MyCare Ohio: 2016 Model of Care

History of MyCare Ohio

Proposed in 2012, the MyCare Ohio program (MCOP) launched in May 2014. Today CareSource MyCare Ohio serves approximately 27,000 members in Ohio's North East (Cleveland), East Central (Akron/Canton) and North East Central (Youngstown) regions. The MyCare program utilizes Care Managers and a broad network of providers to deliver comprehensive care coordination to members across the Medicare and Medicaid covered services continuum.

Population Served

Beneficiaries served by MyCare are individuals older than 18 who are eligible for both Medicaid and Medicare (aka "dual eligible"). Dual eligibles include a Community Well population (those individuals that do not meet an institutional level of care), those that need an institutional level of care and live in Nursing Facilities (NF) and/or those that receive Waiver Services and Home and Community Based Services (HCBS). About 77% of the MyCare membership is voluntarily enrolled and 33% are assigned by the Ohio Department of Medicaid (ODM). CareSource continues to manage both Medicare and Medicaid benefits for approximately 70% of our members. For the remaining members, we administer Medicaid benefits only.

Our dually eligible members are more likely to be over 85 years old or disabled, or under age 65 and eligible for Medicare due to disability. In addition, our members have greater limitations in Activities of Daily Living (ADLs), with one third reporting impairment in three to six ADLs. Primary diagnosis for this population includes hypertension and heart disease.

This population also has higher rates of mental illness, cognitive impairment and higher incidence of diabetes, stroke and disorders related to Alzheimer. Some become eligible because they are sick, others because they are low income. Socioeconomic factors delay access to care, and separate Medicare and Medicaid networks and services contribute to fractioned and uncoordinated care and poor health benefits management.

Examples of members who are eligible for Medicare and Medicaid include many of the following characteristics:

- Lack of a primary care provider or specialty visit within the last six months to a year
- Highest evidence of illness as identified by analytics, claims and pharmacy data

- Highest evidence of current and future risk
- High behavioral health, functional or emergent psychosocial needs, including the frail and elderly and those requiring palliative care
- Educational needs for topics such as fall prevention, disease management or accessing community resources

MyCare beneficiaries eligible for Medicaid and Medicare are among the nation's most vulnerable populations, with multiple chronic conditions and correspondingly complex health care needs. Dual benefit members make up only 9% of the total Ohio Medicaid enrollment, but they account for more than 30% of total Medicaid spending. As a MyCare Ohio Medicare-Medicaid Plan (MMP), CareSource must operate under an approved Model of Care (MOC) which provides the basic framework to meet the needs of each enrollee. The MOC is a vital quality improvement tool and an integral component for ensuring that the unique needs of each enrollee are identified by the MMP and addressed through the plan's care management practices. CareSource conducts an annual evaluation of the MOC to ensure effectiveness of MMP quality, care management, and care coordination.[1]

Program Philosophy

The CS "Heartbeat" and Mission Statement reads: "To make a lasting difference in our member's lives by improving their health and well-being." MyCare is built on a member-centric framework and 100% of members are offered a CM. Services promote independent living and a Care Manager coordinates the full continuum of Medicare and Medicaid benefits, including medical, behavioral, Long Term Services and Supports (LTSS) and social needs for each member.

CY2016 STRUCTURAL ADJUSTMENTS

In order to better serve CareSource MyCare Ohio members, the CareSource Ohio Market completed a leadership realignment which resulted in Regional Directors assuming responsibility for all beneficiaries, regardless of population type (Waiver, Institutional, or Community Well). Redefinition of the staffing roles resulted in greater visibility to delegated vendor contractual compliance across populations.

CareSource upgraded the Inter-RAI Long-Term Care Assessment; further assuring that content collected/documented in Clinical Care Advance reflects national quality standards and supports recognized CMSA clinical practice guidelines, and evidence-based literature. This upgrade aligns with currently available National center for Quality Assurance (NCQA) data. In addition, the general member health risk assessment to

address transitions of care, for example hospital discharge needs, change in health status was revised to better predict risk of readmission.

Staff Orientation and Development

CareSource MyCare Ohio provides a yearly orientation and on-going Staff Development Program. All newly hired staff members are provided with 4 weeks of classroom and field based training. Additionally, staff meetings are held in person and via WebEx throughout the year (Appendix “F” Monthly Training Topics). Directors and the MyCare Clinical Expert of Performance Improvement have direct responsibility for ongoing training of internal and delegated staff. This responsibility includes required annual training (Appendix “G” Required Training Completion Dates) and a plan for training of end users. CareSource University remains a critical partner in assisting with all aspects of orientation, ongoing training and staff development.

Behavioral Health Services

Behavioral Health (BH) is integrated into all aspects of the MyCare clinical services. A dedicated team, noted as another best practice among all MyCare Plans, consists of subject matter experts, each with several years of BH and/or Alcohol and Other Drug (AOD) experience. This team delivers services across the demonstration. BH may function in a primary or secondary Care Management capacity or in a consultative role for acute care situations. Those members brought to the attention of the BH team carry one or more of the following DSM V (or its successor) diagnoses:

- Schizophrenia
- Major Depressive Disorder with Psychotic Features
- Major Depressive Disorder
- Bipolar Disorder
- Schizoaffective Disorder

Many of those that receive BH services also experience homelessness. As is true elsewhere, those affected by chronic or episodic homelessness often have high health care needs. These individuals are far more likely to suffer from chronic medical conditions such as hypertension, smoking-related conditions, obesity, injury and chronic kidney disease complicated by lack of regular medical care. Polypharmacy and substance use contribute to poor health outcomes. MyCare is continually working with ODM to identify and develop programs for evidence-based approaches to care including Peer Support, Assertive Community Treatment (ACT) and Supportive Employment.

In addition to formal contracts with providers, the MyCare BH Team recognizes the importance of building community relationships in support of its members. By reaching out to food banks, housing organizations, occupational and vocational training centers, clubhouses, and other organizations, the team is able to connect beneficiaries with resources to help them reach their optimal level of functioning.

Care Management Administrative Requirements

CareSource conducts professional training sessions on an annual basis for its care managers and staff who participate on the Trans-disciplinary Care Team (TDCT). These training sessions focus on the following topics: person-centered care planning processes, cultural and disability competence, communication, accessibility and accommodations, independent living and recovery, wellness principles, Americans with Disabilities Act (ADA)/Olmstead requirements, and other topics as specified by ODM.

Waiver care managers/waiver service coordinators must participate in annual training on the following topics: Cultural competency/diversity training, Medication management; Level Of Care (LOC); Provider service specifications, including process for requesting home and vehicle modifications and adaptive and assistive equipment; Risk and safety planning–identifying individual risks and the modifications or equipment necessary to maintain a Beneficiary in the home: Individualized service planning and self-direction; Restraints, seclusion and restrictive interventions; Community resources including an overview of at least one other service delivery system, i.e. developmental disabilities, mental health, aging, health, etc., an explanation of the resources available, and training on how to access the services; HIPAA; and Customer Service.

Transitions of Care

MyCare Ohio continues to allow members to maintain current providers and service levels at the time of enrollment as described in the Three-Way Contract. Exceptions include: beneficiary request; provider chooses to discontinue as allowed by Medicare/Medicaid and the Plan, ODM or CMS identify performance issues with a provider that could affect health, safety and welfare.

MyCare Medical Management/Utilization Review

Utilization Management (UM) works closely with the Care Management team to ensure that members receive the highest level of health care, timely care transitions and discharge planning and ongoing care coordination. UM performs utilization management activity, defined as the evaluation of medical necessity, appropriateness,

and efficient use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan. The UM team provides assistance to the care management team, clinicians or members, in cooperation with other parties, to ensure appropriate use of resources.

Model of Care Overview

The primary foundational elements of the MOC are: (1) Health Risk Assessment (2) Individualized Care Plan and (3) Transdisciplinary Care Team (TDCT). CareSource utilizes a single point of contact approach; delegating responsibility for both waiver service coordination and care management provisioning to one (1) Care Manager (CM) for each member.

HEALTH RISK ASSESSMENT

The comprehensive health risk assessment includes a review of the member's medical/behavioral health history, functional needs and Long-Term Services and Supports (LTSS) needs. Psycho-social, socio-economic and cognitive needs are assessed as well as caregiver support, recent changes in medical condition(s), upcoming medical/behavioral health appointments or procedures and end-of-life needs. In addition, a functional assessment is completed to identify potential safety concerns or existing disabilities. The comprehensive assessment identifies barriers to care, potential access issues, quality concerns, under or over-utilization trends as well as member/caregiver educational needs. The field care manager utilizes an extended field-based team including patient navigators, health educators, licensed practical nurses, social workers, and community partners such as the AAA staff and other contracted home care providers.

PERFORMANCE EVALUATION

Health Service Advisory Group (HSAG), contracted by the Ohio Department of Medicaid (ODM) to assess the MyCare Ohio demonstration, identified the CareSource "Unable to Reach" protocol a "best practice". When members cannot be reach clinical data points are used to develop a monitoring health risk assessment and provisional care plan for the member. The MyCare Ohio Care Management Targeted Review Aggregate Report scores CareSource as 76% compliant for "Comprehensive Assessment" domain. Supplemental required reporting identifies CareSource as the highest performing MyCare Ohio Plan (MCOP) for completion of Annual Reassessments (87%).

INDIVIDUALIZED CARE PLAN (ICP)

Depending on the answers to specific HRA questions, an ICP is generated. The Care Plan is comprised of problems, interventions and goals. The problem is specific to the identified issue based on the member's answer to the particular question. The intervention is targeted to address the associated problem and either a short term or long term goal is triggered. Any barriers to service will be monitored and addressed by the care manager. As members transition across care/service settings, all movement will be tracked and monitored through the ICP to ensure seamless transitions. TDCT members will alerted to gaps in services via the ICP.

PERFORMANCE EVALUATION

CareSource CMs were trained using the acronym SMACC (service plan, medications, acuity, claims and care plan) to trigger required documentation actions during each member contact to improve the provision of holistic care. CareSource also began piloting use of the specialized tool in the Skilled Nursing Facilities (SNF) as a means to evaluate baseline and monitor Level of Service (LOS). CareSource implemented use of “invitation letters” to TDCT members to encourage input and participation with Individualized Care Plan (ICP) development and updates. A second annual all CM training related to ICP development and review. The MyCare Ohio Care Management Targeted Review Aggregate Report scores CareSource as 69% compliant in the ICP domain.

Trans-Disciplinary Care Team

The CM is responsible for coordinating care in a seamless manner across the continuum using a Trans-disciplinary care team (TDCT) approach. The TDCT’s overall care management role includes member and caregiver advocacy, health support, health coaching and education, and support of the member’s self-care management and care plan. The TDCT is an interdependent, dynamic group of which the exact composition may change and adapt as dictated by the needs of the individual member. The CM is responsible for documentation of TDCT discussion and any additions or input for plan of care, beneficiary questions and concerns, outreach, education, coaching, documentation of written and verbal educational reinforcements, and member follow up.

PERFORMANCE EVALUATION

CareSource updated the TDCT template in CCA to better drive outreach to include TDCT members and to better align documentation with the TDCT meeting process. The provider portal was also updated to accept TDCT input and alert CMs. Additionally, increased training was provided to the CMs on

authorized representative, Power of Attorney and Legal Guardianship scope and approval(s). The MyCare Ohio Care Management Targeted Review Aggregate Report scores CareSource as 99% compliant in the “Care Manager/Care Management Team” domain.

2016 QUALITY FOCUS: Care Transitions/Discharge Planning

CareSource had a 2016 focus on enhanced discharge planning which is designed to safely transition members from an inpatient admission in an acute care or skilled nursing facility back to home/community or nursing facility. CareSource seeks to empower and educate members/caregivers to be more compliant with the discharge plan, thus improving outcomes while decreasing avoidable readmissions and emergency department revisits.

PERFORMANCE EVALUATION

CareSource was selected to participate in an NCQA Member-Centered Care Planning pilot team which included an on-site NCQA technical assistance review of CM activities. NCQA favored comprehensive transition protocols to guide CMs through level of care (LOC) processes that were developed and implemented in 2016.

PROVIDER NETWORK

CareSource offers members of the MyCare Program a comprehensive network of care. This network includes, but is not limited to, acute care facilities, skilled and long term care facilities, laboratories, radiography facilities, rehabilitation facilities, behavioral health specialists, home health specialists, home and community based care givers, patient navigators, and end of life care specialists. Although CareSource offers a comprehensive network of physicians and providers, should members develop needs for services outside the current network, CareSource may grant approval for utilization of out-of-network facilities and providers when appropriate.

Consistent with Ohio’s efforts to rebalance the proportion of people receiving long-term care at home or in the community versus in nursing homes, CareSource has sought to contract with high quality community-based entities, such as the Area Agencies on Aging (AAAs) and other community-based network partners to ensure a wide range of access and “aging in place” service options for MyCare beneficiaries.

It is the policy of CareSource to ensure the quality and qualifications of organizational providers through a credentialing and re-credentialing process which complies with regulatory and accreditation standards. Any providers found to be noncompliant with the CareSource credentialing requirements will be given the opportunity to provide explanation for the noncompliant area. The information will then be presented to the Credentialing Committee for review and determination of panel status. CareSource contracts require that practitioners cooperate with quality activities including full access to member medical records.

PERFORMANCE EVALUATION

CareSource was determined to be fully compliant during its CMS contract review for Network Management via Health Service Delivery (HSD) Table Submission. The HSD Table lists every contracted provider in the CareSource MyCare network and confirms that healthcare services through a contracted network of providers is consistent with the pattern of care in the network service area. CareSource also works closely with independent, self-employed, providers who provide waiver services to members. CareSource held community provider forums to highlight correct billing practices to ensure accurate and timely payments. Independent non-agency providers supplement the CareSource network and are an integral part in meeting member needs. CareSource maintains a staff in the MyCare Region to assist Health Partners with resolution of concerns.

Medication Therapy Management (MTM)

CareSource is committed to helping members receive the maximum benefit from their medications by providing MTM. CareSource has contracted with Outcomes MTM to provide this service across all lines of business. Outcomes MTM identifies members with opportunities to prevent or address medication-related problems, gaps in care, duplication of therapies, cost opportunities, non-adherence and numerous other quality-focused interventions. They send these activities to their network that includes most retail pharmacies. These interventions are performed by the member's local pharmacist in a face-to-face interaction to maximize an already existing relationship that the member has established with that clinician. That data is then available to CareSource's Care Managers within 24 hours. Finally, pharmacists coordinate care with Care Managers and providers when needs are identified to facilitate member health and safety, as well as avoid unnecessary costs from complications or hospitalizations.

CareSource's MTM program includes a variety of covered services including: medication review; prescriber consultation; member adherence consultation; member education and monitoring; cost-effective alternatives and alerts e.g.; inappropriate dose, drug interaction, untreated indications for drug therapy and unnecessary/suboptimal dose drug therapy.

Wellness, Prevention Services/Disease Management

CareSource offers prevention service reminders through a wide variety of mechanisms including but not limited to the following: website, mail reminders, voice reminders, and member newsletters. Educational materials, reminder calls, and one-on-one focused instruction are used by the Care Manager. The MyCare care management team works closely with the Sales and Marketing team for all community education and health fair events. In addition, the care management team collaborates with the Provider Relations team educating providers on member quality programs along with reviewing the use of information and innovative tracking tools.

Silver Sneakers offers members a fitness membership with access to more than 13,000 locations, with all basic amenities at no extra cost. New health plan members receive their first mailer from Silver Sneakers, the Initial Member Engagement Touch, shortly after joining the plan.

MyCareOhio
Connecting Medicare + Medicaid

[1] SNP-MOC. (2016, August 23). Retrieved July 25, 2017, from https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.html