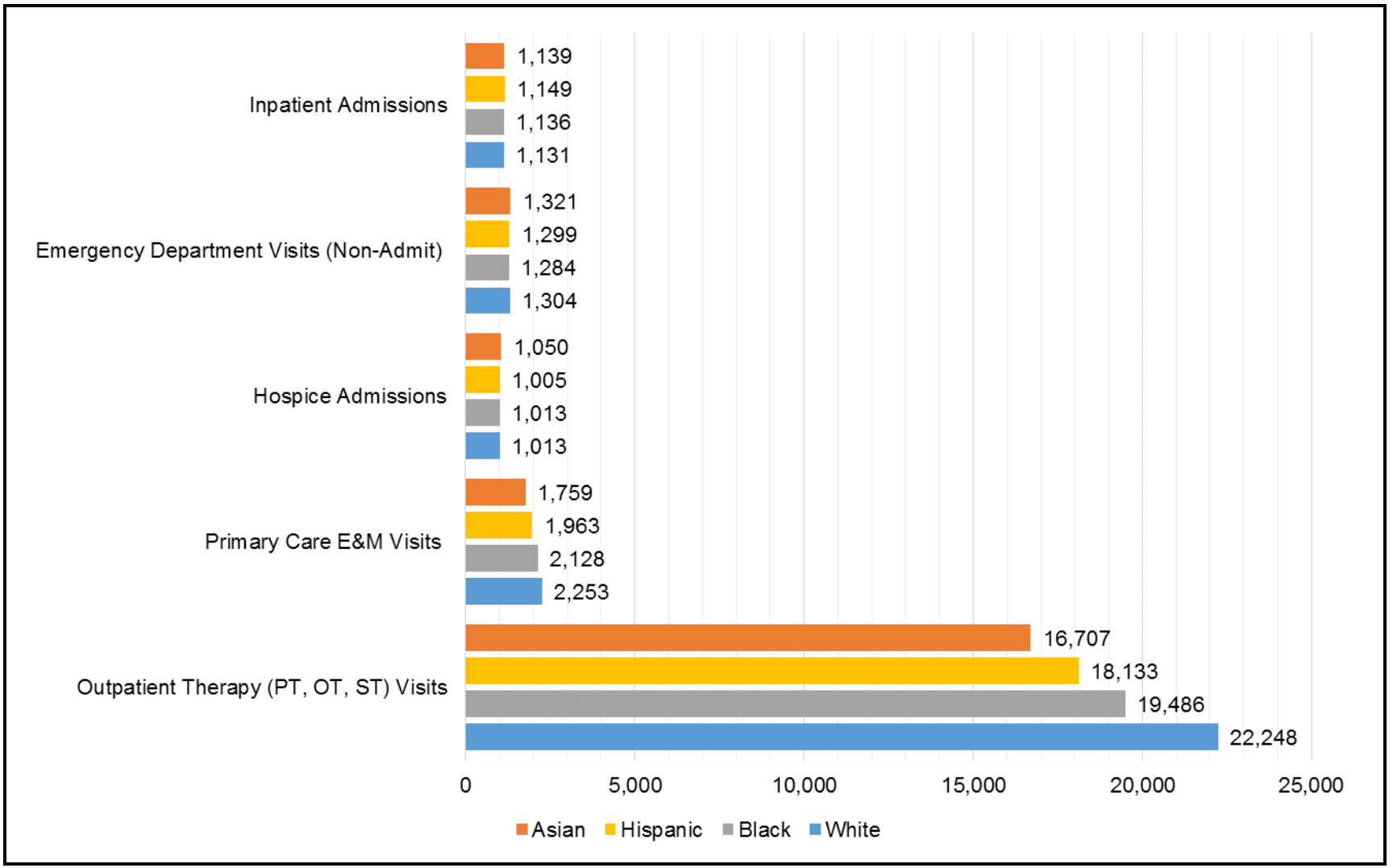
Figure 10 presents counts of services across all demonstration eligibles regardless of having any use of the respective services. Trends for inpatient admissions, emergency department visits, and hospice admissions were broadly similar to those displayed in ***Figure 8***.

Figure 8
Percent with use of selected Medicare services



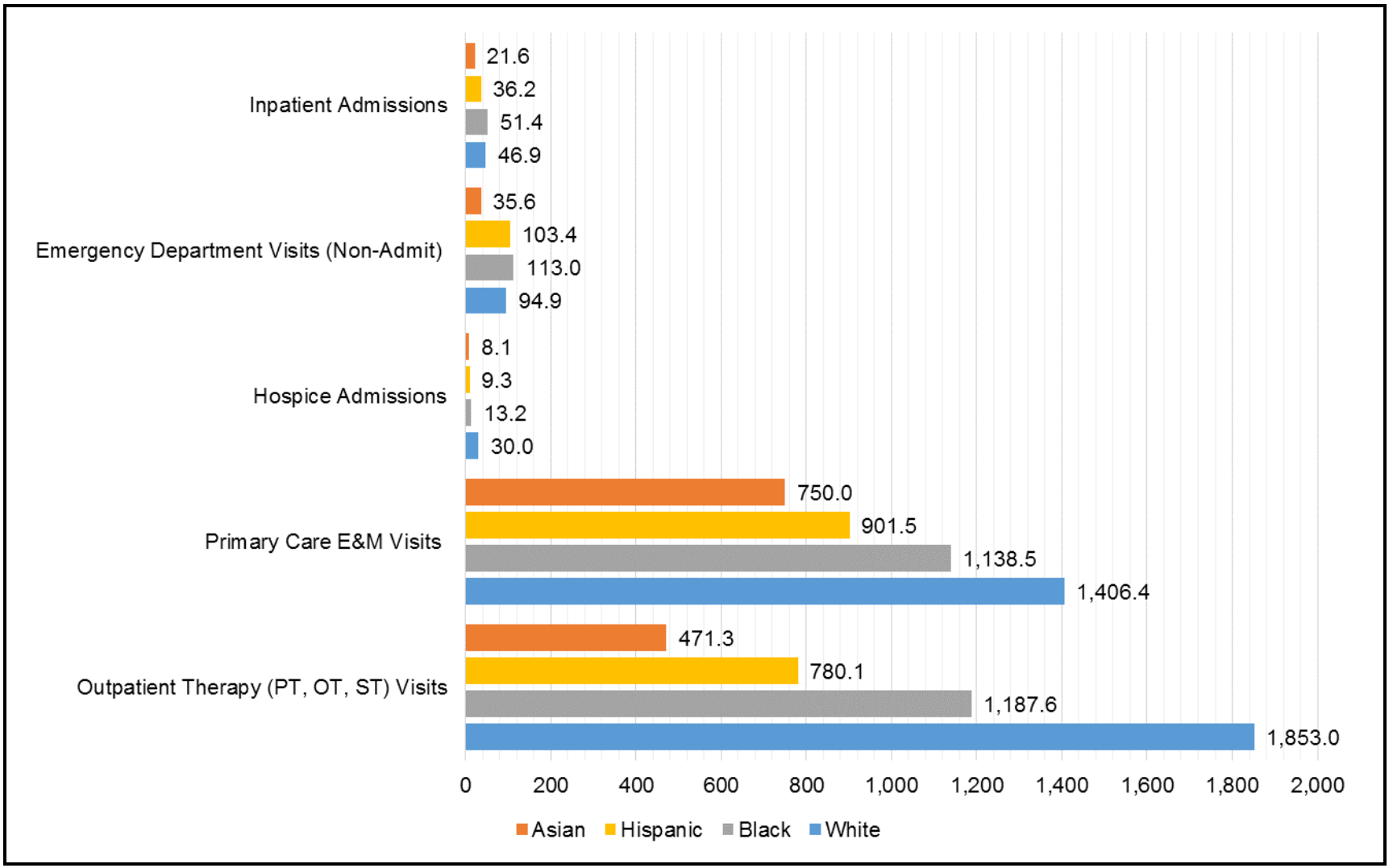
SOURCE: RTI International analysis of Medicare data.

Figure 9
Service use among all demonstration eligibles with use of service per 1,000 user months



SOURCE: RTI International analysis of Medicare data.

Figure 10
Service use among all demonstration eligibles per 1,000 eligible months



SOURCE: RTI International analysis of Medicare data.

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9. Quality of Care

Highlights

- MMPs' performance on the 14 HEDIS measures reported for the demonstration was mixed.
- Implementation of the State-specific quality measures has been challenging for ODM and MyCare Ohio plans. Plan and State officials have raised concerns about the method used to calculate the nursing facility diversion measure for the quality withhold, and ODM has proposed an alternate methodology.
- Audits by the State's External Quality Review Organization identified challenges related to care management. To improve performance, AAAs hired additional registered nurses (RNs), and plans conducted supplemental training and education.

9.1 Quality Management Structures and Activities

This section discusses the components of the MyCare Ohio quality management system, including the roles of CMS, MyCare Ohio plans, and independent entities, and it describes perspectives of State officials and key stakeholders on quality management activities throughout the demonstration. The MyCare Ohio quality management framework contains four primary activities: quality measurement and reporting; joint monitoring and oversight by the State and CMS; quality and performance improvement initiatives undertaken by the plans; and independent quality management structures and activities. As a condition of participation in the demonstration, MyCare Ohio plans are required to maintain organizational and program structures that promote the principles of continuous quality improvement (Ohio three-way contract, 2014, p. 92).

9.1.1 Quality Measures

The MyCare Ohio demonstration requires plans to report standardized quality measures, including:

- A set of core measures specific to all capitated Financial Alignment Initiative demonstrations that address domains of access, assessment, care coordination, enrollee protection, organization structure and staffing, performance and quality improvement, provider network, and systems and service utilization (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html).

- A set of 13 State-specific measures selected by MyCare Ohio staff in consultation with CMS.[19] The measures span five domains: care coordination, organizational structure and staffing, performance and quality improvement, systems, and utilization (CMS, 2014a). The State-specific measures focus on care plan development, centralized enrollee records, post-hospitalization follow-up, self-directed patient care, and nursing facility utilization/safety. State officials said that the ODM selected State-specific measures that aligned with its Quality Strategy, a broad set of goals organized around five priorities: make care safer, improve care coordination, promote evidence-based prevention and treatment practices, support person- and family-centered care, and ensure effective and efficient administration (ODM, 2014).[20]

Performance on several of the core and State-specific measures is used to determine what portion of the capitation rates retained by CMS and the State as a "quality withhold" will be repaid to the plan.

The demonstration also utilizes quality measures required of Medicare Advantage (MA) plans, including applicable measures from the Medicare Part C and Part D Reporting Requirements, such as appeals and grievances, pharmacy access, payment structures, and medication therapy management.

MyCare Ohio plans are required to submit three additional measure sets as part of the MA requirement:

- A modified version of the MA Prescription Drug plan (MA-PD) Consumer Assessment of Healthcare Providers and Systems survey that, in addition to the core survey used by MA plans, included 10 supplemental questions proposed by the RTI Evaluation Team to capture beneficiary experience specific to integration, behavioral health and LTSS;

- The subset of Medicare Healthcare Effectiveness Data and Information Set (HEDIS) measures, a standard measurement set used extensively by managed care plans that are required of all MA plans; and

- Selected Health Outcomes Survey (HOS) measures based on a recurring survey of a random sample of Medicare beneficiaries to assess physical and mental health outcomes (Ohio three-way contract, 2014).

Data related to the core and State-specific measures are discussed in relevant sections of this report.

In addition, the RTI Aggregate Evaluation Plan identified a set of quality measures that will be calculated by the RTI Team using encounter and FFS data. Many of these measures are part of the HEDIS measurement set and are largely clinical in nature (e.g., preventive screens,

[19] In 2016, CMS and ODM increased the number of Ohio-specific measures to 15. This change will be discussed in greater detail in future reports.

[20] Updates to the State's Quality Strategy will be described in the next evaluation report.

follow-up care) or related to service use (e.g., avoidable hospitalizations, emergency department use) (Walsh et.al., 2013, pp. 77–85).

As noted in the Memorandum of Understanding, the measures serve a variety of purposes, including monitoring, performance assessment, and evaluation (MOU, 2012, p. 76). A subset of the measures is also used for the pay-for-performance quality withhold (see below). Each measure has a minimum performance standard; failure to meet the minimum standard results in a penalty for noncompliance (MyCare Ohio Provider Agreement, 2016, Appendix M).

ODM evaluates plan performance on measures separately for Medicare-Medicaid beneficiaries and Medicaid-only beneficiaries. State officials reported challenges with the core and State-specific measure sets. ODM staff commented that many of the process measures were not meaningful to Ohio and that plans did not have the capacity to manage data or drive improvement across so many different aspects of care, a sentiment echoed by plan officials. One plan representative commented that "…We use MDS data, nursing facility survey data…HEDIS, HOS….CMS measures…Just wrapping your arms around all the different [data] sources for [quality measurement] can be a challenge." The representative reported that the custom (State-specific) measures were the most difficult to work with.

ODM staff commented that CMS gave Ohio considerable flexibility in choosing the State-specific measures, as well as the minimum performance standards. According to an ODM representative, the process of developing these measures was challenging, due to a lack of national standards specific to the Medicare-Medicaid population. In the areas for which there were not national quality measures (e.g., HEDIS, CAHPS, National Quality Forum, AHRQ), such as rebalancing (see ***Section 1.4.2, Rebalancing***, and ***Section 7.1.4, Performance Incentives***), State officials said they collaborated with CMS to establish benchmarks in areas for which they wanted to promote improvement. ODM staff said they analyzed baseline data and set targets by region.

There were three withhold measures for the first portion of demonstration year 1 (calendar year 2014); six measures for the second portion of demonstration year 1 (2015); and nine measures for demonstration years 2 and 3.[21]

For calendar years 2014 and 2015, the quality withhold benchmark for nursing facility diversion was a decline of 5 percent or more from the baseline year. As noted in ***Section 7.1.4***, ODM reported that none of the plans met the benchmark during the demonstration's first 2 calendar years; however, based on anecdotal reports and observed trends in encounter data and the Money Follows the Person demonstration (see ***Section 1.4, Overview of State Context***), State

[21] Calendar year 2014 (first part of demonstration year 1) includes the following measures: Assessments (Core), Consumer Governance Board (Core), Nursing Facility Diversion (State-Specific). Calendar year 2015 (second part of demonstration year 1) includes the following measures: Assessments (Core), Consumer Governance Board (Core), Customer Service (Core), Encounter Data, (Core), Getting Appointments and Care Quickly (Core), and Nursing Facility Diversion (State-Specific).
Calendar years 2016–2017 (demonstration years 2–3) includes the following measures: Plan all-cause readmissions (Core), Annual flu vaccine (Core), Follow-up after hospitalization for mental illness (Core), Reducing the risk of falling (Core), Controlling blood pressure (Core), Medication adherence for diabetes medications (Core), Encounter Data (Core), Nursing Facility Diversion (State-Specific), and Long Term Care Overall Balance (State-Specific).

officials believed that plans are making progress in transitioning enrollees from nursing facilities to community settings.

ODM staff noted that both the nursing facility diversion measure and the rebalancing measure are based on the number of days in nursing facilities, as indicated in MDS data; they do not reflect a recognition that some nursing facility stays—notably, short-term rehabilitation stays—may be medically appropriate to improve enrollees' functional status and enable them to live in the community.

Because of these concerns, ODM and CMS agreed that for demonstration year 2 (calendar year 2016) and beyond, the nursing facility diversion and rebalancing measures would be revised. ODM staff reported that besides modifications to reflect the appropriateness of certain nursing facility stays, the revised measures may include enrollment criteria, so that a nursing facility stay would be counted only for beneficiaries who have been enrolled in a plan for a minimum time period, such as 3 to 6 months. Representatives of one MMP commented during the December 2016 site visit that the plan was at a disadvantage under the existing measure because it had a high number of new enrollees residing in nursing facilities. Plan staff believed that a revised methodology with minimum enrollment criteria was needed to appropriately reflect their rebalancing activities with new enrollees.

9.1.2 State and CMS Quality Management Structures and Activities

Contract Management Team Monitoring and Oversight

The CMT plays an integral role in quality management through its compliance monitoring activities (see ***Section 2.1, Joint Management of the Demonstration***). State officials credited CMT meetings with facilitating consistent data submission across plans. Early in the demonstration, plans were not submitting data in consistent formats, thus making it difficult to compare performance. By the time of the October 2014 site visit, however, the CMT could make "apples-to-apples" comparisons.

According to ODM staff, challenges associated with the nursing facility diversion measure for the quality withhold have been a major focus of the CMT's attention.

State Compliance Assessment System

If a MyCare Ohio plan fails to comply with any of the demonstration's requirements, ODM may assess various compliance actions, independent of the CMT, including corrective action plans and monetary fines (ODM, 2015, Appendix N). Additionally, plans may receive points for various actions that can add up to financial penalties. Egregious or ongoing cases of noncompliance can result in contract termination. Decisions on MyCare Ohio compliance actions are based on the severity of noncompliance, patterns of repeated noncompliance, and the number of enrollees affected. Regardless of whether ODM imposes fines or assesses points, plans are required to initiate corrective action plans as soon as the violations or deficiencies are identified. Corrective action plans are defined as structured activities, processes or quality improvement initiatives to address deficiencies (MyCare Ohio Provider Agreement, 2016, Appendix N).

State officials noted that the compliance monitoring processes and structures are not always meant to be punitive. Even if a plan is meeting contractual standards, it may receive extra attention or technical assistance if it is an outlier on a particular measure. For example, plans' call centers are required to answer 80 percent of all beneficiary calls within 30 seconds (Ohio three-way contract, 2014, p. 79); hypothetically, if one plan reports that 81 percent of its calls were answered within the required time frame, but the other four plans reported that their call centers answered 90 percent of calls within 30 seconds, the plan's contract administrator might work with it to align its performance with that of the other plans.

The evaluation team's review of the compliance log for MyCare Ohio plans showed that reasons for ODM compliance actions have varied widely, including lack of timely care coordination, delays in providing medically necessary services, failure to meet provider panel requirements, and findings from management audits by the External Quality Review Organization (EQRO).

9.1.3 MyCare Ohio Plans' Quality Management Structures and Activities

MyCare Ohio plans are required to implement performance/quality improvement projects during the demonstration period (Ohio three-way contract, 2014, p. 97). In the first year, MyCare Ohio plans were required to submit at least two improvement projects, one on long-term care rebalancing and a second on cardiovascular disease (CMS, 2014b). The former initiative satisfies Medicare's quality improvement project (QIP) requirement, and the latter satisfies Medicare's chronic care improvement program (CCIP) requirement.

ODM reported that MyCare Ohio plans collected baseline data for the CCIPs in the demonstration's first year, and implementation began in the second year. ODM staff indicated that most of the plans' CCIP activities involved provider education to and promotion of adherence to hypertension medication. For example, ODM staff noted that plans were recommending strategies such as using the 90-day prescription refill option. One plan provided enrollee education on hypertension medication adherence through the member newsletter, talking points for case managers, on-hold messaging during member phone calls, and pharmacy blast faxes. ODM staff reported that in 2015, CMS removed the requirement for plans to report on CCIPs.

QIPs began in 2014 and are currently in the third year. Baseline results and two annual updates have been submitted. As described by MMP staff, these initiatives involve identifying members with the desire and readiness to transition to community settings and coordinating the resources and services (such as housing and HCBS) needed for smooth, successful transitions. As of December 2016, ODM did not have data available on results or trends from the QIPs.

9.1.4 Independent Quality Management Structures and Activities

External quality review. The Ohio Department of Medicaid expanded the contract of its existing External Quality Review Organization, Health Services Advisory Group (HSAG), to perform these functions for oversight of the MyCare Ohio plans. According to ODM staff, HSAG's care management reviews have examined areas such as risk stratification, assessment, and follow-up to address identified needs.

ODM staff reported that HSAG audits have identified MMP challenges with post-acute care transitions, follow-up after significant healthcare events, and engagement of primary care providers (see ***Section 2.2.2, Provider Arrangements and Services***). ODM plans to continue improvement efforts in these areas in 2017.

In response to enrollee complaints about transportation (see ***Section 5.2.2, New or Expanded Benefits***), ODM directed HSAG to review MyCare Ohio plans' transportation policies, procedures, and vendor oversight in 2016. ODM reported that all plans had passed the review.

ODM staff commented that reviews by Medicare's Quality Improvement Organizations (QIOs) address some of the same areas covered in EQRO audits. State officials said the timing of CMS and ODM quality reviews has been better coordinated in 2016 than it was previously but recommended additional coordination to avoid duplication in the content of audit protocols.

Office of the State's Long-Term Care Ombudsman

As discussed in ***Section 5.2.9***, Ohio has established a formal role for the State Long-Term Care Ombudsman Program to handle complaints about MyCare Ohio. ODM has included the ombudsman's office in the process of designing the demonstration, in the Implementation Team, in CMT meetings, as well as meetings with individual plans. Ombudsmen attend plans' Beneficiary Advisory Committee meetings (see ***Section 6.2.2***) to ensure that enrollees have opportunities to share individual concerns, and they follow up with plans after the meetings to hold plan leadership accountable for addressing participants' needs.

9.2 Results for Selected Quality Measures

ODM staff cited 2015 CAHPS and HEDIS results as the demonstration's greatest successes in quality management. Provider, enrollee, and ODM representatives expressed frustration about the lag time for compiling data on plan performance and outcomes.

Fourteen Medicare HEDIS measures for MMP enrollees are reported in ***Table 32***. RTI identified these measures for reporting in this Annual Report after reviewing the list of measures we previously identified in RTI's Aggregate Evaluation Plan as well as the available HEDIS data on them for completeness, reasonability, and sample size; 2015 calendar year data were available for all five of the MyCare Ohio MMPs. Detailed descriptions of the measures can be found in the RTI Aggregate Evaluation Plan.[22] Results were reported for measures where sample size was greater than 30 beneficiaries. Four MMPs did not meet this criterion for three measures (adult body mass index [BMI] assessment, breast cancer screening, and colorectal cancer screening). In addition to reporting the results for each MMP, the mean value for MA plans in 2015 for each measure is provided for comparison.

As noted in ***Section 5.2.1, Overall Satisfaction with MyCare Ohio***, we, w provide national benchmarks from MA plans, with the recognition that health and sociographic characteristics of MA enrollees may vary from those of demonstration enrollees. Previous

[22] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf

studies on health plan performance reveal poorer quality ratings for plans serving a higher proportion of dual eligible beneficiaries and beneficiaries with disabilities. In particular, HEDIS measure performance is slightly worse among plans active in areas with lower income and populations with a higher proportion of minorities (Office of the Assistant Secretary for Planning and Evaluation, 2016). Benchmarks should be considered with that limitation in mind. These findings on MyCare Ohio HEDIS measure performance represent the early experience in the demonstration, and are likely to change over time as MMPs gain more experience in working with enrollees. Monitoring trends over time in MMP performance may be more important than the comparison to the national MA plans given the population differences. Several years of HEDIS results are likely needed to know how well MMPs perform relative to each other and whether they perform above or below any potential benchmark.

For each measure reported for MyCare Ohio, results across MMPs vary, and there was not a consistent trend across measures for one MMP versus other MMPs. For one measure reported (antidepressant medication management), all plans performed better than the national Medicare HMO benchmark value. All plans also reported more outpatient visits per 1,000 members than the Medicare HMO benchmark value, which is desirable. For three measures reported (annual monitoring for patients on persistent medications, initiation and engagement of alcohol and other drug dependence treatment, and follow-up after hospitalization for mental illness), nearly all plans (four out of five) performed better than the national benchmark value.

For the remaining measures, the majority of plans performed below the benchmark value. These measures are related to adults' access to preventive/ambulatory health services, comprehensive diabetes care, blood pressure control, disease modifying anti-rheumatic drug therapy in rheumatoid arthritis, plan all-cause readmissions, and emergency department visits.

Table 32
Selected HEDIS measures for MyCare Ohio plans, 2015

Measure	National Medicare Advantage Plan Mean (%)	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	United (%)
Adult BMI assessment	93.0	—	—	—	93.0	—
Adults' access to preventive/ambulatory health services	94.7	94.2	93.0	95.4	93.3	94.8
Annual monitoring for patients on persistent medications						
Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	92.6	92.6	93.1	93.6	93.6	93.7
Annual monitoring for members on digoxin	57.4	76.2	80.7	72.6	67.7	70.2
Annual monitoring for members on diuretics	92.9	93.5	93.8	94.0	95.3	94.6
Total rate of members on persistent medications receiving annual monitoring	91.9	92.8	93.2	93.5	93.9	93.8
Antidepressant medication management						
Effective acute phase treatment[1]	69.6	93.3	82.5	91.8	73.5	84.9
Effective continuation phase treatment[2]	55.6	91.7	77.6	87.4	64.8	76.8
Blood pressure control[3]	67.6	48.8	47.7	48.7	57.0	52.3
Breast cancer screening	72.3	—	—	—	45.2	—
Care of older adults						
Advance care planning	—	6.9	28.4	19.7	51.7	14.1
Medication review	—	35.0	57.7	55.5	78.8	44.5
Functional status assessment	—	31.9	45.4	38.4	63.1	32.6
Pain assessment	—	31.7	67.8	64.0	78.6	49.4
Colorectal cancer screening	66.7	—	—	—	55.7	—

(continued)

Table 32 (continued)
Selected HEDIS measures for MyCare Ohio plans, 2015

Measure	National Medicare Advantage Plan Mean (%)	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	United (%)
Comprehensive diabetes care						
Received hemoglobin A1c (HbA1c) testing	93.1	88.3	87.5	87.8	90.5	83.9
Poor control of HbA1c level (>9.0%) (higher is worse)	28.4	53.6	45.1	59.9	45.8	94.6
Good control of HbA1c level (<8.0%)	61.8	41.1	44.7	38.0	47.8	4.5
Received eye exam (retinal)	68.3	48.1	58.6	61.1	55.1	51.8
Received medical attention for nephropathy	95.5	95.4	92.4	93.4	94.0	92.5
Blood pressure control (<140/90 mm Hg)	60.9	45.9	53.5	55.1	61.1	0.9
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	76.7	62.1	60.9	77.4	58.5	64.5
Follow-up after hospitalization for mental illness	51.0	72.7	31.6	66.1	65.7	76.9
Initiation and engagement of alcohol and other drug (AOD) dependence treatment						
Initiation of AOD treatment[4]	32.3	23.4	67.1	43.7	55.1	41.1
Engagement of AOD treatment[5]	3.2	2.8	12.8	6.7	8.6	5.6
Plan all-cause readmissions (average adjusted probability total**)** (higher is worse)	17.3	20.9	25.3	25.5	22.9	26.1
Ambulatory care (per 1,000 members)						
Outpatient visits	9,161.2	11,784.9	10,845.7	13,607.8	12,007.6	12,738.2
Emergency department visits (higher is worse)	607.8	1,349.6	1,546.1	1,274.6	1,400.7	1,176.4

— = not available.

[1] Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

[2] Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

[3] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for members 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for members 60–85 years of age.

Table 32 (continued)
Selected HEDIS measures for MyCare Ohio plans, 2015

[4] Represents percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

[5] Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

NOTES: Data for fall risk management, physical activity in older adults, and management of urinary incontinence in older adults are not available for calendar year 2015. Medicare HMO benchmark values were not available for all measures (e.g., care of older adults measures). Data for which the final sample size was <30 were determined too small to present; in cases where final sample size was unavailable, RTI used eligible population to make this determination. Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf.

SOURCE: RTI analysis of 2015 HEDIS measures.

10. Cost Savings Calculation

Highlights

- RTI conducted a preliminary estimate of Medicare savings using a difference-in-differences analysis examining beneficiaries eligible for the demonstration in the Ohio demonstration area and comparison areas.
- The results of the preliminary cost analyses of beneficiaries eligible for the demonstration do not show statistically significant savings or losses as a result of the demonstration over the first two demonstration period. This aligns with CMS expectations, given rate structure and modifications during the demonstration period covered. However, statistically significant savings are observed in the first demonstration period.

As part of the Ohio capitated model demonstration under the Financial Alignment Initiative, Ohio, CMS, and health plans have entered into a three-way contract to provide services to Medicare-Medicaid enrollees (CMS, 2013). Participating health plans receive prospective blended capitation payment to provide both Medicare and Medicaid services for enrollees. CMS and Ohio developed risk-adjusted capitation rates for Medicare Parts A, B, and D, and Medicaid services to reflect the characteristics of enrollees. The Medicare component of the payment is risk-adjusted using CMS' hierarchical risk adjustment model. The rate development process is described in greater detail in the Memorandum of Understanding and the three-way contract, and a description of the Medicaid and risk-adjusted Medicare components of the rate are described in the Final Rate Reports.

The capitation payment incorporates savings assumptions over the course of the demonstration. The same savings percentage is prospectively applied to both the Medicare and Medicaid components of the capitation payment, so that both payers can recognize proportional savings from this integrated payment approach, regardless of whether the savings is driven disproportionately by changes in utilization of services typically covered by Medicare or Medicaid. The goal of this methodology is to minimize cost-shifting, to align incentives between Medicare and Medicaid, and to support the best possible outcomes for enrollees.

This chapter presents preliminary Medicare Parts A and B savings calculations for the first 32 months of the demonstration period using an intent-to-treat (ITT) analytic framework that includes beneficiaries eligible for the demonstration rather than only those who enrolled. Approximately 100,000 Medicare-Medicaid beneficiaries in Ohio were eligible for and over 69,000 (69 percent) enrolled in the demonstration as of December 2016.

The Medicare calculation presented here uses the capitation rate that CMS pays to MyCare Ohio plans for beneficiaries enrolled in the demonstration, and not the actual payments that plans made to providers for services, so the savings are calculated from the perspective of

the Medicare program. A similar approach will be applied to the Medicaid savings calculation when data is available. Part D costs are not included in the savings analysis.

The results shown here reflect quality withhold repayments for the period May 2014 to December 2015 but do not include quality withhold repayments for 2016. Note that Medicare and Medicaid savings calculations will be conducted by RTI for each year of the demonstration as data are available.

The following sections discuss the analytic approach and results of these analyses.

10.1 Evaluation Design

To assess the impact of the demonstration on Medicare costs for Medicare-Medicaid enrollees, RTI used an ITT approach comparing the population eligible for the Ohio demonstration with a comparison group not affected by the demonstration. An ITT approach diminishes the potential for selection bias and highlights the effect of the demonstration on all beneficiaries in the demonstration eligible population. All Medicare-Medicaid enrollees eligible for the demonstration constitute the evaluation sample, regardless of whether they enrolled in the demonstration or actively participated in the demonstration care model. Therefore, the analyses presented here cover demonstration eligible beneficiaries including those who opted out, or who participated but subsequently disenrolled; who were eligible but were not contacted by the State or participating plans; and those who enrolled but did not seek services.

Beneficiaries eligible for the demonstration were identified using quarterly files submitted by the State of Ohio. These files include information on all beneficiaries eligible for the demonstration, as well as indicators for whether each beneficiary was enrolled.

A comparison group was identified in two steps. First, RTI identified comparison areas that are most similar to Ohio with regard to area-level measures of health care market characteristics such as Medicare and Medicaid spending and State policy affecting Medicaid-Medicare enrollees. Second, beneficiaries were selected using a propensity score model (described in further detail below). Further discussion of the comparison group selection process is detailed in ***Appendix A***.

RTI used a difference-in-differences (DID) approach to evaluate the impact of the demonstration on Medicare costs. DID refers to an analytic strategy whereby two groups—one affected by the policy intervention and one not affected by it—are compared on an outcome of interest before and after the policy intervention. The predemonstration period included 2 years prior to the start of the Ohio demonstration (May 1, 2012–April 30, 2014), the first demonstration period (demonstration year 1) included the first 20 months of the demonstration (May 1, 2014–December 31, 2015) and the second demonstration period (demonstration year 2) included calendar year 2016 (January 1, 2016–December 31, 2016).

To estimate the average treatment effect on the demonstration eligible population for monthly Medicare expenditures, RTI ran generalized linear models (GLMs) with a gamma distribution and a log link. This is a commonly used approach in analysis of skewed data or in cases where a high proportion of observations may have values equal to zero. The model also

employed propensity score weighting and adjusted for clustering of observations at the county level.

The GLM model included indicators for demonstration period, an indicator for assignment to the demonstration group versus the comparison group, and an interaction term for demonstration period and demonstration assignment. The model also included demographic variables and area-level variables. The interaction term represents the combined effect of being part of the demonstration eligible group during the demonstration periods and is the key policy variable of interest. The interaction term is a way to measure the impact of both time and demonstration group status. Separate models were run to distinguish between overall savings (pre- versus post-demonstration) as well as savings for each demonstration period. Because the DID variable was estimated using a non-linear model, RTI employed a post-estimation procedure to obtain the marginal effects of demonstration impact. The aggregation of the individual marginal effects represents the net demonstration impact and are reported below.

- Demographic variables included in the model were:
  - Gender
  - Race
  - ESRD status.
- Area-level variables included in the savings model were:
  - Medicare spending per Medicare-Medicaid enrollee age 19 or older
  - Medicare Advantage penetration rate
  - Medicaid-to-Medicare fee for service (FFS) fee index for all services
  - Medicaid spending per Medicare-Medicaid enrollee age 19 or older
  - Proportion of Medicare-Medicaid enrollees using
    - Nursing facilities age 65 or older
    - Home and community-based services (HCBS) age 65 or older
    - Personal care age 65 or older
    - Medicaid managed care age 19 or older
  - Population per square mile, and physicians per 1,000 population

Additional area-based variables—such as the percent of adults with a college degree and proximity to hospitals or nursing facilities—were used as proxies for sociodemographic indicators and local area characteristics. Note that these variables were also used in the

comparison group selection process. Individual beneficiary demographic characteristics are controlled for in the models and are also accounted for in the propensity score weights used in the analysis.

In addition to the variables noted here, the propensity score weights used in the cost savings analyses also include Hierarchical Condition Category (HCC) risk score. HCC risk score is not included as an independent variable in the regression models predicting costs because HCC risk score is directly related to capitated payments. Due to the potential for differences in diagnoses coding for enrollees compared to beneficiaries in FFS after the start of the demonstration, the HCC risk score used to calculate the weights was "frozen" to the value at the start of the demonstration period. Diagnoses codes are the basis for risk score calculations, and by freezing the score prior to any potential impact of the demonstration, we are able to control for baseline health status using diagnosis codes available prior to the demonstration.

10.2 Medicare Expenditures: Constructing the Dependent Variable

RTI gathered predemonstration and demonstration monthly Medicare expenditure data for both the demonstration and comparison groups from two data sources. Capitation payments paid to Medicare Advantage plans in the predemonstration and demonstration periods and paid to MyCare Ohio plans during the demonstration period were obtained from CMS Medicare Advantage and Prescription Drug system (MARx) data. The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments in the system at the time of the data pull (April 2017). Medicare claims were used to calculate Medicare Parts A and B expenditures for FFS beneficiaries. ***Table 33*** summarizes the data sources for Medicare expenditure data.

Table 33
Data sources for monthly Medicare expenditures

Group	Predemonstration May 1, 2012–April 30, 2014	Demonstration period May 1, 2014–December 31, 2016
Demonstration group	Medicare FFS	Medicare FFS for non-enrollees
	Medicare Advantage Capitation	Medicare Advantage Capitation for non-enrollees
		MyCare Ohio Capitation for enrollees
Comparison group	Medicare FFS	Medicare FFS
	Medicare Advantage Capitation	Medicare Advantage Capitation

FFS = fee for service.

A number of adjustments were made to the monthly Medicare expenditures to ensure that observed expenditures variations are not due to differences in Medicare payment policies in different areas of the country or the construction of the capitation rates. ***Table 34*** summarizes each adjustment and the application of the adjustments to FFS expenditures or to the capitation rate.

The capitation payments MARx reflect the savings assumptions applied to the MyCare Ohio and Medicare components of the rate (1 percent for May 1, 2014–December 31, 2015, and

two percent for calendar year 2016), but do not reflect the quality withhold amounts (withhold of 1 percent in the first demonstration period and two percent in the second demonstration period). The results shown here reflect quality withhold repayments for the first demonstration period.

Table 34
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
FFS	Indirect Medical Education (IME)	Capitation rates do not include IME	Do not include IME amount from FFS payments
FFS	Disproportionate Share Hospital (DSH) Payments and Uncompensated Care Payments (UCP)	Capitation rates reflect DSH and UCP adjustments	Include DSH and UCP payments in total FFS payment amounts.
FFS	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013 (reflected in the claims data). Because the pre-demonstration period includes months prior to April 1, 2013 it is necessary to apply the adjustment to these months of data so that any observed changes are not due to sequestration.	Reduced FFS claim payments incurred before April 2013 by 2% so all claims reflect this adjustment.
Capitation rate (MA and MMP)	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013. Sequestration is not reflected in the capitation rates.	Reduced capitation rate by 2%
Capitation rate (MA)	Bad debt	The capitation rate includes an upward adjustment to account for bad debt. Bad debt is not part of FFS claim payment amount and therefore needs to be removed from the capitation rate for the savings analysis. (Note, "bad debt" is reflected in the hospital "pass through" payment separate from the total claim payment amount)	Reduced capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.93 for CY 2012, 0.91 for CY 2013, 0.89 for CY 2014, 0.89 for CY 2015, and 0.97 for CY 2016.

(continued)

Table 34 (continued)
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
Capitation rate (MMP)	Bad debt	The capitation rate includes an upward adjustment to account for bad debt. Bad debt is not part of FFS claim payment amount and therefore needs to be removed from the capitation rate for the savings analysis. (Note, "bad debt" is reflected in the hospital "pass through" payment separate from the total claim payment amount)	Reduced blended capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.87 for CY 2013, 0.88 for CY 2014, 0.89 for CY 2015, and 0.94 for CY 2016. Reduced the FFS portion of the capitation rate by an additional 1.89% for CY 2014, by an additional 1.71% for CY 2015, and by an additional 1.84% for CY 2016 to account for the disproportional share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS.
FFS and capitation rate (MA and MMP)	Average Geographic Adjustments (AGA)	The Medicare portion of the capitation rate reflects the most current hospital wage index and physician geographic practice cost index by county. FFS claims also reflect geographic payment adjustments. In order to ensure that change over time is not related to differential change in geographic payment adjustments, both the FFS and the capitation rates were "unadjusted" using the appropriate county-specific AGA factor.	Medicare expenditures were divided by the appropriate county-specific AGA factor for each year. Note that for 2014 and 2015, a single year-specific AGA factor based on claims paid in the year, rather than the AGA factor used in Medicare Advantage (based on 5 years of data and lagged 3 years) was used to account for year specific policies. Note also that the AGA factor applied to the capitated rates for 2014 reflected the 50/50 blend that was applicable to the payment year. A 2016 single year-specific AGA factor will be incorporated in future calculations as it becomes available.

(continued)

Table 34 (continued)
Adjustments to Medicare expenditures variable

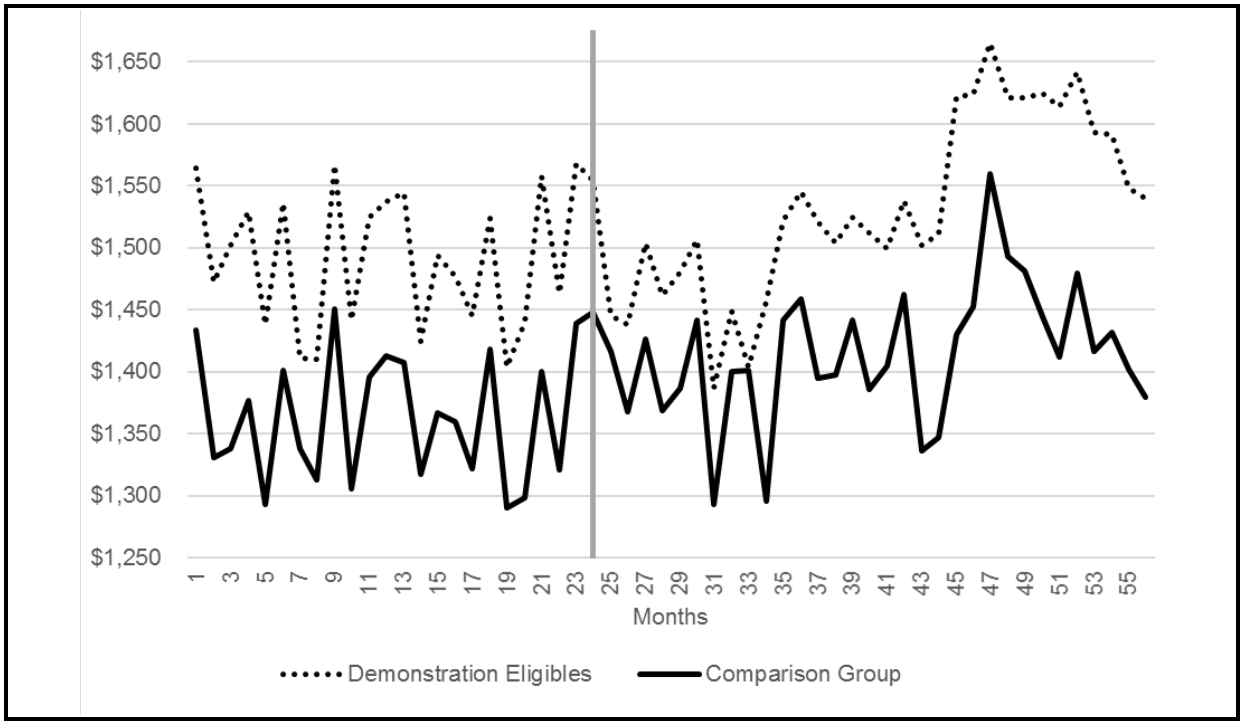
Data source	Adjustment description	Reason for adjustment	Adjustment detail
Capitation rate (MA and MMP)	Education user fee	No adjustment needed.	Capitation rates in the MARX database do not reflect the education user fee adjustment (this adjustment is applied retrospectively). Education user fees are not applicable in the FFS context and do not cover specific Part A and Part B services. While they result in a small reduction in the capitation payment received, we did not account for this reduction in the capitated rate.
Capitation rate (MMP)	Quality withhold	A 1% quality withhold was applied in the first demonstration year and a 2% quality withhold was applied in the second demonstration year but the withholds are not reflected in the capitation rate used in the analysis.	Final quality withhold repayments were incorporated into the dependent variable construction for the first demonstration year. 2016 quality withhold repayments will be incorporated into future calculations as they become available.

CY = calendar year; FFS = fee for service; MMP = Medicare-Medicaid Plan.

10.3 Results

The first step in the analysis was to plot the unweighted mean monthly Medicare expenditures for both the demonstration group and the comparison group. ***Figure 11*** indicates that the demonstration group and the comparison group had parallel trends in mean monthly expenditures during the 24-month predemonstration period, which is an important assumption to the DID analysis.

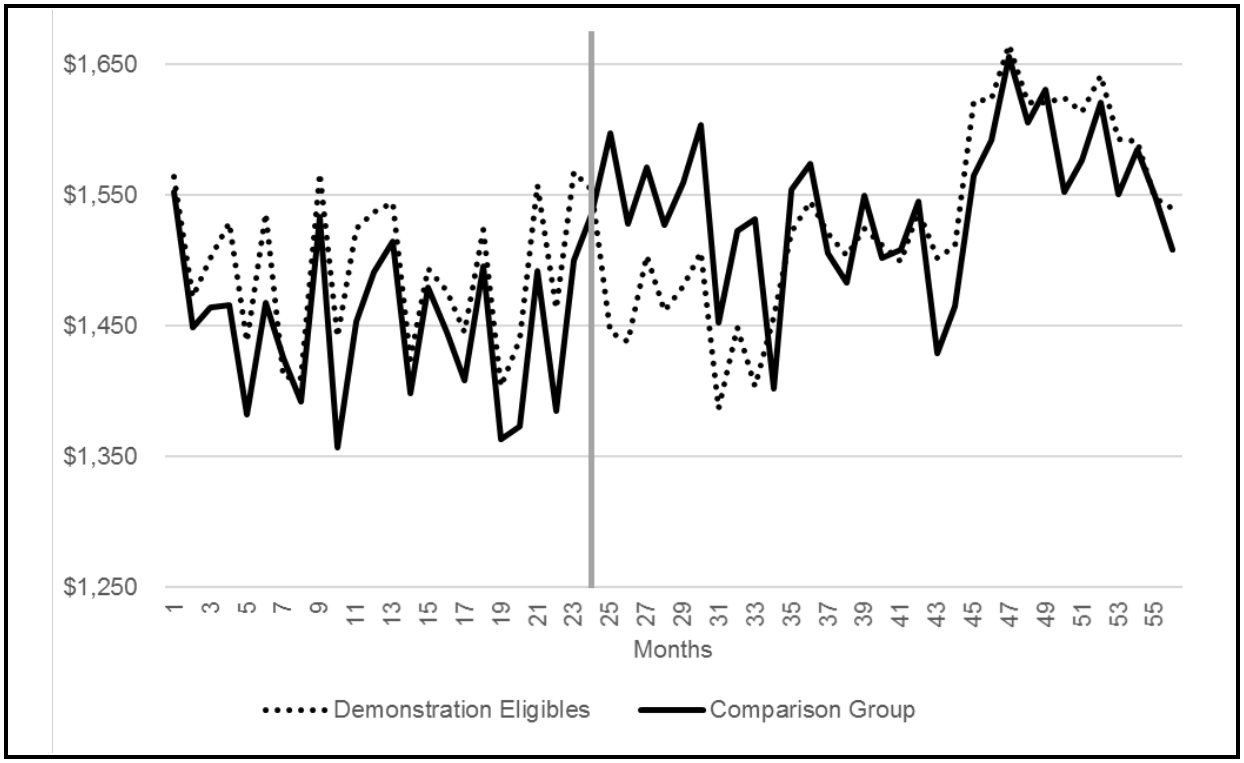
Figure 11
Mean monthly Medicare expenditures, predemonstration and demonstration period, MyCare Ohio eligible and comparison group, May 2012–December 2016



SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: OH AR2 Output/ RelativePercentTableOH_OCT).

Figure 12 demonstrates the same plot of mean monthly Medicare expenditures for both the demonstration group and the comparison group, after applying the propensity weights and establishes the parallel trends for both groups.

Figure 12
Mean monthly Medicare expenditures (weighted), predemonstration and demonstration period, MyCare Ohio eligibles and comparison group, May 2012–December 2016



SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: OH AR2 Output/ RelativePercentTableOH_OCT).

Table 35 and ***Table 36*** show the mean monthly Medicare expenditures for the demonstration group and comparison group in the predemonstration and each demonstration period, unweighted. The unweighted tables show a decrease in mean monthly Medicare expenditures for the demonstration eligible group in demonstration period 1 and an increase for the comparison group over the same period. There was an increase in mean monthly Medicare expenditures in demonstration period 2 for both the demonstration group and the comparison group. The unweighted mean decrease in demonstration period 1 was $2.81 PMPM for demonstration eligible beneficiaries and the unweighted mean increase $29.57 PMPM for the comparison group. The unweighted mean increase in demonstration period 2 was $112.54 PMPM for demonstration eligible beneficiaries and $80.51 PMPM for the comparison group. A decrease in mean monthly expenditures was shown for the demonstration group in the demonstration period, but an increase was shown in the comparison group for demonstration period 1 and for both groups in demonstration period 2 (***Table 37*** and ***Table 38***).

The DID values in each table represent the overall impact on savings using descriptive statistics. These effects are descriptive in that they are arithmetic combinations of simple means, without controlling for covariates. The change in the demonstration group minus the change in the comparison group is the DID value. This value would be equal to zero if the differences

between predemonstration and the demonstration period were the same for both the demonstration group and the comparison group. A negative value would indicate savings for the demonstration group, and a positive value would indicate losses for the demonstration group. The unweighted DID values (***Tables 35*** and ***36***) in demonstration periods 1 and 2 are not statistically significant (illustrated by the 95 percent confidence intervals that include 0), however the confidence intervals for the negative value in demonstration period 1 is very close to 0 showing insignificant savings). The weighted DID (***Tables 37*** and ***38***) values in demonstration periods 1 and 2 are negative (indicating savings) and statistically significant in period 1, but not in period 2 (illustrated by the 95 percent confidence intervals that exclude 0 in period 1 and include 0 in period 2).

Table 35
Mean monthly Medicare expenditures for MyCare Ohio eligibles and comparison group, predemonstration period and demonstration period 1, unweighted

Group	Predemonstration period May 2012–April 2014	Demonstration period 1 May 2014–Dec 2015	Difference
Demonstration group	$1,495.11 ($1,457.51, $1,532.70)	$1,492.30 ($1,455.48, $1,529.13)	−$2.81 (−$32.40, $26.79)
Comparison group	$1,367.03 ($1,303.74, $1,430.33)	$1,396.61 ($1,328.18, $1,465.032)	$29.57 ($14.71, $44.44)
Difference-in-difference	—	—	−$32.38 (−$65.16, $0.40)

— = data not available.

NOTE: 95 percent confidence intervals are shown in parentheses below estimates.

SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: Programming Specifications/Cap Savings Calculation/ Ohio/lgs_ohcs503_v2_log).

Table 36
Mean monthly Medicare expenditures for MyCare Ohio eligibles and comparison group, predemonstration period and demonstration period 2, unweighted

Group	Predemonstration period May 2012–April 2014	Demonstration period 2 Jan 2016–Dec 2016	Difference
Demonstration group	$1,495.11 ($1,457.51, $1,532.70)	$1,607.65 ($1,559.04, $1,656.27)	$112.54 ($74.15, $150.94)
Comparison group	$1,367.03 ($1,303.74, $1,430.33)	$1,447.55 ($1,389.39, $1,505.70)	$80.51 ($45.80, $115.23)
Difference-in-difference	—	—	$32.03 (−$19.50, $83.56)

— = data not available.

NOTE: 95 percent confidence intervals are shown in parentheses below estimates.

SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: Programming Specifications/Cap Savings Calculation/ Ohio/lgs_ohcs503_v2_log).

Table 37
Mean monthly Medicare expenditures for MyCare Ohio eligibles and comparison group, predemonstration period and demonstration period 1, weighted

Group	Predemonstration period May 2012–April 2014	Demonstration period 1 May 2014–Dec 2015	Difference
Demonstration group	$1,495.11 ($1,457.51, $1,532.70)	$1,492.30 ($1,455.48, $1,529.13)	−$2.81 (−$32.40, $26.79)
Comparison group	$1,453.62 ($1,364.18, $1,543.06)	1,528.62 ($1,431.20, $1,626.04)	$75.00 ($45.41, $104.60)
Difference-in-difference	—	—	−$77.81 (−$119.43, -$36.19)

— = data not available.

NOTE: 95 percent confidence intervals are shown in parentheses below estimates.

SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: Programming Specifications/Cap Savings Calculation/ Ohio/lgs_ohcs503_v2_log).

Table 38
Mean monthly Medicare expenditures for MyCare Ohio eligibles and comparison group, predemonstration period and demonstration period 2, weighted

Group	Predemonstration period May 2012–April 2014	Demonstration period 2 Jan 2016–Dec 2016	Difference
Demonstration group	$1,495.11 ($1,457.51, $1,532.70)	$1,607.65 ($1,559.04, $1,656.27)	$112.55 ($74.15, $150.94)
Comparison group	$1,453.62 ($1,364.18, $1,543.06)	$1,582.45 ($1,487.18, $1,677.73)	$128.84 ($25.80, $231.87)
Difference-in-difference	—	—	−$16.29 (−$126.15, $93.57)

— = data not available.

NOTE: 95 percent confidence intervals are shown in parenthesis below estimates.

SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: Programming Specifications/Cap Savings Calculation/ Ohio/lgs_ohcs503_v2_log).

10.3.1 Regression Analysis

While the descriptive statistics are informative, to get a more accurate estimate of savings, RTI conducted a multivariate regression analysis to estimate savings controlling for beneficiary and area-level characteristics. Given the structure of the data, RTI used the GLM procedure in Stata with a gamma distribution and a log link, and adjusted for clustering at the county level.

In addition to controlling for beneficiary and market area characteristics, the model included a time trend variable (coded as months 1–56), a dichotomous variable for whether the observation was from the predemonstration or demonstration period ("Post"), a variable to

indicate whether the observation was from a beneficiary in the comparison group or the demonstration group ("Intervention"), and an interaction term ("Intervention*Post") which is the DID estimate in the multivariate model for the net effect of demonstration eligibility. We also ran a model specific to the year of the demonstration and for this we included a dummy variable for each year of the demonstration ("DemoYear1" and "DemoYear2") and two interaction terms ("Intervention*DemoYear1"and "Intervention*DemoYear2").

Table 39 shows the main results from the DID analysis for demonstration years 1 and 2, and for the entire demonstration period, controlling for beneficiary demographics and market characteristics. To obtain the effect of the demonstration from the non-linear model we calculated the marginal effect of coefficient of the interaction term. The marginal effect of the demonstration for the intervention group over the two demonstration periods in aggregate was negative (−41.27) but savings were not statistically significant, indicating that there were no savings or losses to Medicare as a result of the demonstration using the ITT analysis framework. The estimate of the effect of the demonstration in period 1 indicated $65.36 in savings which were statistically significant, and $2.27 in losses for demonstration period 2 which were not statistically significant using the ITT framework.

Table 39
Demonstration effects on Medicare savings for eligible beneficiaries—Difference-in-difference regression results, MyCare Ohio eligibles and comparison group

Covariate	Adjusted coefficient DID	*p*-value	95% confidence interval	90% confidence interval	80% confidence interval[1]
Intervention*DemoYear1 (May 2014–December 2015)	−65.36	0.0002	(−99.65, −31.07)	(−94.14, −36.58)	(−87.78, −42.94)
Intervention*DemoYear2 (January 2016–December 2016)	2.27	0.9653	(−99.81, 104.35)	(−83.40, 87.94)	(−64.48, 69.01)
Intervention*Demo Period (May 2014-December 2016)	−41.27	0.1228	(−93.70, 11.15)	(−85.27, 2.73)	(−75.55, −6.99)

[1] 80 percent confidence intervals are provided for comparison purposes only.

SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: Programming Specifications/Cap Savings Calculation/ Ohio/lgs_ohcs483_v2_log).

Table 40 shows the magnitude of the DID estimate relative to the adjusted mean outcome value in the predemonstration and demonstration periods. The second and third columns represent the post-regression, mean predicted savings or loss for each group and period, based on the composition of a reference population (the comparison group in the demonstration period). These values show how different the two groups were in each period, and the relative direction of any potential effect in each group over time. The remaining columns show the DID estimate (the coefficient on Intervention*Post), the *p*-value demonstrating significance, and the relative percent change of the DID estimate compared to the mean monthly Medicare expenditures for the comparison group in the entire demonstration period.

The adjusted mean for monthly expenditures increased between the predemonstration and demonstration period for the demonstration and comparison groups. The DID estimate of −41.27

(the coefficient on Intervention*Post) is negative, but the savings are not statistically significant ($p < 0.1228$), indicating that there were no statistically significant savings or losses in Medicare Parts A and B from the demonstration, using the ITT analysis framework. The adjusted coefficient on the DID estimate for the demonstration overall (−$41.27, in ***Table 40***) is between the marginal effect of the DID estimate from demonstration year 1 (−$65.36 in ***Table 39***) and the marginal effect of the DID estimate from demonstration year 2 ($2.27, also in ***Table 39***). The DID estimate for demonstration years 1 and 2 in aggregate reflected an annual relative cost decrease of −2.63 percent (***Table 40***), but this was not statistically significant.

Table 40
Adjusted means and overall impact estimate for eligible beneficiaries in the demonstration and comparison groups, MyCare Ohio eligibles and comparison group

Group	Adjusted mean for predemonstration period	Adjusted mean for demonstration period	Relative difference (%)	Adjusted coefficient DID	*p*-value
Demonstration group	$1,317.45 ($1,135.60, $1,499.30)	$1,309.61 ($1,126.38, $1,492.84)	−2.63%	−41.27 95% CI (−93.70, 11.15) 90% CI (−85.27, 2.73)	0.1228
Comparison group	$1,539.38 ($1,452.75, $1,626.01)	$1,570.69 ($1,482.65, $1,658.73)			

CI = confidence interval; DID = difference-in-differences.

SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: Programming Specifications/Cap Savings Calculation/ Ohio/lgs_ohcs483_v2_log and Programming Specifications/Cap Savings Calculation/ Ohio/lgs_ohcs493_v2_log).

In addition to the cost savings analysis on all eligible beneficiaries (ITT approach), RTI conducted several sensitivity analyses to provide additional information on potential savings or losses associated with the demonstration overall and for the subset of beneficiaries enrolled in the demonstration. These sensitivity analyses included (1) simulating capitated rates for eligible enrollees not enrolled in the demonstration and comparing these rates to actual FFS expenditures; (2) predicting FFS expenditures for beneficiaries enrolled in the demonstration and comparing to the actual capitated rates; and (3) calculating a DID estimate based on a subgroup of beneficiaries enrolled in the demonstration with at least 3 months of eligibility in the baseline period. The results of these analyses are presented in ***Appendix D***.

The findings of the sensitivity analyses indicate that the predicted capitated rates are statistically significantly lower than actual FFS expenditures for non-enrollees and that predicted FFS expenditures are higher than actual capitated rates for enrollees. The enrollee subgroup DID analysis indicates additional costs compared to a comparison group, and this finding is statistically significant. For further discussion of these results see ***Appendix D***. Note that these sensitivity analyses do not control for unobservable characteristics that may be related to the decision to enroll in the demonstration. The enrollee subgroup DID analysis was conducted to learn more about the potential impact of the demonstration on the subset of beneficiaries touched by the demonstration for at least 3 months. Note that similar 3-month eligibility criteria were applied to the comparison group for the baseline and demonstration periods for this analysis and weights were recalculated. The enrollee subgroup analysis is limited by the absence of person-

level data on characteristics that potentially would lead an individual in a comparison area to enroll in a similar demonstration, and thus the results should be considered in the context of this limitation.

10.4 Discussion

The results of the preliminary multivariate analyses presented here do not indicate statistically significant Medicare savings or losses during the first 32 months of the Ohio demonstration. However, statistically significant savings are observed in the first demonstration period. The savings calculated here are based on capitation rates that CMS paid MyCare Ohio plans for enrollees and the FFS expenditures and Medicare Advantage capitation rates for eligible beneficiaries that did not enroll in the demonstration. The estimates do not take into account actual payments for services incurred by enrollees and paid by the MyCare Ohio plans.

It should also be noted that the demonstration year 2 results for the enrollee subgroup in part reflect a risk adjustment-related change that increased the capitation payments for eligible individuals enrolled in Ohio MMPs in 2016.

RTI will continue to examine these results and will rerun the analyses when complete information on quality withholds become available. Once Medicaid data become available for the first demonstration period and a similar calculation can be conducted on the Medicaid costs, it will be possible to have a more complete understanding of potential savings from the first 2 demonstration periods of the MyCare Ohio demonstration. Additional Medicare and Medicaid savings calculations will be conducted by the evaluation contractor for each year of the demonstration as data are available and future reports will show updated results for the first 2 years of the demonstration based on data reflecting additional claims runout, risk score reconciliation, and any retroactive adjustments.

11. Conclusions

11.1 Implementation-related Successes, Challenges, and Lessons Learned

Implementation of MyCare Ohio has presented significant challenges, most notably in the areas of enrollment, financing and payment, and care coordination. State officials and MyCare Ohio plans have taken active approaches to address each of these challenges, with varying results.

The demonstration achieved notable successes in administrative areas that ODM and MMPs were able to control directly. When faced with enrollment challenges due to discrepancies among CMS, ODM, and county IT systems in the demonstration's first year, ODM formed staff teams focused on streamlining and systematizing the reconciliation process. ODM noted that in subsequent years, the number of discrepancies was greatly reduced, and discrepancies have been resolved quickly. ODM took a similar approach to difficulties in processing encounter data needed for rate setting. After forming an encounter data team, the State reduced backlogs significantly. ODM officials were optimistic that they could achieve the goal of processing at least 95 percent of remaining encounter data by Summer 2017.

Provider payment processes were especially challenging early in the demonstration; MMPs lacked experience with Ohio's LTSS and behavioral health (BH) payment and delivery systems, and the State's LTSS and BH providers did not have prior experience with managed care. MMPs took the lead in addressing the issue, by convening LTSS and BH collaboratives and providing extensive provider training on billing and payment. As a result, State officials, stakeholders, and plan staff agree that the early systemic problems with LTSS payments were resolved in 2015. Remaining barriers to payment for BH services are being addressed as part of the State's transition to a managed BH care system.

The major challenge for the remainder of the demonstration is in the area of care coordination. ODM and MMPs have pursued improvements through hiring, training, organization of care management functions, and enrollee outreach. Stakeholders report that enrollees' awareness of care managers has increased. However, State officials and stakeholders agree that the full potential of care coordination to improve enrollee health and well-being has not yet been realized.

State and enrollee representatives have identified a need to improve person-centered care planning and focus more on meeting enrollees' needs. Although the demonstration's care coordination model includes an important role for primary care physicians in care planning, they generally have not been involved in care teams.

The RTI evaluation team's review of MyCare Ohio implementation experience through 2016 suggests two key lessons learned. First, successful care coordination requires a delicate balance between providing strong MMP oversight and accountability while simultaneously allowing enough flexibility for plans to develop effective and innovative approaches. Because they believed that this has not been achieved, ODM officials proposed a change to the care coordination model through an amendment to the three-way contract. The amendment was approved, and the three-way contract was updated in 2017.

The second lesson is that the demonstration's success ultimately rests on care coordinators' ability to integrate services across the medical, LTSS, and BH delivery systems. MMPs have had difficulty finding care coordinators with the skills and experience to achieve this goal. In the remainder of the demonstration, efforts to increase the capacity of care coordinators through strategies such as enhanced staff development, additional hiring, and mentoring activities could help improve the quality and effectiveness of care coordination. Increased efforts to engage PCPs also will be critical to advance the demonstration's care coordination goals. PCPs have the potential to provide an important source of clinical expertise on care teams, and based on ongoing relationships with patients, they could provide the added input needed for more customized, person-centered care planning.

11.2 Demonstration Impact on Service Utilization and Cost Savings

Quantitative findings of demonstration impacts show that the Ohio demonstration, when analyzing all demonstration eligibles compared to the comparison group, resulted in statistically significant changes in most utilization patterns, including changes in RTI quality of care and care coordination measures. Successes included lower monthly inpatient admissions (including inpatient admissions for overall and chronic ambulatory care-sensitive conditions), skilled nursing facility admissions, and a lower probability of any long-stay nursing facility use over the demonstration period. Results for the LTSS and severe and persistent mental illness (SPMI) populations, when compared with similar beneficiaries in the comparison group, varied somewhat from the results for all eligibles.

Conversely, no effect was found on monthly emergency room (ER) visits overall or on the all-cause 30-day readmission rate (although the LTSS population had lower use on this latter measure), and the demonstration resulted in higher preventable ER visits. Physician evaluation and management visits decreased, and there was no effect on the probability of monthly follow-up after mental health discharges. The readmissions findings may relate to site visit informant reports of mixed MMP experiences with efforts to arrange smooth post-discharge transitions. Results for follow-up after mental health discharges may be associated with reported challenges in sharing of BH information (see ***Section 4.2, Information Exchange***). Moreover, these varied results support the view expressed during site visits that care management has improved during the demonstration, but that additional progress is needed (see ***Section 10.1***). The 2017 changes to the three-way contract are intended to advance this goal. Results for the LTSS and SPMI populations were similar, except that there was also no effect in the LTSS population for overall ambulatory care sensitive conditions inpatient admissions or physician evaluation and management visits.

CAHPS results also showed some improvements. In particular, the overall rating measure showed considerable improvement in the majority of plans. Nearly all respondents felt that their personal doctors understood how their health problems affected their everyday lives, and most had the same doctor prior to enrolling in MyCare Ohio.

Although the results across utilization settings are mixed in terms of direction, the balance of these early findings suggests a potential shift toward lower utilization as a result of the demonstration. Potentially, undesired results could be improved if MMPs improve their care coordination and management activities. In particular, efforts to improve PCP or physician

extender involvement in care management (see ***Section 2.2.2, Provider Arrangements and Services***) and improve communication and coordination with BH providers (see ***Section 4.2, Information Exchange***) would be important. Beneficiaries with more involvement with primary care practitioners may be less likely to visit ERs. Given that approximately 43 percent of eligible MyCare beneficiaries had an SPMI diagnosis, increased care coordination efforts in conjunction with BH providers may potentially improve performance on the two ER utilization measures and the measures for inpatient readmission and follow-up after discharge for mental illness. The evaluation team will continue to monitor these issues, as well as any changes in coordination of BH services following completion of the State's transition to a managed BH care system in 2018.

The results of the preliminary multivariate cost savings analyses presented here do not indicate statistically significant Medicare savings or losses during the first 32 months of the Ohio demonstration. However, statistically significant savings are observed in the first demonstration period. The savings calculated here are based on capitation rates paid by CMS to MyCare Ohio plans for enrollees, and the FFS expenditures and Medicare Advantage capitation rates for eligible beneficiaries that did not enroll in the demonstration. The estimates do not take into account actual payments for services incurred by enrollees and paid by the MyCare Ohio plans. RTI will continue to examine these results and will rerun the analyses when more data become available. Once Medicaid data become available and a similar calculation can be conducted on the Medicaid costs, it will be possible to have a more complete understanding of potential savings from the MyCare Ohio demonstration. Additional Medicare and Medicaid savings calculations will be conducted by the evaluation contractor for each year of the demonstration as data are available.

11.3 Next Steps

The RTI evaluation team will continue to collect information on a quarterly basis from Ohio officials through the online State Data Reporting System, covering enrollment statistics and updates on key aspects of implementation. The team will continue conducting quarterly calls with MyCare Ohio staff and will request the results of any evaluation activities conducted by the State or other entities, such as results from the Consumer Assessment of Healthcare Providers and Systems and State-specific demonstration measures the plans are required to report to CMS. RTI will conduct additional site visits and focus groups over the course of the demonstration.

As noted previously, Ohio received an extension from CMS to continue the demonstration through December 2019. The additional two years of implementation will provide further opportunities to evaluate the demonstration's performance. The next report will include a qualitative update on demonstration implementation and descriptive analyses of quality and utilization measures for those eligible for the demonstration and for an out-of-State comparison group.

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References

Centers for Medicare & Medicaid Services (CMS): Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Ohio-Specific Reporting Requirements. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014ReportingAppendixOH.pdf. 2014a. As obtained on January 16, 2015.

Centers for Medicare & Medicaid Services (CMS): Contract Year 2014 Chronic Care Improvement Program and Quality Improvement Project Information for Medicare-Medicaid Plans in Ohio. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPCCIPQIPGuidanceOH.pdf. 2014b. As obtained on January 16, 2015.

Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office (MMCO): Financial Alignment Initiative. Ohio. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Ohio.html. n.d. As obtained on March 1, 2017.

Centers for Medicare & Medicaid Services (CMS) and The State of Ohio: Memorandum of Understanding (MOU) Between The Centers for Medicare & Medicaid Services (CMS) and The State of Ohio Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. Demonstration to Develop an Integrated Care Delivery System. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OHMOU.pdf. 2012. As obtained on November 17, 2016.

Centers for Medicare & Medicaid Services (CMS) and The State of Ohio: Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with The State of Ohio Department of Medicaid. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioContract.pdf. 2014. As obtained on November 17, 2016.

Centers for Medicare & Medicaid Services (CMS) and The State of Ohio: Summary of Contract Changes. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OHSummaryContractChanges052016.pdf. 2016. As obtained on November 17, 2016.

Ohio Department of Job and Family Services: State Demonstration to Integrate Care for Medicare-Medicaid Enrollees. Proposal to the Center for Medicare and Medicaid Innovation. http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/ICDS/Concepts%20and%20Proposals/Final-Proposal-to-CMS-4022012.pdf. 2012. As obtained on January 5, 2017.

Ohio Governor's Office of Health Transformation: Ohio's Demonstration Model to Integrate Care for Dual Eligibles. http://healthtransformation.ohio.gov/LinkClick.aspx?fileticket=5vmU1slVuvI%3d&tabid=105. February 1, 2011. As obtained on January 5, 2017.

Ohio Department of Medicaid (ODM): Ohio Recognized as National Leader in Transitioning Individuals into Home and Community Based Care Settings. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=fZEelvzaxCo%3d&tabid=125. 2013. As obtained on January 14, 2015.

Ohio Department of Medicaid (ODM): Quality Strategy. http://medicaid.ohio.gov/MEDICAID101/QualityStrategyandMeasures.aspx. 2014. As obtained on January 16, 2015.

Ohio Department of Medicaid (ODM): MyCare Ohio Provider Agreement for MyCare Ohio Plan. http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/ICDS/SFY2015-MyCareOhio-PA.pdf. 2015. As obtained on January 16, 2015.

Ohio Department of Medicaid (ODM): MyCare Ohio Provider Agreement for MyCare Ohio Plan. https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/ICDS/SFY2016-07-MyCareOhio-PA.pdf. 2016. As obtained on January 25, 2017.

Ohio Department of Medicaid (ODM): Balancing Incentive Program. http://www.medicaid.ohio.gov/INITIATIVES/BalancingIncentiveProgram.aspx. n.d. As obtained on January 5, 2017.

Ohio Governor's Office of Health Transformation: Rebalancing Medicaid Long-Term Care. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=zcwnvBWWkGo%3D&tabid=86. n.d.-a. As obtained on November 28, 2016.

Ohio Governor's Office of Health Transformation: Create a Unified Long-Term Care System. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=PpzaF58Kd0E%3D&tabid=86. n.d.-b. As obtained on November 28, 2016.

Ohio Governor's Office of Health Transformation: Rebuild Community Behavioral Health System Capacity. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=3ex6FYrAIU4%3D&tabid=252. 2015. As obtained on January 5, 2017.

Ohio Governor's Office of Health Transformation: Ohio's Medicaid Behavioral Health Redesign. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=2p-58m6D8tw%3D&tabid=122. Updated June 2016. As obtained on January 5, 2017.

RTI International: State Data Reporting System (SDRS), 2015 and 2016.

U.S. Department of Health and Human Services (DHHS): The Beacon Community Program. https://www.healthit.gov/sites/default/files/beacon-communities-lessons-learned.pdf. 2012. As obtained on April 4, 2017.

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Appendix A:
Comparison Group Methodology for Ohio Demonstration Year 1

CMS contracted with RTI International to monitor the implementation of demonstrations under the Financial Alignment Initiative (FAI) and to evaluate their impact on beneficiary experience, quality, utilization, and cost. This appendix presents the comparison group selection and assessment results for the FAI demonstration in the State of Ohio.

This appendix lists the geographic comparison areas for Ohio, provides propensity model estimates, and shows the similarities between the comparison and demonstration groups in terms of their propensity score distributions. Separate analyses were conducted for three time periods for the Ohio demonstration: baseline year 1 (May 1, 2012–April 30, 2013), baseline year 2 (May 1, 2013–April 30, 2014), and the first demonstration period (20 months from May 1, 2014–December 31, 2015). Analyses were conducted for each period because eligible beneficiaries are identified separately for each time period.

A.1 Comparison Areas

The Ohio demonstration area consists of 25 counties that are part of nine metropolitan statistical areas (MSAs) (Columbus; Toledo; Canton-Massillon; Youngstown-Warren-Boardman; Dayton; Akron; Cleveland-Elyria; Springfield; and Cincinnati) and 4 non-metropolitan counties in Ohio. Using a distance score methodology, the comparison area is composed of 83 counties in 15 MSAs from 6 States, and includes 46 non-metropolitan counties in Ohio. The pool of States was limited to those with timely submission of Medicaid data to CMS. All comparison MSAs are listed in ***Table A-1***.

Table A-1
Comparison areas in six comparison States

Ohio MSAs	**Illinois MSA**	**Texas MSAs**
Columbus (5 counties)	Rockford	Abilene
Dayton (1 county)	**New York MSA**	Dallas-Fort Worth-Arlington (11 counties)
Lima	Albany-Schenectady-Troy	**West Virginia MSAs**
Mansfield	**Pennsylvania MSAs**	Beckley
Weirton-Steubenville	Erie	Parkersburg-Vienna
Wheeling	Reading	
Rest-of-State (46 counties)		

The Ohio demonstration was restricted to dual eligible beneficiaries who had not been attributed to another Federal Medicare shared savings initiative. Attribution to other savings initiatives was ascertained using the beneficiary-level version of the CMS Master Data Management file. Beneficiaries in the demonstration group during the demonstration period were identified from quarterly finder files of participants in the Ohio MyCare demonstration. Beneficiaries qualified for the demonstration group if they participated for at least one month

during the demonstration period. During the two baseline periods, all beneficiaries who met the age restriction and MSA residency requirements were selected for the demonstration and comparison groups. Beneficiaries were omitted from further analyses if they had missing geographic data; passed away before the beginning of the analysis period; had zero months of eligibility as a dual eligible; lived in both a demonstration area and a comparison area during the analysis period; were in another shared savings program; or were missing Hierarchical Condition Category (HCC) risk scores during a year.

Table A-2 below shows the distribution of beneficiaries by comparison State in the first baseline year. Comparison areas within the State of Ohio contributed the largest share of comparison beneficiaries. State shares were very similar in baseline year 2 and demonstration year 1. Since at least three States were included and no State contributed more than half of the total comparison beneficiaries, per RTI's comparison group selection methodology it was not necessary to do any sampling to reduce the influence of a single State. The total number of comparison beneficiaries was comparatively stable throughout the three time periods (148,635 in baseline year 1, 140,806 in baseline year 2, and 162,952 in demonstration year 1).

Table A-2
Distribution of comparison group beneficiaries for the Ohio demonstration, first baseline year, by comparison State

Comparison State	Percent of comparison beneficiaries
Illinois	6.09
New York	13.68
Ohio	45.34
Pennsylvania	13.92
Texas	16.37
West Virginia	4.61
Total percent	100
Total beneficiaries	148,635

A.2 Propensity Score Estimates

RTI's methodology uses propensity scores to examine initial differences between the demonstration and comparison groups and then to weight the data to improve the match between them. The comparability of the two groups is examined with respect to both individual beneficiary characteristics as well as the overall distributions of propensity scores. This section describes the results of the model that generates propensity scores and subsequent sections show how weighting eliminates initial differences between the groups.

A propensity score is the predicted probability that a beneficiary is a member of the demonstration group based on a set of observed variables. Our propensity score models include a combination of beneficiary-level and region-level characteristics measured at the ZIP code (ZIP Code Tabulation Area) level. Region-level covariates were drawn from a factor analysis of ZIP-

based variables for the population aged 64 years or younger. These covariates capture features of the age, employment, marital, and family status of households in each region. Measures of the distance to hospitals and nursing homes were also included.

The logistic regression coefficients, standard errors, and z-values for the covariates included in the propensity model for Ohio are shown in ***Table A-3***. These coefficients and the underlying data are used to generate propensity scores for each beneficiary in the model. In general, individual covariates had similar effects in each period, indicating that the data were generally similar across each period. The coefficients for several variables reflected differences between the demonstration and comparison groups. Relative to the comparison group, demonstration participants were more likely to be white or black, as well as live in a metropolitan area. The magnitude of these differences may also be seen in ***Tables A-4*** through ***A-6***.

Table A-3
Logistic regression estimates for Ohio propensity score models

Characteristic	Baseline year 1			Baseline year 2			Demonstration year 1		
	Coefficient	Standard error	z-score	Coefficient	Standard error	z-score	Coefficient	Standard error	z-score
Age (years)	0.002	0.000	5.38	0.002	0.000	6.32	0.003	0.000	8.69
Died during year (0/1)	−0.123	0.016	−7.64	−0.099	0.017	−5.78	−0.255	0.018	−13.89
Female (0/1)	0.044	0.009	4.77	0.038	0.009	4.03	0.185	0.010	18.13
White (0/1)	0.765	0.019	41.10	0.774	0.019	40.41	0.543	0.020	27.60
Black (0/1)	1.438	0.021	68.90	1.411	0.021	65.78	1.260	0.022	58.03
Disability as reason for original Medicare entitlement (0/1)	0.057	0.013	4.57	0.041	0.013	3.14	−0.060	0.014	−4.34
ESRD (0/1)	0.259	0.026	9.79	0.214	0.028	7.72	0.222	0.030	7.37
Prop. mos. eligible during period	−0.609	0.014	−43.03	−0.473	0.015	−32.34	−0.265	0.015	−17.21
HCC risk score	0.079	0.004	19.94	0.085	0.004	21.35	0.158	0.004	37.57
MSA (0/1)	1.474	0.016	90.01	1.465	0.017	85.84	1.510	0.021	73.45
% of pop. living in married household	−0.015	0.000	−34.00	−0.016	0.000	−35.66	−0.031	0.001	−61.20
% of households w/member >= 60 yrs.	0.011	0.001	14.69	0.011	0.001	13.93	0.021	0.001	26.48
% of households w/member < 18 yrs.	−0.022	0.001	−32.34	−0.027	0.001	−38.10	−0.028	0.001	−37.99
% of adults with college education	0.020	0.000	42.06	0.022	0.001	44.85	0.026	0.001	47.03
% of adults with self-care limitation	0.039	0.003	14.31	0.035	0.003	12.70	0.002	0.003	0.80
Distance to nearest hospital (mi.)	−0.082	0.001	−55.85	−0.082	0.002	−53.98	−0.072	0.002	−43.21
Distance to nearest nursing home (mi.)	−0.040	0.002	−18.42	−0.036	0.002	−16.26	−0.035	0.003	−14.12
Intercept	−0.351	0.054	−6.49	−0.342	0.056	−6.14	−0.492	0.059	−8.35

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MSA = Metropolitan Statistical Area.

A.3 Propensity Score Overlap

Propensity score weighting is used to mitigate the potential for selection bias by increasing the equivalence between the demonstration and comparison groups. Any beneficiaries who have estimated propensity scores below the smallest estimated value in the demonstration group are removed from the comparison group. This resulted in the removal of 142 comparison group beneficiaries in baseline year 1, 54 in baseline year 2, and 26 beneficiaries in the first demonstration period.

The distributions of propensity scores by group are shown for each time period in ***Figures A-1*** through ***A-3*** before and after propensity score weighting. Estimated scores covered nearly the entire probability range in both groups. In each period, demonstration group scores were skewed to the left, as opposed to the unweighted comparison beneficiary scores, which are sharply skewed to the right. In the first demonstration period (year 3), scores among the demonstration group were somewhat less skewed to the left than in the baseline years.

The figures show that Inverse Probability of Treatment Weighting (IPTW) pulls the distribution of weighted comparison group propensity scores (dotted line) much closer to that of the demonstration group (solid line). Weighting shifted the comparison group distribution to the right, greatly increasing the comparability of the demonstration and comparison groups.

Figure A-1
Distribution of beneficiary-level propensity scores in the Ohio demonstration and comparison groups, weighted and unweighted, May 2012–April 2013

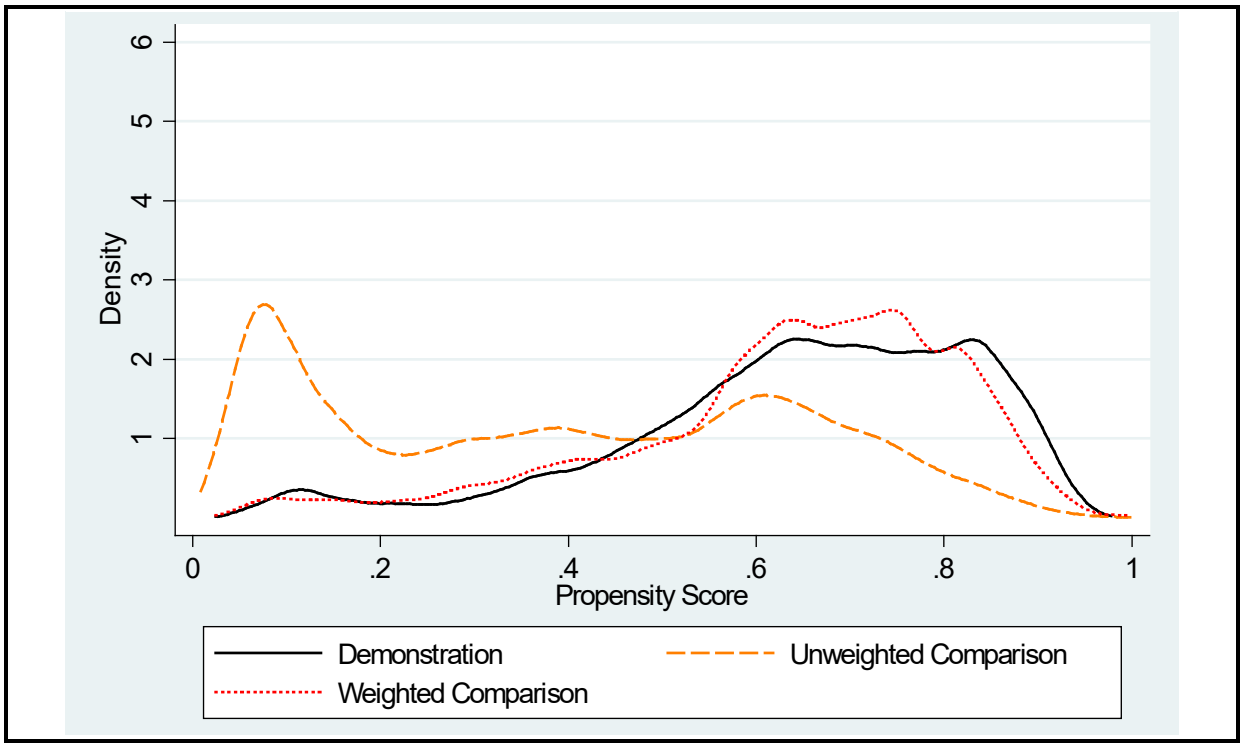


Figure A-2
Distribution of beneficiary-level propensity scores in the Ohio demonstration and comparison groups, weighted and unweighted, May 2013–April 2014

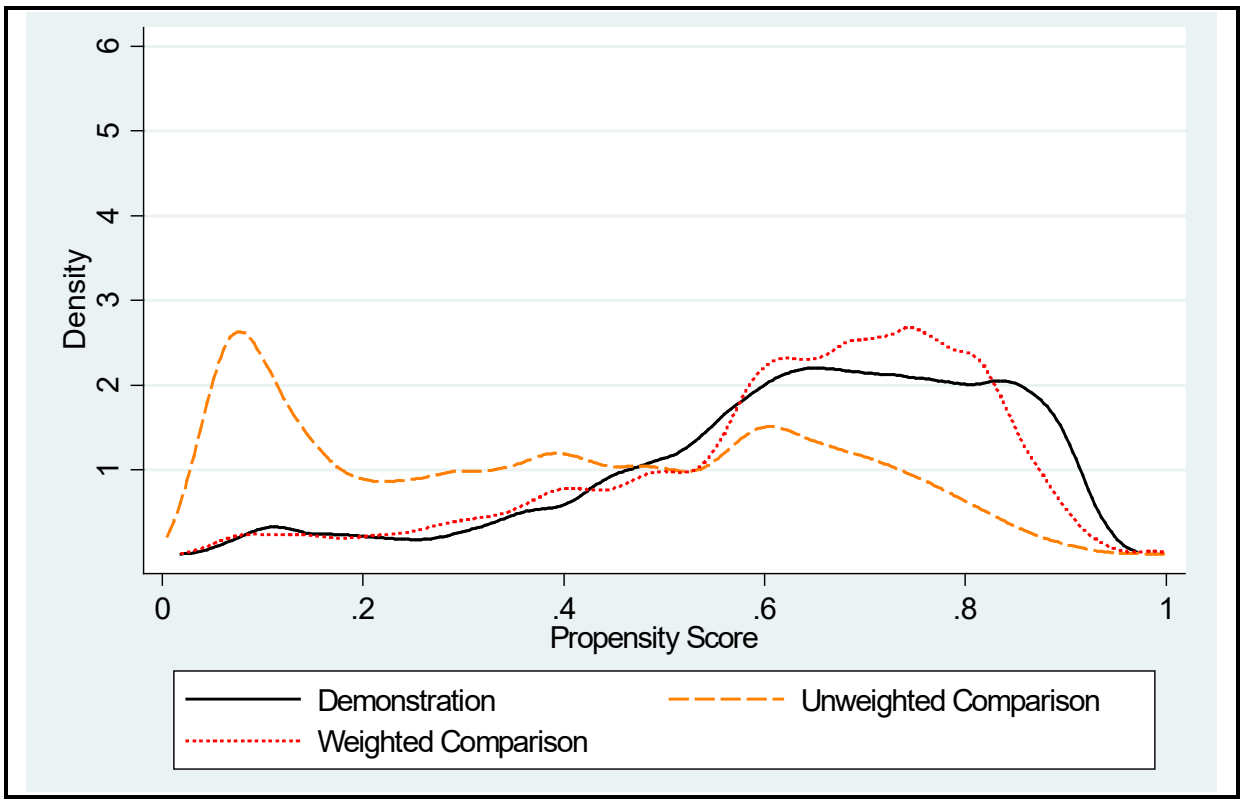
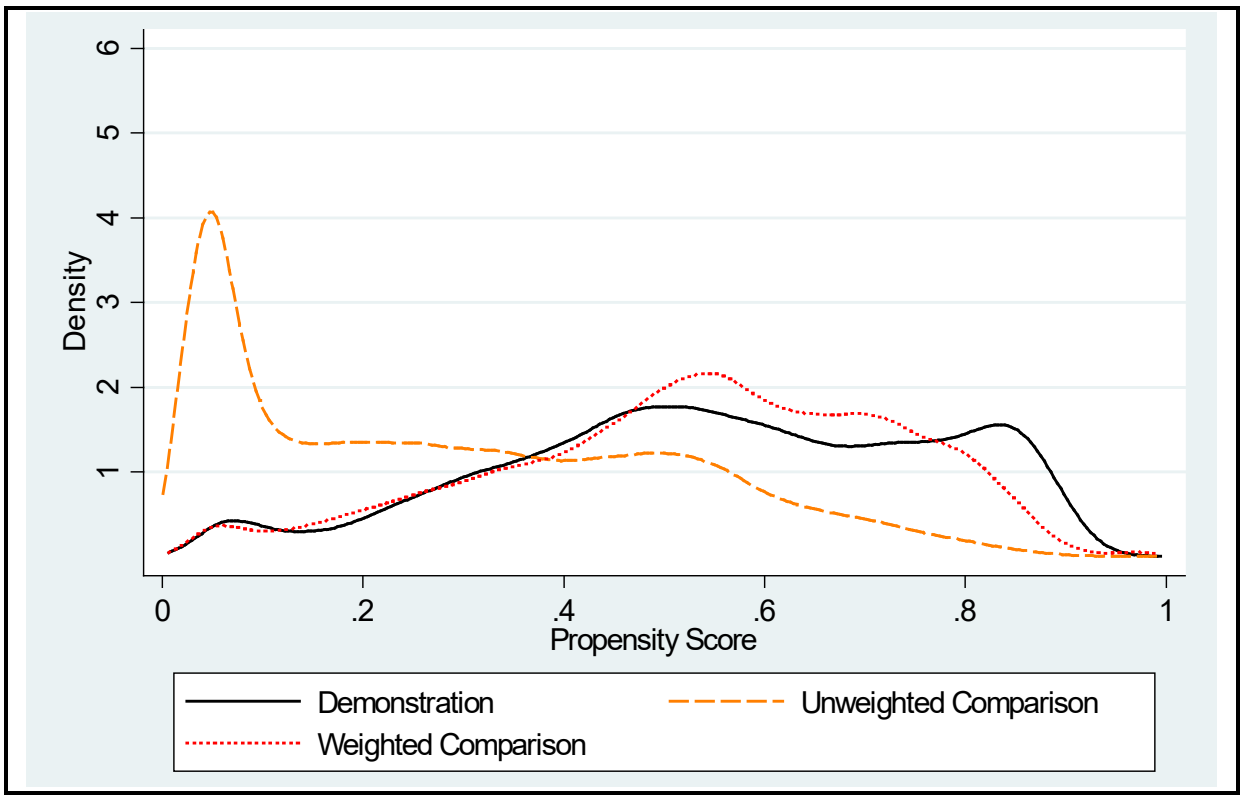


Figure A-3
Distribution of beneficiary-level propensity scores in the Ohio demonstration and comparison groups, weighted and unweighted, May 2014–December 2015



A.4 Group Comparability

Covariate balance refers to the extent to which the characteristics used in the propensity score are similar (or "balanced") for the demonstration and comparison groups. Group differences are measured by a standardized difference (the difference in group means divided by the pooled standard deviation of the covariate). We follow an informal standard that has developed within the literature; groups are considered to be comparable if the standardized covariate difference is less than 0.10 standard deviations.

The group means and standardized differences for all beneficiary characteristics are shown for each time period in ***Tables A-4*** through ***A-6***. The column of unweighted standardized differences indicates that several of these variables were not balanced before running the propensity model. The area-level variables consistently exhibited larger standardized differences than individual-level variables across the three time periods. Individuals in comparison areas had higher rates of households that were married; and more households with a member under 18 years of age. Average distances to both hospitals and nursing homes were longer for the comparison areas. These differences were relatively stable across time periods.

The results of propensity score weighting for Ohio are illustrated in the far right column (weighted standardized differences) in ***TablesA-4*** through ***A-6***.

With very few exceptions, in each period propensity weighting pulled comparison group means closer to the demonstration group means, thereby reducing the standardized differences and improving the match between the two groups. In each year, weighting reduced the magnitude of the group differences below the desired standard of 0.10 SDs for all covariates with few exceptions: the share of comparison group beneficiaries who were black in each time period; the share of beneficiaries who were white in the first demonstration period (year 3); and the share of beneficiaries living in a married household in baseline year 2 and the first demonstration period.

Table A-4
Ohio dual eligible beneficiary covariate means by group before and after weighting by propensity score—Baseline Period 1: May 1, 2012–April 30, 2013

Year 1	Demo mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age	63.601	63.637	63.281	−0.002	0.017
Died	0.094	0.090	0.094	0.016	0.002
Female	0.625	0.617	0.623	0.016	0.005
White	0.666	0.844	0.712	−0.423	−0.100
Black	0.297	0.092	0.250	0.538	0.106
Disability as reason for original Medicare entitlement	0.519	0.508	0.526	0.023	−0.014
ESRD	0.035	0.022	0.032	0.077	0.020
Prop. mos. eligible during period	0.763	0.796	0.772	−0.105	−0.030
HCC score	1.457	1.370	1.442	0.077	0.012
MSA	0.961	0.675	0.959	0.798	0.012
% of pop. living in married household	64.109	72.232	65.772	−0.532	−0.098
% of households w/member >= 60 yrs.	33.202	34.489	33.232	−0.182	−0.004
% of adults with college degree	21.137	18.101	21.428	0.260	−0.023
% of adults with self-care limitation	3.697	3.407	3.581	0.145	0.045
% of households w/member younger than age 18	30.858	32.690	30.685	−0.261	0.022
Distance to nearest hospital	4.620	8.822	4.581	−0.867	0.011
Distance to nearest nursing home	3.310	6.077	3.343	−0.823	−0.013

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MSA = Metropolitan Statistical Area; PS = propensity score.

Table A-5
Ohio dual eligible beneficiary covariate means by group before and after weighting by propensity score—Baseline Period 2: May 1, 2013–April 30, 2014

Year 2	Demo mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age	63.816	63.429	63.529	0.021	0.015
Died	0.088	0.083	0.088	0.020	0.003
Female	0.623	0.614	0.621	0.018	0.004
White	0.667	0.840	0.713	−0.411	−0.099
Black	0.295	0.093	0.248	0.527	0.105
Disability as reason for original Medicare entitlement	0.520	0.519	0.527	0.003	−0.014
ESRD	0.033	0.022	0.030	0.065	0.017
Share mos. elig. during period	0.779	0.802	0.785	−0.074	−0.019
HCC score	1.523	1.417	1.507	0.092	0.013
MSA	0.961	0.678	0.959	0.793	0.010
% of pop. living in married household	63.723	71.679	65.727	−0.518	−0.119
% of households w/member older than age 60	33.813	35.295	33.785	−0.207	0.004
% of adults with college degree	21.419	18.157	21.717	0.278	−0.024
% of adults with self-care limitation	3.686	3.414	3.556	0.135	0.050
% of households w/member younger than age 18	30.391	32.334	30.260	−0.281	0.017
Distance to nearest hospital	4.644	8.840	4.596	−0.865	0.013
Distance to nearest nursing home	3.313	6.070	3.343	−0.817	−0.012

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MSA = Metropolitan Statistical Area; PS = propensity score.

Table A-6
Ohio dual eligible beneficiary covariate means by group before and after weighting by propensity score—Demonstration Period 1: May 1, 2014–December 31, 2015

Year 3	Demo mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age	65.428	63.902	65.073	0.083	0.020
Died	0.090	0.095	0.091	−0.018	−0.003
Female	0.649	0.609	0.644	0.083	0.010
White	0.622	0.836	0.671	−0.496	−0.103
Black	0.331	0.093	0.281	0.608	0.110
Disability as reason for original Medicare entitlement	0.493	0.526	0.500	−0.065	−0.013
ESRD	0.032	0.021	0.030	0.070	0.010
Share mos. elig. during period	0.710	0.699	0.710	0.036	0.003
HCC score	1.576	1.371	1.572	0.174	0.003
MSA	0.966	0.681	0.964	0.804	0.012
% of pop. living in married household	61.599	71.463	63.986	−0.641	−0.143
% of households w/member older than age 60	34.385	35.930	34.394	−0.212	−0.001
% of adults with college degree	21.249	18.529	21.658	0.231	−0.033
% of adults with self-care limitation	3.820	3.495	3.739	0.158	0.026
% of households w/member younger than age 18	30.014	32.102	29.650	−0.304	0.048
Distance to nearest hospital	4.479	8.791	4.482	−0.901	−0.001
Distance to nearest nursing home	3.188	6.057	3.235	−0.865	−0.020

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MSA = Metropolitan Statistical Area; PS = propensity score.

A.5 Summary

Our analyses revealed differences between the Ohio demonstration and comparison groups before covariate balancing with regard to several area-level characteristics as well as demographics. However, the propensity score-based weighting process reduced these disparities to standardized differences of less than 0.15 over the three time periods. The weighted score distributions were similar for the two groups, with propensities covering a wide range of probabilities in both groups. The weighted data reduce the risk that selection bias will contaminate outcome analyses of the Ohio demonstration.

The propensity weights account for observed differences between the demonstration and comparison groups when computing descriptive statistics for each Evaluation Report. In addition, these covariates may also be incorporated in the multiple regression models used to estimate demonstration effects for the Final Report to further reduce the potential for biased estimates.

Appendix B:
Analysis Methodology

Methodology

We briefly describe the overall evaluation design, the data used, and the populations and measures analyzed.

Evaluation Design

RTI International is using an intent-to-treat (ITT) approach for the impact analyses conducted for the evaluation, comparing the eligible population under each State demonstration with a similar population that is not affected by the demonstration (i.e., a comparison group). ITT refers to an evaluation design in which all Medicare-Medicaid enrollees eligible for the demonstration constitute the evaluation sample, regardless of whether they actively participated in demonstration models. Thus, under the ITT framework, analyses include all beneficiaries eligible for the demonstration, including those who are eligible but are not contacted by the State or participating providers to enroll in the demonstration or care model; those who enroll but do not engage with the care model; and a group of similar eligible individuals in the comparison group.

Results for special populations within each of the demonstration and comparison groups are also presented in this section (e.g., those with any long-term services and supports [LTSS] use in the demonstration and comparison groups; those with any behavioral health claims in the demonstration and comparison groups). In addition, one group for which descriptive results are also reported are *not* compared to the comparison group because this group does not exist within the comparison group: Ohio demonstration enrollees. For this group, we compare them to in-State non-enrollees.

Comparison Group Identification

The comparison group will serve to provide an estimate of what would have happened to the demonstration group in the absence of the demonstration. Thus, the comparison group members should be similar to the demonstration group members in terms of their characteristics and health care and LTSS needs, and they should reside in areas that are similar to the demonstration State in terms of the health care system and the larger environment. For this evaluation, identifying the comparison group members entailed two steps: (1) selecting the geographic area from which the comparison group would be drawn and (2) identifying the individuals who would be included in the comparison group.

To construct Ohio's comparison group, we used both in-State and out-of-State areas. We compared demonstration and potential comparison areas on a range of measures, including spending per Medicare-Medicaid enrollee by each program, the shares of LTSS delivered in facility-based and community settings, and the extent of Medicare and Medicaid managed care penetration. Using statistical analysis, we selected the individual comparison metropolitan statistical areas (MSAs) that most closely match the values found in the demonstration area on the selected measures. We also considered other factors when selecting comparison States, such

as timeliness of Medicaid data submission to CMS. We identified a comparison group from MSAs in Ohio, Illinois, New York, Pennsylvania, Texas, and West Virginia at least as large as the eligible population in Ohio. For details of the comparison group identification strategy, see ***Appendix A***.

Data

Evaluation Report analyses used data from a number of sources. First, the State provided quarterly finder files containing identifying information on all demonstration eligible beneficiaries in the demonstration period. Second, RTI obtained administrative data on beneficiary demographic, enrollment, and service use characteristics from CMS data systems for both demonstration and comparison group members. Third, these administrative data were merged with Medicare claims and encounter data on utilization of Medicare services, as well as the Minimum Data Set (MDS), which is derived from assessments conducted by nursing home staff.

Although Medicaid service data on use of LTSS, behavioral health, and other Medicaid-reimbursed services were not available for the demonstration period and therefore are not included in this report, CMS administrative data identifying eligible beneficiaries who used *any* Medicaid-reimbursed LTSS or *any* Medicare behavioral health services were available, so that their Medicare service use could be presented in this report. Future reports will include findings on Medicaid service use once data are available.

Populations and Services Analyzed

The populations analyzed in the report include all demonstration eligible beneficiaries, as well as the following special populations: those receiving any LTSS; those with any behavioral health service use in the last 2 years for a severe and persistent mental illness (SPMI); demonstration enrollees; and demographic groups (race/ethnicity).

For each group and service type analyzed, we provide estimates of three access to care and utilization measures: the percent of demonstration eligible beneficiaries with any use of a service, and the counts of service use for both all eligible beneficiaries and users of the respective service.

The 12 service settings analyzed include both institutional (inpatient, inpatient psychiatric, inpatient non-psychiatric, emergency department visits not leading to admission, emergency department psychiatric visits, observation stays, skilled nursing facility, and hospice) and community settings (primary care, outpatient as well as independent physical, speech, and occupational therapy, and other hospital outpatient services).

In addition, six quality measures representing specific utilization types of interest are presented: 30-day all-cause risk-standardized readmission rate; preventable emergency room visits; rate of 30-day follow-up after hospitalization for mental illness; ambulatory care-sensitive condition overall composite rate (Agency for Healthcare Research and Quality [AHRQ] Prevention Quality Indicator [PQI] #90); ambulatory care-sensitive condition chronic composite rate (AHRQ PQI #92); and depression screening rate.

Five nursing facility (NF)-related measures are presented from the MDS: two measures of annual NF utilization (admission rate and percentage of long-stay NF users) and three characteristics of new long-stay NF residents at admission (functional status, percentage with severe cognitive impairment, percentage with low level of care need).

The analyses were conducted for each of the years in the 2-year predemonstration period (May 1, 2012, to April 30, 2014) and for the first demonstration period (May 1, 2014, to December 31, 2015) for both the demonstration and comparison groups in each of the three analytic periods.

Table B-1 presents descriptive statistics on the independent variables used in multivariate difference-in-differences regressions for impact analyses. Independent variables include demographic and health characteristics and market- and area-level characteristics. Results are presented for six groups: all demonstration eligibles in the Financial Alignment Initiative (FAI) State, its comparison group, demonstration enrollees, non-enrollees, demonstration eligibles with any long-stay NF use, and demonstration eligibles with an SPMI.

The most prevalent age group overall, as well as among those with SPMI, included ages zero to 64, although most people among the LTSS user group were older than 75 years. In the comparison group, 48.5 percent were between ages 0 and 64, whereas 44.9 percent were older than 65 in the demonstration group. Across all groups, the majority of eligible beneficiaries were female (LTSS was 70.3 percent; SPMI was 66.8 percent) and white (59 and 68.1 percent in the enrollee and LTSS groups, respectively). About half of the demonstration group has disability as their original entitlement to Medicare (28.7 and 57.9 percent in the LTSS and SPMI populations, respectively). Hierarchical Condition Category (HCC) scores ranged from 1.6 in the demonstration and comparison group to 2.1 in the LTSS user group. The HCC score is a measure of the predicted relative annual cost of a Medicare beneficiary based on the diagnosis codes present in recent Medicare claims. Beneficiaries with a score of 1 are predicted to have average cost in terms of annual Medicare expenditures. Beneficiaries with HCC scores lower than 1 are predicted to have below-average costs, whereas beneficiaries with scores of 2 are predicted to have twice the average annual cost. The vast majority of eligible beneficiaries resided in the MSAs, compared to non-metropolitan areas. The percent of months of dual eligibility was lowest for LTSS users.

There were limited differences in area- and market-level characteristics. Those who were in the comparison group resided in counties with a lower population density, relative to those in the demonstration group (313.8 vs. 771.9). Additionally, those in the comparison group resided in counties with lower Medicaid spending per dual eligible, relative to counties in the demonstration group ($24,399 vs. $32,395). Enrollees resided in counties with a lower percentage of the population living in married households, relative to non-enrollees (60.5 vs. 63.8), as well as counties with a lower percentage of adults with college education (20.6 vs. 22.7) and a higher percentage of adults with self-care limitations (3.9 vs. 3.7).

Table B-1
Characteristics of demonstration eligible beneficiaries in current demonstration year by group

Characteristics	Demonstration	Comparison	Enrollees	Non-enrollees	LTSS users	SPMI diagnosis
Number of beneficiaries	117,834	183,032	83,169	34,665	57,755	50,186
Demographic characteristics						
Age						
0 to 64	44.9	48.5	49.5	33.9	19.6	53.2
65 to 74	22.9	21.2	22.9	23.0	25.4	19.9
75 and older	32.2	30.3	27.6	43.1	55.0	26.9
Female						
No	34.8	38.8	35.9	32.1	29.7	33.2
Yes	65.2	61.2	64.1	67.9	70.3	66.8
Race/Ethnicity						
White	61.7	83.4	59.0	68.1	68.1	68.6
Black	33.6	9.4	35.7	28.4	29.1	28.3
Hispanic	1.3	2.9	1.5	0.7	0.6	1.1
Asian	1.7	2.0	1.8	1.2	0.8	0.5
Disability as reason for original Medicare entitlement						
No (0)	51.1	48.0	47.3	60.2	71.3	42.1
Yes (1)	48.9	52.0	52.7	39.8	28.7	57.9
ESRD status						
No (0)	96.6	97.8	96.6	96.8	96.1	97.4
Yes (1)	3.4	2.2	3.4	3.2	3.9	2.6
MSA						
Non-metro (0)	3.4	31.9	3.4	3.4	3.6	3.6
Metro (1)	96.6	68.1	96.6	96.6	96.4	96.4
Months with full-dual eligibility during year (%)	0.7	0.7	0.7	0.6	0.7	0.7
HCC score	1.6	1.6	1.5	1.9	2.1	1.8

(continued)

Table B-1 (continued)
Characteristics of demonstration eligible beneficiaries in current demonstration year by group

Characteristics	Demonstration	Comparison	Enrollees	Non-enrollees	LTSS users	SPMI diagnosis
Market characteristics						
Medicare spending per dual, ages 19+ ($)	9,746	9,464	9,747	9,745	9,751	9,753
MA penetration rate	0.4	0.3	0.4	0.4	0.4	0.4
Medicaid-to-Medicare fee index (FFS)	0.6	0.6	0.6	0.6	0.6	0.6
Medicaid spending per dual, ages 19+ ($)	32,395	24,399	32,391	32,405	32,323	32,344
Fraction of duals using NF, ages 65+	0.4	0.4	0.4	0.4	0.4	0.4
Fraction of duals using HCBS, ages 65+	0.3	0.2	0.3	0.3	0.3	0.3
Fraction of duals using personal care, ages 65+	0.0	0.0	0.0	0.0	0.0	0.0
Fraction of duals with Medicaid managed care, ages 19+	0.0	0.3	0.0	0.0	0.0	0.0
Population per square mile, all ages	771.9	313.8	769.5	777.6	771.4	771.8
Patient care physicians per 1,000 population	0.8	0.7	0.8	0.8	0.8	0.8
Area characteristics						
% of pop. living in married households	61.5	64.0	60.5	63.8	64.2	62.7
% of adults with college education	21.2	21.7	20.6	22.7	22.8	21.7
% of adults with self-care limitations	3.8	3.7	3.9	3.7	3.7	3.8
% of household with individuals younger than 18	30.0	29.6	30.0	30.0	29.8	29.8
% of household with individuals older than 60	34.4	34.4	34.2	34.9	35.2	34.4
Distance to nearest hospital	4.4	4.5	4.4	4.6	4.6	4.5
Distance to nearest nursing facility	3.2	3.2	3.1	3.3	3.3	3.2

ESRD = end-stage renal disease; FFS = fee for service; HCBS = home and community-based services; HCC = Hierarchical Condition Category; LTSS = long-term services and supports; MA = Medicare Advantage, MSA = metropolitan statistical area; NF = nursing facility; SPMI = severe and persistent mental illness.

Detailed Population Definitions

Demonstration eligible beneficiaries. Beneficiaries are identified in a given month if they were a Medicare-Medicaid enrollee and met any other specific demonstration eligibility criteria. Beneficiaries in the demonstration period are identified from quarterly State finder files, whereas beneficiaries in the 2-year period preceding the demonstration implementation date are identified by applying the eligibility criteria in each separate predemonstration quarter.

Additional special populations were identified for the analyses as follows:

- *Enrollees*. A beneficiary was defined as an enrollee if they were enrolled in the demonstration during the demonstration period.

- *Age*. Age was defined as a categorical variable where beneficiaries were identified as *0 to 64*, *65 to 74,* and *75 years and older* during the observation year (e.g., predemonstration period 1, predemonstration period 2, and demonstration period 1).

- *Gende*r. Gender was defined as binary variable where beneficiaries were either male or female.

- *Race/Ethnicity*. Race/ethnicity was defined as a categorical variable where beneficiaries were categorized as *White*, *Black*, *Hispanic*, or *Asian*.

- *Long-term care services and supports (LTSS*). A beneficiary was defined as using LTSS if there was any use of institutional based services or home and community-based services during the observation year.

- *Severe and persistent mental illness (SPMI).* A beneficiary was defined as having a SPMI if a beneficiary had incurred a Medicare claim for severe and persistent mental illness within the past 2 years.

Detailed Utilization and Expenditure Measure Definitions

For any health care service type, the methodology for estimating average monthly utilization and the percentage of users takes into account differences in the number of eligibility months across beneficiaries. Because full-benefit dual eligibility status for the demonstration can vary by month over time for any individual, the methodology used determines dual eligibility status for the demonstration for each person on a monthly basis during a predemonstration or demonstration period. That is, an individual can meet the demonstration's eligibility criteria for up to 12 months during the observation year. The methodology adds the total months of full-benefit dual eligibility for the demonstration across the population of interest and uses it in the denominator in the measures in ***Section 8***, creating average monthly utilization information for each service type. The methodology effectively produces average monthly use statistics for each year that account for variation in the number of dual eligible beneficiaries in each month of the observation year.

The utilization measures below were calculated as the aggregate sum of the unit of measurement (e.g., counts) divided by the aggregated number of eligible member months [and user months] within each group (*g*) where group is defined as (1) Ohio base year 1, (2) Comparison base year 1, (3) Ohio base year 2, (4) Comparison base year 2, (5) Ohio demonstration year 1, (6) Comparison demonstration year 1.

We calculated the average number of services per 1,000 eligible months and per 1,000 user months by beneficiary group (*g*). We defined *user month* as an eligible month where the number of units of utilization used [for a given service] was greater than zero during the month. We weight each observation using yearly propensity weights. The average yearly utilization outcomes are measured as:

$$Y_g = \frac{\Sigma_{ig} Z_{ig}}{\left(\frac{1}{1{,}000}\right) * \Sigma_{ig} n_{ig}}$$

Where

Y_g = average count of the number services used [for a given service] per eligible or user month within group *g*.
Z_{ig} = the total units of utilization [for a given service] for individual *i* in group *g*.
n_{ig} = the total number of eligible/user months for individual *i* in group *g*.

The denominator above is scaled by $\frac{1}{1{,}000}$ such that the result is interpreted in terms of average monthly utilization per 1,000 eligible beneficiaries. This presentation is preferable, compared with per eligible, because some of the services are used less frequently and would result in small estimates.

The average percentage of users [of a given service] per eligible month during the predemonstration or demonstration year is measured as follows:

$$U = \frac{\Sigma_{ig} X_{ig}}{\Sigma_{ig} n_{ig}} \quad \text{x } 100$$

Where

U_{ig} = average percentage of users [for a particular service] in a given month among beneficiaries in group *g*.
X_{ig} = the total number of eligible months of service use for an individual *i* in group *g*.
n_{ig} = the total number of eligible or user months for an individual *i* in group *g*.

Quality of Care and Care Coordination Measures

Similar to the utilization measures, for the appendix tables of descriptive statistics, the quality of care and care coordination measures were calculated as the aggregated sum of the numerator divided by the aggregated sum of the denominator for each respective outcome within

each beneficiary group, except for the average 30-day all-cause risk-standardized readmission rate and the 30-day follow-up after hospitalization for mental illness, which are reported as percentages.

Average 30-day all-cause risk-standardized readmission rate (percent) was calculated as follows:

$$30 - Risk\ Standardized\ Readmission\ = \frac{\left(\frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} n_{ig}} X\ C\right)}{Prob_g}$$

Where

C = the national average of 30-day readmission rate, .238.
X_{ig} = the total number of readmissions for individual i in group g.
n_{ig} = the total number of hospital admissions for individual i in group g.
$Prob_g$ = the annual average adjusted probability of readmission for individuals in group g. The average adjusted probability equals:

Average adjusted probability of readmission by demonstration group

Demonstration group	Average adjusted probability of readmission
Predemonstration year 1	
Ohio	0.219
Comparison	0.204
Predemonstration year 2	
Ohio	0.222
Comparison	0.207
Demonstration year 1	
Ohio	0.227
Comparison	0.211

Rate of 30-day follow-up in a physician or outpatient setting after hospitalization for mental illness (percent) was calculated as follows:

$$MHFU\ = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} n_{ig}} * 100$$

Where

MHFU = the average rate of 30-day follow-up care after hospitalization for a mental illness (percent) for individual*s in* group g.

X_{ig} = the total number of discharges from a hospital stay for mental health that had a follow-up for mental health within 30 days of discharge for individual *i* in group *g*.

n_{ig} = the total number of discharges from a hospital stay for mental health for individual *i* in group *g*.

Average ambulatory care-sensitive condition admissions per eligible beneficiary, overall and chronic composite (PQI #90 and PQI #92) was calculated as follows:

$$ACSC_{ig} = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

$ACSC_g$ = the average number of ambulatory care-sensitive condition admissions per eligible month for overall/chronic composites for individuals in group *g*.

X_{ig} = the total number of discharges that meet the criteria for AHRQ PQI #90 [or PQI #92] for individual *i* in group *g*.

n_{ig} = the total number of eligible months for individual *i* in group *g*.

Preventable emergency room (ER) visits per eligible month was calculated as follows:

$$ER_{ig} = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

ER_g = the average number of preventable ER visits per eligible month for individuals in group *g*.

X_{ig} = the total number ER visits that are considered preventable based in the diagnosis for individual *i* in group *g*.

n_{ig} = the total number of eligible months for individual *i* in group *g*.

Average number of beneficiaries per eligible month who received depression screening during the observation year was calculated as follows:

$$D_g = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

D_g = the average number of beneficiaries per eligible month who received depression screening in group *g*.

X_{ig} = the total number eligible beneficiaries age 65+ who ever received depression screening in group *g*.

n_{ig} = the total number of eligible months among beneficiaries in group *g*.

Average rate of beneficiaries per positive depression screening who received a follow-up plan during the observation year was calculated as follows:

$$PD_g = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

PD_g = the average number of beneficiaries per positive depression screening who received a follow-up plan among beneficiaries in group *g*.
X_{ig} = the total number beneficiaries who received a positive depression screen and a follow-up plan in group *g*.
n_{ig} = the total number of beneficiaries who received a positive depression screen in group *g*.

Minimum Data Set Measures

Two measures of annual NF-related utilization are derived from the MDS. The rate of new long-stay NF admissions per 1,000 eligible beneficiaries is calculated as the number of NF admissions for whom there is no record of NF use in the 100 days prior to the current admission and who subsequently stay in the NF for 101 days or more. Individuals are included in this measure only if their NF admission occurred after their first month of demonstration eligibility. The percentage of long-stay NF users is calculated as the number of individuals who have stayed in a NF for 101 days or more, who were long-stay after the first month of demonstration eligibility. The probability of any long-stay NF use includes both new admissions from the community and continuation of a stay in a NF.

Characteristics of new long-stay NF residents at admission are also included in order to monitor NF case mix and acuity levels. Functional status and low level of care need are determined by the Resource Utilization Groups Version IV (RUG-IV). Residents with low care need are defined as those who did not require physical assistance in any of the four late-loss activities of daily living (ADLs) and who were in the three lowest RUG-IV categories. Severe cognitive impairment is assessed by the Brief Interview for Mental Status (BIMS), poor short-term memory, or severely impaired decision-making skills.

Regression Outcome Measures

Five utilization measures are used as dependent variables in regression analysis to estimate the difference-in-differences effect for the entire demonstration period as well as the effect in each demonstration year. These measures are derived from Medicare inpatient, outpatient, carrier, and skilled nursing facility claims and encounter data and MDS long-term NF use. All dependent variables are based on a monthly basis except for the MDS long-stay NF measure and 30-day inpatient readmission measure, which are annual.

The outcome measures include the following:

- *Monthly Inpatient Admissions* is the count of the number of inpatient admissions in which a beneficiary has an admission date within the observed month.

- *Monthly Emergency Department Use* is the count of the number of emergency department visits that occurred during the month that did not result in an inpatient admission.

- *Monthly Physician Visits* is the count of any evaluation and management visit within the month where the visit occurred in the outpatient or office setting, NF, domiciliary, rest home, or custodial care setting, or a federally qualified health center or a rural health center.

- *Monthly Skilled Nursing Facility Admissions* is the count of any skilled nursing facility admissions within the month.

- *Long-Stay Nursing Facility Use* is the annual probability of residing in a nursing home for 101 days or more during the year.

In addition to the five measures above, this evaluation will estimate the demonstration effects on quality of care. The following quality of care and care coordination measures use claims/encounter-level information and are adopted from standardized Healthcare Effectiveness Data and Information Set and National Quality Forum (NQF) measures. The outcomes are reported monthly, with the exception of the 30-day all-cause risk-standardized readmission rate, which is annual.

- *30-day all-cause risk-standardized readmissions (NQF #1768)* is the count of the number risk-standardized readmissions, defined above, that occurs during the year.

- *Preventable ER visits* is the count of ER visits among adults. The lists of diagnoses that are considered as either preventable/avoidable, or treatable in a primary care setting were developed by researchers at the New York University Center for Health and Public Service Research.[23]

- *30-day follow-up after hospitalization for mental illness (NQF #576)* is estimated as the monthly probability of any follow-up visits within 30-days post-hospitalization for a mental illness.

- *Ambulatory care-sensitive condition (ACSC) admissions—overall composite (AHRQ PQI # 90)* is the monthly probability of any acute admissions that meet the AHRQ PQI #90 (Prevention Quality Overall Composite) criteria within the month.

[23] http://wagner.nyu.edu/faculty/billings/nyued-background

- *Ambulatory care-sensitive condition (ACSC) admissions—chronic composite (AHRQ PQI # 92)* is the monthly probability of any admissions that meet the AHRQ PQI #92 criteria within the month.

Regression Methodology for Determining Demonstration Impact

The regressions across the entire demonstration period compare all demonstration eligible beneficiaries in the FAI State to its comparison group. The regression methodology accounts for both those with and without use of the specific service (e.g., for inpatient services, both those with and without any inpatient use). A restricted difference-in-differences equation will be estimated as follows:

$$\text{Dependent variable}_i = \beta_0 + \beta_1 \text{PostYear} + \beta_2 \text{Demonstration} + \beta_3 \text{PostYear} * \text{Demonstration} + \beta_4 \text{Demographics} + \beta_{5\text{-}j}\, \text{Market} + \varepsilon \quad (1)$$

where separate models will be estimated for each dependent variable. *PostYear* is an indicator of whether the observation is from the pre- or post demonstration period, *Demonstration* is an indicator of whether the beneficiary was in the demonstration group, and *PostYear* * *Demonstration* is an interaction term. *Demographics* and *Market* represent vectors of beneficiary and market characteristics, respectively.

Under this specification, the coefficient β_0 reflects the comparison group predemonstration period mean adjusted for demographic and market effects, β_1 reflects the average difference between post period and predemonstration period in the comparison group, β_2 reflects the difference in the demonstration group and comparison group at predemonstration, and β_3 is the overall average demonstration effect during the demonstration period. This last term is the difference-in-differences estimator and the primary policy variable of interest, but in all regression models, because of nonlinearities in the underlying distributions, post-regression predictions of demonstration impact are performed to obtain the marginal effects of demonstration impact.

In addition to estimating the model described in Equation 1, a less restrictive model was estimated to produce year-by-year effects of the demonstration. The specification of the unrestricted model is as follows:

$$\text{Dependent variable} = \beta_0 + \beta_{1\text{-}k} \text{PostYear}_{1\text{-}n} + \beta_2 \text{Demonstration} + \beta_{3\text{-}k} \text{PostYear}_{1\text{-}n} * \text{Demonstration} + \beta_4\, \text{Demographics} + \beta_{5\text{-}j}\, \text{Market} + \varepsilon \quad (2)$$

Equation 2 differs from the previous one in that separate difference-in-differences coefficients are estimated for each year. Under this specification, the coefficients $\beta_{3\text{-}k}$ would reflect the impact of the demonstration in each respective year, whereas the previous equation reflects the impact of the entire demonstration period. This specification measures whether changes in dependent variables occur in the first year of the demonstration only, continuously over time, or in some other pattern. Depending on the outcome of interest, we will estimate the equations using logistic regression, Generalized Linear Models with a log link, or count models such as negative binomial or Poisson regressions (e.g., for the number of inpatient admissions). We use regression results to calculate the marginal effects of demonstration impact.

Impact estimates across the entire demonstration period are determined using the difference-in-differences methodology and presented in figures for all demonstration eligible beneficiaries, and then for two special populations of interest—demonstration eligible beneficiaries with any LTSS use, and demonstration eligible beneficiaries with SPMI. A table follows each figure displaying the annual demonstration difference-in-differences effect for each separate demonstration period for each of these populations. In each figure, the point estimate is displayed for each measure, as well as the 90 percent confidence interval (black) and the 80 percent confidence interval (green). The 80 percent confidence interval is narrower than the 90 percent confidence interval. If the confidence interval includes the value of zero, it is not statistically significant at that confidence level.

For only the full demonstration eligible population and not each special population, an additional table presents estimates of the regression-adjusted mean values of the utilization measures for the demonstration and comparison groups by year for each service. The purpose of this table is to understand the magnitude of the difference-in-differences estimate relative to the adjusted mean outcome value in each period. The adjusted mean values show how different the two groups were in each period, and the relative direction of any potential effect in each group over time. The values in the third and fourth columns represent the post-regression, mean predicted value of the outcomes for each group and period, based on the composition of a reference population (the comparison group in the demonstration period). The difference-in-differences estimate is also provided for reference, along with the *p*-value and the relative percent change of the difference-in-differences estimate compared to an average mean use rate for the comparison group in the entire demonstration period.

The relative percent annual change for the difference-in-differences estimate for each outcome measure is calculated as [Overall difference-in-differences effect] / [Adjusted mean outcome value of comparison group in the demonstration period].

Table B-2 provides an illustrative example of the regression output for each independent variable in the negative binomial regression on monthly inpatient admissions across the entire demonstration period.

Table B-2
Negative binomial regression results on monthly inpatient admissions

Independent variables	Coefficient	Standard error	z-value	*p*-value
Post period	−0.0837	0.0175	−4.790	0.000
Demonstration group	0.0526	0.0377	1.400	0.163
Interaction of post period x demonstration group	−0.2093	0.0191	−10.960	0.000
Trend	−0.0009	0.0008	−1.070	0.285
Age	−0.0012	0.0006	−2.000	0.046
Female	0.0090	0.0120	0.750	0.454
Black	0.0114	0.0145	0.790	0.431
Asian	−0.3585	0.0367	−9.770	0.000
Hispanic	−0.1450	0.0211	−6.870	0.000
Other race	−0.2116	0.0304	−6.970	0.000
Disability as reason for original Medicare entitlement	−0.0141	0.0118	−1.200	0.231
End-stage renal disease	1.3724	0.0201	68.380	0.000
Hierarchical Condition Category (HCC) score	0.3321	0.0037	89.340	0.000
Percent of months of demonstration eligibility	−1.3834	0.0272	−50.950	0.000
Metropolitan statistical area (MSA) residence	0.0300	0.0449	0.670	0.504
Percent of population living in a married household	−0.0020	0.0005	−4.210	0.000
Percent of households with family member >= 60 years old	−0.0022	0.0008	−2.640	0.008
Percent of households with family member < 18 years old	−0.0037	0.0010	−3.750	0.000
Percent of adults with college education	−0.0021	0.0007	−2.840	0.005
Percent of adults with self-care limitation	0.0007	0.0013	0.560	0.575
Distance to nearest hospital	−0.0024	0.0026	−0.940	0.347
Distance to nearest nursing facility	0.0043	0.0038	1.140	0.253
Medicare spending per full-benefit dual eligible	−0.0001	0.0001	−1.060	0.287
Medicare Advantage penetration rate	−0.3381	0.2349	−1.440	0.150
Medicaid-to-Medicare fee index	0.7488	0.4019	1.860	0.062
Medicaid spending per full-benefit dual eligible	0.0000	0.0000	−0.360	0.721
Nursing facility users per full-benefit dual eligible over 65	0.2916	0.3274	0.890	0.373
HCBS users per full-benefit dual eligible over 65	0.0533	0.1316	0.400	0.686
Medicaid managed care users per full-benefit dual eligible	−0.1359	0.0714	−1.900	0.057
Population per square mile	0.0000	0.0001	0.480	0.629
Patient care physicians per 1,000 (total) population	−0.1228	0.1980	−0.620	0.535
Participating in shared savings program	0.2631	0.0372	7.060	0.000
Intercept	−1.8230	0.5086	−3.580	0.000

n = 10,603,401 person months

Appendix C:
Descriptive Tables

Tables in ***Appendix C*** present results on the average percentage of demonstration eligible beneficiaries using selected Medicare service types during the months in which they met demonstration eligibility criteria in the predemonstration and demonstration periods. In addition, average counts of service use and payments are presented across all such eligible months, and for the subset of these months in which eligible beneficiaries were users of each respective service type. Data is shown for the predemonstration and demonstration period for both Ohio eligible beneficiaries (the demonstration group) and the comparison group. Similar tables of Medicaid service utilization are also presented, as well as tables for the RTI quality of care and care coordination measures.

Tables are presented for the overall demonstration eligible population (***Tables C-1*** through ***C-3***), followed by tables on Ohio demonstration eligible beneficiaries who were enrollees and non-enrollees (***Tables C-4*** and ***C-5***).

Table C-1
Proportion and utilization for institutional and non-institutional services for the Ohio demonstration eligible beneficiaries and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Number of demonstration beneficiaries		175,564	175,837	117,834
Number of comparison beneficiaries		157,852	158,772	183,032
Institutional setting				
Inpatient admissions[1]	Demonstration group			
% with use		4.9	4.8	4.2
Utilization per 1,000 user months		1,158.2	1,154.1	1,133.4
Utilization per 1,000 eligible months		56.9	55.1	47.7
Inpatient admissions[1]	Comparison group			
% with use		4.5	4.4	4.5
Utilization per 1,000 user months		1,155.5	1,157.6	1,155.2
Utilization per 1,000 eligible months		52.0	51.2	52.4
Inpatient psychiatric	Demonstration group			
% with use		0.4	0.4	0.3
Utilization per 1,000 user months		1,091.5	1,093.7	1,075.6
Utilization per 1,000 eligible months		4.7	4.7	3.6
Inpatient psychiatric	Comparison group			
% with use		0.4	0.4	0.3
Utilization per 1,000 user months		1,093.7	1,077.1	1,070.5
Utilization per 1,000 eligible months		4.1	4.0	3.7

(continued)

Table C-1 (continued)
Proportion and utilization for institutional and non-institutional services for the Ohio demonstration eligible beneficiaries and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Inpatient non-psychiatric	Demonstration group			
% with use		4.5	4.4	3.9
Utilization per 1,000 user months		1,151.0	1,147.2	1,128.6
Utilization per 1,000 eligible months		52.2	50.4	44.1
Inpatient non-psychiatric	Comparison group			
% with use		4.2	4.1	4.2
Utilization per 1,000 user months		1,149.5	1,152.6	1,151.0
Utilization per 1,000 eligible months		47.8	47.2	48.7
Emergency department use (non-admit)	Demonstration group			
% with use		7.3	7.3	7.7
Utilization per 1,000 user months		1,274.4	1,272.1	1,296.0
Utilization per 1,000 eligible months		92.5	93.1	99.8
Emergency department use (non-admit)	Comparison group			
% with use		7.9	8.0	8.2
Utilization per 1,000 user months		1,320.1	1,351.1	1,334.5
Utilization per 1,000 eligible months		103.8	107.6	109.9
Emergency department use (psychiatric)	Demonstration group			
% with use		0.3	0.3	0.3
Utilization per 1,000 user months		1,197.1	1,174.2	1,188.9
Utilization per 1,000 eligible months		3.9	4.0	3.9
Emergency department use (psychiatric)	Comparison group			
% with use		0.5	0.4	0.5
Utilization per 1,000 user months		1,209.5	1,265.3	1,243.0
Utilization per 1,000 eligible months		5.5	5.4	5.7

(continued)

Table C-1 (continued)
Proportion and utilization for institutional and non-institutional services for the Ohio demonstration eligible beneficiaries and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Observation stays	Demonstration group			
% with use		0.9	1.1	1.3
Utilization per 1,000 user months		1,064.8	1,062.7	1,118.0
Utilization per 1,000 eligible months		9.1	11.7	14.4
Observation stays	Comparison group			
% with use		0.9	1.0	1.2
Utilization per 1,000 user months		1,079.0	1,078.8	1,093.0
Utilization per 1,000 eligible months		10.2	11.2	13.0
Skilled nursing facility	Demonstration group			
% with use		1.7	1.7	1.6
Utilization per 1,000 user months		1,096.5	1,095.6	1,088.2
Utilization per 1,000 eligible months		18.9	18.3	17.6
Skilled nursing facility	Comparison group			
% with use		1.3	1.3	1.3
Utilization per 1,000 user months		1,086.0	1,089.7	1,089.5
Utilization per 1,000 eligible months		14.6	13.7	14.3
Hospice	Demonstration group			
% with use		2.6	2.5	2.3
Utilization per 1,000 user months		1,027.6	1,012.8	1,012.8
Utilization per 1,000 eligible months		27.0	25.4	23.1
Hospice	Comparison group			
% with use		1.6	1.5	1.5
Utilization per 1,000 user months		1,078.3	1,021.5	1,026.4
Utilization per 1,000 eligible months		17.3	15.5	15.3

(continued)

Table C-1 (continued)
Proportion and utilization for institutional and non-institutional services for the Ohio demonstration eligible beneficiaries and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Non-institutional setting				
Primary care E&M visits	Demonstration group			
% with use		59.9	61.1	58.6
Utilization per 1,000 user months		1,976.8	2,032.5	2,199.5
Utilization per 1,000 eligible months		1,183.5	1,242.8	1,288.7
Primary care E&M visits	Comparison group			
% with use		53.2	55.8	57.3
Utilization per 1,000 user months		1,869.1	1,931.1	1,996.1
Utilization per 1,000 eligible months		993.8	1,078.1	1,144.6
Outpatient therapy (PT, OT, ST)	Demonstration group			
% with use		6.7	7.0	7.3
Utilization per 1,000 user months		20,919.8	22,616.0	21,354.1
Utilization per 1,000 eligible months		1,405.7	1,577.2	1,568.1
Outpatient therapy (PT, OT, ST)	Comparison group			
% with use		5.1	5.4	6.1
Utilization per 1,000 user months		21,682.6	23,001.4	23,940.0
Utilization per 1,000 eligible months		1,113.8	1,245.5	1,461.2
Independent therapy (PT, OT, ST)	Demonstration group			
% with use		0.7	0.8	0.8
Utilization per 1,000 user months		9,086.8	13,184.8	14,260.7
Utilization per 1,000 eligible months		67.9	108.2	110.9
Independent therapy (PT, OT, ST)	Comparison group			
% with use		1.2	1.2	1.3
Utilization per 1,000 user months		10,164.1	10,651.7	11,548.7
Utilization per 1,000 eligible months		121.8	131.5	148.8

(continued)

Table C-1 (continued)
Proportion and utilization for institutional and non-institutional services for the Ohio demonstration eligible beneficiaries and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Other hospital outpatient services	Demonstration group			
% with use		29.1	29.9	27.4
Utilization per 1,000 user months		—	—	—
Utilization per 1,000 eligible months		—	—	—
Other hospital outpatient services	Comparison group			
% with use		31.0	31.5	32.9
Utilization per 1,000 user months		—	—	—
Utilization per 1,000 eligible months		—	—	—

— = data not available. E&M = evaluation and management; OT = occupational therapy, PT = physical therapy, ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long-term care hospital admissions.

[2] Results for the Demonstration group may be inflated due to a data anomaly under investigation.

SOURCE: RTI International analysis of Medicare data.

Table C-2
Quality of care and care coordination outcomes for demonstration eligible and comparison beneficiaries for the Ohio demonstration

Quality and care coordination measures	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
30-day all-cause risk-standardized readmission rate (%)	Demonstration group	20.1	19.6	19.2
	Comparison group	20.9	20.6	21.0
Preventable ER visits per eligible months	Demonstration group	0.045	0.045	0.050
	Comparison group	0.050	0.052	0.052
Rate of 30-day follow up after hospitalization for mental illness (%)	Demonstration group	40.7	40.8	37.2
	Comparison group	46.6	47.8	46.3
Ambulatory care-sensitive condition admissions per eligible months—overall composite (AHRQ PQI # 90)	Demonstration group	0.009	0.008	0.008
	Comparison group	0.008	0.008	0.009
Ambulatory care-sensitive condition admissions per eligible months—chronic composite (AHRQ PQI # 92)	Demonstration group	0.006	0.005	0.006
	Comparison group	0.005	0.005	0.006
Screening for clinical depression per eligible months	Demonstration group	0.001	0.001	0.002
	Comparison group	0.001	0.001	0.005

AHRQ PQI =Agency for Healthcare Research and Quality Prevention Quality Indicator; ER = emergency room.

NOTES: The last quarter of demonstration year 1 (October–December 2015) was the first quarter of the switch from ICD9 to ICD10 codes. Some differences between demonstration year 1 and the predemonstration period may have resulted from misalignment of ICD9 and ICD10 codes.

SOURCE: RTI International analysis of Medicare data.

Table C-3
Minimum Data Set long-stay nursing facility utilization and characteristics at admission for the Ohio demonstration and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Annual nursing facility utilization				
Number of demonstration beneficiaries	Demonstration group	105,928	109,098	78,656
New long-stay nursing facility admissions per 1,000 eligibles		23.5	22.7	38.4
Number of comparison beneficiaries	Comparison group	102,647	105,200	110,424
New long-stay nursing facility admissions per 1,000 eligibles		21.8	19.4	31.4
Number of demonstration beneficiaries	Demonstration group	134,122	137,022	97,810
Long-stay nursing facility users as % of eligibles		23.4	22.7	23.4
Number of comparison beneficiaries	Comparison group	122,279	125,023	130,526
Long-stay nursing facility users as % of eligibles		18.0	17.6	18.1
Characteristics of new long-stay nursing facility residents at admission				
Number of admitted demonstration beneficiaries	Demonstration group	2,491	2,479	3,020
Number of admitted comparison beneficiaries	Comparison group	2,237	2,041	3,472
Functional status (RUG-IV ADL scale)	Demonstration group	7.8	7.7	7.5
Functional status (RUG-IV ADL scale)	Comparison group	8.1	8.1	8.2
Percent with severe cognitive impairment	Demonstration group	37.1	35.0	31.7
Percent with severe cognitive impairment	Comparison group	38.5	38.4	34.4
Percent with low level of care need	Demonstration group	2.0	2.1	2.8
Percent with low level of care need	Comparison group	2.6	1.8	1.9

RUG-IV ADL = Resource Utilization Group IV Activities of Daily Living.

SOURCE: RTI International analysis of Minimum Data Set data.

Table C-4
Proportion and utilization for institutional and non-institutional services for the Ohio demonstration enrollees and non-enrollees

Measures by setting	Group	Demonstration year 1
Number of enrollees		83,169
Number of non-enrollees		34,665
Institutional setting		
Inpatient admissions[1]	Enrollees	
% with use		3.82
Utilization per 1,000 user months		1,115.65
Utilization per 1,000 eligible months		42.62
Inpatient admissions[1]	Non-enrollees	
% with use		4.78
Utilization per 1,000 user months		1,141.69
Utilization per 1,000 eligible months		54.63
Inpatient psychiatric	Enrollees	
% with use		0.33
Utilization per 1,000 user months		1,081.94
Utilization per 1,000 eligible months		3.56
Inpatient psychiatric	Non-enrollees	
% with use		0.28
Utilization per 1,000 user months		1,060.37
Utilization per 1,000 eligible months		2.97
Inpatient non-psychiatric	Enrollees	
% with use		3.52
Utilization per 1,000 user months		1,109.66
Utilization per 1,000 eligible months		39.04
Inpatient non-psychiatric	Non-enrollees	
% with use		4.53
Utilization per 1,000 user months		1,139.07
Utilization per 1,000 eligible months		51.59
Emergency department use (non-admit)	Enrollees	
% with use		8.01
Utilization per 1,000 user months		1,319.61
Utilization per 1,000 eligible months		105.68
Emergency department use (non-admit)	Non-enrollees	
% with use		6.42
Utilization per 1,000 user months		1,252.47
Utilization per 1,000 eligible months		80.39

(continued)

Table C-4 (continued)
Proportion and utilization for institutional and non-institutional services for the Ohio demonstration enrollees and non-enrollees

Measures by setting	Group	Demonstration year 1
Emergency department use (psychiatric)	Enrollees	
% with use		0.35
Utilization per 1,000 user months		1,230.29
Utilization per 1,000 eligible months		4.28
Emergency department use (psychiatric)	Non-enrollees	
% with use		0.24
Utilization per 1,000 user months		1,138.03
Utilization per 1,000 eligible months		2.77
Observation stays	Enrollees	
% with use		1.31
Utilization per 1,000 user months		1,149.80
Utilization per 1,000 eligible months		15.08
Observation stays	Non-enrollees	
% with use		1.21
Utilization per 1,000 user months		1,093.91
Utilization per 1,000 eligible months		13.23
Skilled nursing facility	Enrollees	
% with use		1.50
Utilization per 1,000 user months		1,087.73
Utilization per 1,000 eligible months		16.28
Skilled nursing facility	Non-enrollees	
% with use		2.06
Utilization per 1,000 user months		1,091.63
Utilization per 1,000 eligible months		22.50
Hospice	Enrollees	
% with use		1.92
Utilization per 1,000 user months		1,018.00
Utilization per 1,000 eligible months		19.50
Hospice	Non-enrollees	
% with use		3.74
Utilization per 1,000 user months		1,009.89
Utilization per 1,000 eligible months		37.75

(continued)

Table C-4 (continued)
Proportion and utilization for institutional and non-institutional services for the Ohio demonstration enrollees and non-enrollees

Measures by setting	Group	Demonstration year 1
Non-institutional setting		
Primary care E&M visits	Enrollees	
% with use		54.05
Utilization per 1,000 user months		2,253.92
Utilization per 1,000 eligible months		1,218.14
Primary care E&M visits	Non-enrollees	
% with use		69.99
Utilization per 1,000 user months		2,277.92
Utilization per 1,000 eligible months		1,594.27
Outpatient Therapy (PT, OT, ST)	Enrollees	
% with use		5.82
Utilization per 1,000 user months		18,469.10
Utilization per 1,000 eligible months		1,075.72
Outpatient therapy (PT, OT, ST)	Non-enrollees	
% with use		11.69
Utilization per 1,000 user months		24,271.39
Utilization per 1,000 eligible months		2,837.50
Independent therapy (PT, OT, ST)	Enrollees	
% with use		0.61
Utilization per 1,000 user months		10,119.29
Utilization per 1,000 eligible months		62.16
Independent therapy (PT, OT, ST)	Non-enrollees	
% with use		1.10
Utilization per 1,000 user months		17,939.28
Utilization per 1,000 eligible months		197.42
Other hospital outpatient services	Enrollees	
% with use		25.51
Utilization per 1,000 user months		—
Utilization per 1,000 eligible months		—
Other hospital outpatient services	Non-enrollees	
% with use		29.99
Utilization per 1,000 user months		—
Utilization per 1,000 eligible months		—

— = data not available. E&M = evaluation and management; OT = occupational therapy; PT = physical therapy; ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long term care hospital admissions.

[2] Results for the demonstration group may be inflated due to a data anomaly under investigation.

SOURCE: RTI International analysis of Medicare data.

Table C-5
Quality of care and care coordination outcomes for enrollees and non-enrollees for the Ohio demonstration

Quality and care coordination measures	Group	Demonstration year 1
30-day all-cause risk-standardized readmission rate (%)	Enrollees	18.9
	Non-enrollees	19.8
Preventable ER visits per eligible months	Enrollees	0.054
	Non-enrollees	0.038
Rate of 30-day follow up after hospitalization for mental illness (%)	Enrollees	37.0
	Non-enrollees	39.1
Ambulatory care-sensitive condition admissions per eligible months—overall composite (AHRQ PQI # 90)	Enrollees	0.005
	Non-enrollees	0.009
Ambulatory care-sensitive condition admissions per eligible months—chronic composite (AHRQ PQI # 92)	Enrollees	0.004
	Non-enrollees	0.006
Screening for clinical depression per eligible months	Enrollees	0.001
	Non-enrollees	0.002

AHRQ PQI =Agency for Healthcare Research and Quality Prevention Quality Indicator; ER = emergency room.

SOURCE: RTI International analysis of Medicare data.

Appendix D:
Sensitivity Analysis Tables

Tables in ***Appendix D*** present results from sensitivity analyses focusing on the Ohio demonstration cost saving models.

D.1 Predicting Capitated Rates for Non-Enrollees

The goal of this analysis was to identify beneficiaries eligible for the Ohio demonstration in the first demonstration period (May 2014–December 2015) and to look at what the capitation rate would have been (had they enrolled) compared to their actual fee-for-service (FFS) expenditures in the demonstration period.

D.1.1 Sample Identification

- Eligible but non-enrolled Ohio beneficiaries in demonstration period 1 (May 1, 2014–December 31, 2015). Predicted capitated rates were calculated using the beneficiary risk score and the county of residence.

D.1.2 Calculating the Capitated Rate for Eligible by Non-Enrolled Beneficiaries

- Predicted capitated rates were calculated using the monthly beneficiary risk score (final resolved) and the base rate associated with the beneficiary's county of residence.

- Mean predicted capitated rates were compared to mean FFS expenditures (non-Winsorized). Note that bad debt was removed from the capitated rate as this is not reflected in FFS payments. Sequestration was reflected in both the FFS payments and the capitated payment. Disproportionate share hospital payments and uncompensated care payment amounts were included in the FFS expenditures, as these amounts are reflected in the capitated rates.

- The predicted capitated rate was $1,498 compared to actual FFS expenditures of $1,577 suggesting potential gross Medicare savings for the non-enrolled beneficiary population had this population been enrolled during demonstration period 1.

Table D-1
Observed FFS and predicted capitated rates for eligible but not enrolled beneficiaries

Variable	Obs	Mean	Std. err.	Std. dev.	[95% conf. interval]	
Predicted cap	525,972	1,498.1	2.2	1,605.4	1,493.8	1,502.5
Observed FFS	525,972	1,576.8	8.7	5,916.8	1,560.8	15,92.8
Difference	525,972	−78.7	7.9	5,727.8	−94.2	−63.2

FFS = fee for service.

NOTES: RTI also tested the accuracy of the predicted capitated rate by generating a predicted capitated rate for enrollees and comparing it to the actual capitated rate from the plan payment files. RTI's mean predicted capitated rate for enrollees was $1,350.4 compared to an actual capitated rate of $1,316.0 (difference of −$34.4). Observed FFS and predicted capitated values reflect parallel adjustments.

D.2 Predicting FFS Expenditures for Enrollees

The goal of this analysis is the converse of what is presented in Analysis D.1. Here, we look at predicted FFS expenditures for enrollees based on a model predicting FFS expenditures for non-enrollees.

D.2.1 Methods

A data set with observations from base year 2 and from demonstration year 1 was created from the full data set to allow us to look at expenditures between the two periods. Beneficiary expenditures were summed across all months of each period and then "annualized" to represent the full 12 months of base year 2 (or 20 months of demonstration year 1).

The estimation process involved two steps. First, using non-enrollees, we regressed demonstration year 1 expenditures on base year 2 expenditures, base year 2 Hierarchical Condition Category (HCC) score, and a set of base year 2 demographic and area-level variables. We used an unlogged dependent variable and ran ordinary least squares (OLS) models with and without propensity score weights (using the frozen HCC scores in the composition of the weights). The data were clustered by Federal Information Processing Standards (FIPS) code. This model explained 22.6 percent of the variation in expenditures for non-enrollees.

In the second step, we used the covariate values for demonstration enrollees estimated in the OLS non-enrollee model (from step 1) to calculate predicted expenditures for enrollees. We compared the predicted expenditure values for enrollees to the actual capitated payments made under the demonstration.

D.2.2 Results

Enrollees had lower expenditures in base year 2 ($1,280 for enrollees vs. $1,797 for non-enrollees) and a lower mean HCC score (1.381 for enrollees vs. 1.735 for non-enrollees).

Actual capitated payments for enrollees were, on average, $450 per month lower than the predicted mean expenditures for enrollees in demonstration year 1 suggesting gross Medicare savings under the capitated Medicare rates for the enrolled population compared to the predicted FFS expenditures for this same population had they not been enrolled during demonstration period 1. Mean predicted expenditures for enrollees were $432 per month lower than actual expenditures for non-enrollees.

Table D-2
Mean values of model covariates by group

Covariate	Eligible but not enrolled (N= 23,328)	Enrolled (N = 56,687)
Average monthly FFS expenditures in demo year 1	$2,334	N/A
Average monthly capitated payments in demo year 1	N/A	$1,455
Average monthly FFS expenditures in base year 2	$1,797	$1,280
HCC score	1.735	1.381
Age	67.363	59.447
Also in another CMS demonstration	0.420	0.276
Female	0.675	0.637
Black	0.275	0.360
Asian	0.014	0.022
Other	0.010	0.010
Hispanic	0.008	0.017
Disability as reason for original Medicare entitlement	0.419	0.568
ESRD	0.038	0.036
Patient care physicians per 1,000 population	0.842	0.844
% of households w/ member >= 60 yrs.	34.020	33.384
% of households w/ member < 18 yrs.	30.247	30.367
% of those aged <65 years with college education	22.394	20.038
% of those aged <65 years with self-care limitation	3.657	3.837
Fraction of duals with Medicaid managed care, ages 19+	0.016	0.016
Medicare Advantage penetration rate, all enrl	0.417	0.416
% of pop. living in married household	64.518	60.925
Population per square mile, all ages	774.752	769.035
Medicaid spending per dual, ages 19+	32,432.980	32,392.200
Medicare spending per dual, ages 19+	9,748.355	9,746.102
Fraction of duals using nursing facilities, ages 65+	0.440	0.438
Fraction of duals using personal care, ages 65+	0.000	0.000
Distance to nearest hospital (miles)	4.622	4.404
Distance to nearest nursing home (miles)	3.320	3.160

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; FFS = fee for service.

SOURCE: RTI Program: predictingFFS: Summary statistics: mean by categories of: enrollee

Table D-3
Expenditure prediction results from an unweighted OLS model

Enrollee observations = 23,328	Mean expenditures over the first year of the demonstration (20 months)	95% confidence interval	
Predicted FFS for enrollees	$38,098	$37,781	$38,415
Actual PMPM for enrollees	$29,097	$28,825	$29,370
Difference	$9,000 ($450 per month)	P = 0.0000	

FFS = fee for service; OLS = ordinary least squares; PMPM = per member per month.

SOURCE: RTI program: predictingFFS unweighted FFS3a

D.3 Enrollee Subgroup Analyses

The enrollee subgroup analyses focused on a subgroup of beneficiaries identified as enrolled for at least 3 months in the demonstration period and with at least 3 months of baseline eligibility. Note that a subset of the comparison group developed for the ITT analysis was used in the enrollee subgroup analyses. Comparison group beneficiaries used in the enrollee subgroup analyses were required to have at least 3 months of eligibility in the demonstration period (May 1, 2014–December 31, 2015) and at least 3 months of eligibility in the predemonstration period (March 1, 2012–February 28, 2014), analogous to the criteria for identifying enrollees. The results indicate additional costs associated with enrollees. This enrollee subgroup analysis is limited by the absence of person-level data on characteristics that potentially would lead an individual in a comparison area to enroll in a similar demonstration, and thus the results should be considered in the context of this limitation.

Table D-4
Ohio demonstration, mean monthly Medicare expenditures, revised enrollee subgroup analysis, predemonstration period and demonstration period 1, weighted

Group	Predemonstration period April 2012–March 2014	Demonstration period 1 April 2014–December 2015	Difference
Demonstration group	$1,157.10 ($1,117.09, $1,197.11)	$1,387.81 ($1,351.30, $1,424.32)	$230.71 ($212.29, $249.13)
Comparison group	$1,184.73 ($1,135.33, $1,234.14)	$1,376.19 ($1,302.41, $1,449.97)	$191.46 ($159.94, $222.97)
Difference-in-difference	—	—	$39.25 ($2.86, $75.65)

SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: Programming Specifications/Cap Savings Calculation/ Ohio/lgs_ohcs513_v2_log).

Table D-5
Ohio demonstration, mean monthly Medicare expenditures, revised enrollee subgroup analysis, predemonstration period and demonstration period 2, weighted

Group	Predemonstration period April 2012–March 2014	Demonstration period 1 April 2014–December 2015	Difference
Demonstration group	$1,157.10 ($1,117.09, $1,197.11)	$1,554.40 ($1,514.98, $1,593.82)	$397.30 ($374.62, $419.98)
Comparison group	$1,184.73 ($1,135.33, $1,234.14)	$1,491.72 ($1,394.43, $1,589.02)	$306.99 ($221.28, $392.70)
Difference-in-difference	—	—	$90.31 ($1.77, $178.86)

SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: Programming Specifications/Cap Savings Calculation/ Ohio/lgs_ohcs513_v2_log).

Table D-6
Demonstration effects on Medicare savings, revised enrollee subgroup analysis, DID regression results, Ohio demonstration (weighted)

Covariate	Adjusted coefficient DID	*p*-value	95% confidence interval	90% confidence interval	80% confidence interval[1]
Intervention*DemoYear1 (May 2014–December 2015)	25.74	0.0655	(-1.65, 53.13)	(2.75, 48.73)	(7.83, 43.65)
Intervention*DemoYear2 (January 2016–December 2016)	91.56	0.0308	(8.48, 174.63)	(21.84, 161.28)	(37.24, 145.88)
Intervention*Demo Period (May 2014-December 2016)	42.49	0.0253	(5.27, 79.71)	(11.25, 73.73)	(18.15, 66.83)

[1] 80 percent confidence intervals are provided for comparison purposes only.

NOTE: Adjusted coefficient greater than zero are not indicative of Medicare savings.

SOURCE: RTI Analysis of Ohio demonstration eligible and comparison group Medicare data (program: Programming Specifications/Cap Savings Calculation/ Ohio/lgs_ohcs513_v2_log).

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Appendix E:
Summary of Predemonstration and Demonstration Design Features for Medicare and Medicaid Beneficiaries in Ohio

Table E-1
Demonstration design features

Key features	Predemonstration	Demonstration[1]
Summary of covered benefits		
Medicare	Medicare Parts, A, B, and D	Medicare Parts A, B, and D
Medicaid	Medicaid State Plan services and HCBS waivers	Medicaid State Plan services and HCBS waivers
Payment method (capitated/ FFS/MFFS)		
Medicare	FFS or capitated	Capitated
Medicaid (capitated managed care or FFS)		
Primary/medical	FFS	Capitated
Behavioral health	FFS	Capitated
LTSS (excluding HCBS waiver services)	FFS	Capitated
HCBS waiver services	FFS	Capitated
Care coordination/case management		
Care coordination for medical, behavioral health, LTSS and social needs, and by whom	N/A for integrated case management. In five counties care coordination for all services is provided by community behavioral health centers designated as health homes for persons with SPMI.	MyCare Ohio MMPs provide integrated care management. Individuals with SPMI can choose to have care coordination of all services provided by either the plan or a health home, if available in their area.
Enrollment/assignment		
Enrollment method	N/A. FFS. Medicare-Medicaid enrollees are not eligible to enroll in Medicaid managed care.	Enrollment in a MyCare Ohio plan is mandatory for Medicaid services. Beneficiaries were passively enrolled in the demonstration as of January 2015 and may opt out of demonstration enrollment (i.e., opt out of receiving Medicare services from a MyCare Ohio plan). Beneficiaries who opt out or withdraw from the demonstration will continue to receive Medicaid services through a MyCare Ohio plan.
Attribution/assignment method	N/A	N/A

(continued)

Table E-1 (continued)
Demonstration design features

Key features	Predemonstration	Demonstration[1]
Implementation		
Geographic area	N/A	Regional—7 regions of 3 to 5 counties each, including major urban centers (Akron, Canton, Cincinnati, Cleveland, Columbus, Dayton, Toledo, and Youngstown).
Phase-in plan	N/A	The demonstration was implemented in two phases. Phase 1, which began May 1, 2014, was limited to opt-in enrollment and rolled out across demonstration counties over a 3-month period. Beneficiaries who did not opt in or opt out during Phase 1 were passively enrolled effective January 1, 2015 (Phase 2).
Implementation date	N/A	MyCare Ohio plans began providing coverage for enrollees on May 1, 2014, starting with opt-in enrollees.

FFS = fee for service; HCBS = home and community-based services; LTSS = long-term services and supports; MFFS = managed fee for service; N/A = not applicable; SPMI = severe and persistent mental illness.

[1] Information related to the demonstration in this table is from the Ohio three-way contract, 2014; the MOU, 2012; and the Ohio Health Home SPA, 2012.