

# EVALUATION OF OHIO'S MYCARE DEMONSTRATION

*Scripps Gerontology Center,  
Miami University*

**John R. Bowlbis**

**Robert Applebaum**

**Jennifer Heston-Mullins**

**Matt Nelson**

**Katherine M. Abbott**

*Ohio Colleges of Medicine  
Government Resource Center,  
The Ohio State University*

**Lorin Ranbom**

**Virginia A. Folcik Nivar**

**Michael Nau**



SCRIPPS GERONTOLOGY CENTER



SCRIPPS GERONTOLOGY CENTER

100 Bishop Circle, Upham Hall 396, Oxford, OH 45056

[MiamiOH.edu/ScrippsAging.org](http://MiamiOH.edu/ScrippsAging.org) | 513.529.2914 | [Scripps@MiamiOH.edu](mailto:Scripps@MiamiOH.edu)

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## EXECUTIVE SUMMARY

In May 2014, Ohio began implementation of the Financial Alignment Initiative (FAI) in partnership with the Centers for Medicare and Medicaid Services (CMS). The FAI capitated models, which were implemented in ten states, were based on a concern that the Medicaid and Medicare programs were not well integrated, and each program had an incentive to shift costs to the other. The motivation for the initiative was that the lack of coordination resulted in poor quality outcomes for individuals and high expenditures for both the states and the federal government.

CMS contracted with a national evaluator, the Research Triangle Institute (RTI) to evaluate the FAI initiatives. The report for Ohio was released in November 2018 and on average, results were positive for the demonstration overall, but mixed for the population enrolled in the long-term services component of the demonstration. Unfortunately, the evaluation did not include Medicaid expenditures, an issue of paramount importance to state policy makers. With no other evaluation data available for Ohio's MyCare program, The Ohio Department of Medicaid (ODM) funded the Scripps Gerontology Center at Miami University (Scripps) and the Ohio Colleges of Medicine Government Resource Center at the Ohio State University (GRC) to conduct an independent evaluation of the demonstration. The evaluation includes both an impact evaluation, using both Medicare and Medicaid expenditure and utilization data, and a process evaluation.

In evaluation research, the gold standard is to randomly assign individuals, or in some large-scale studies, even counties, into treatment and comparison groups. Because MyCare has been implemented in the demonstration counties since 2014, random assignment was not possible. The counties where MyCare was implemented were not selected at random, are located primarily in the urban areas of the state, and have very different demographic profiles, so the evaluation design had to account for such differences. The MyCare impact evaluation uses a method designed for this type of scenario called a difference-in-differences analysis, which compares the treatment group (individuals in MyCare counties) to a comparison group (individuals in non-MyCare counties) before and after the implementation of MyCare. This methodology

examines the effect on the group that the intervention intended to target, or more formally, an intent-to-treat analysis. Under this approach, the evaluation results compare the outcomes of all dual eligible individuals in the MyCare counties to all individuals with dual eligibility who live in the non-MyCare counties.

The study also included a process evaluation to better explain how the demonstration operates. The process evaluation data collection included: (1) interviews and focus groups with key stakeholders at state and regional levels, including MyCare plans and providers, (2) a review of MyCare descriptive data, and (3) interviews with MyCare members.

The MyCare Ohio demonstration was created to provide members access to services for medical, behavioral, social, long-term care, pharmacy, and specialty needs. The five MyCare Ohio Plans (MCOPs)—Buckeye Health Plan (Buckeye), CareSource, Molina Healthcare of Ohio (Molina), Aetna Better Health of Ohio (Aetna), and UnitedHealthcare (United)—provide integrated Medicare and Medicaid services across 29 counties grouped into seven regions, which were centered around the main urban areas of the state.

By November 2021, MyCare was serving 144,000 Ohioans, covering about 57% of those who are dually eligible for Medicare and Medicaid across the state. Most individuals who are dually eligible and live in one of the covered geographic regions must enroll in MyCare. They have the option to voluntarily enroll in any of the MCOPs available in their region. If they do not choose a plan, they are automatically enrolled by ODM into a MCOP for both their Medicaid and Medicare benefits. Beneficiaries can select to have the MCOP continue to coordinate both their Medicaid and Medicare benefits (called “opt-in”), or they may choose to “opt-out” from the Medicare portion of the demonstration and choose either fee-for-service Medicare or pick from an array of Medicare Advantage plans. Four in ten MyCare members opted-out of the Medicare component of the demonstration.

MyCare covers two distinct populations referred to within the MyCare program as Community Well (CW) and Long-Term Services and Supports (LTSS). The CW population includes individuals with moderate, little, or no disability who reside in the

community. However, many of these individuals do experience substantial health challenges. The LTSS population includes individuals who have severe disability who reside in a home or apartment community setting, in an assisted living residence (AL), or in a skilled nursing facility (NF). LTSS MyCare members in the community may receive home and community-based services (HCBS) in-home or through AL waiver services and receive care management to coordinate their acute and long-term care needs. This report focuses on both the CW and LTSS target populations.

Under the rules of the demonstration, MCOPs must provide care management services to all enrolled members that promotes their ability to live independently and that coordinates the full set of Medicare and Medicaid benefits across the continuum of care, regardless if they are opted-in or opted-out. Additionally, the MCOPs are required to contract with the Area Agencies on Aging (AAAs) within each region to provide coordination of HCBS waiver services for beneficiaries age 60 and older with long-term service needs.

## Major Study Findings

### Expenditures on Health and Long-Term Services

- Overall, dually eligible individuals in MyCare counties had higher unadjusted total Medicare and Medicaid expenditures relative to individuals in the non-MyCare counties in the years before the implementation of MyCare. After the implementation of MyCare, the unadjusted total Medicare and Medicaid expenditures in MyCare and non-MyCare counties were similar, though the MyCare counties had lower Medicare and Medicaid expenditures in the CW subgroup and higher expenditures in the LTSS subgroup.
- Using a statistical technique that adjusts for differences between the MyCare and non-MyCare groups, overall findings found that Medicare and Medicaid expenditures were \$274 per person, per month lower in MyCare counties **compared** to the non-MyCare counties after the implementation of MyCare, with \$78 attributed to Medicare and \$196 to Medicaid.



- For the CW subgroup, the total Medicare and Medicaid adjusted expenditures were \$318 per month lower for MyCare counties in **comparison** to the non-MyCare counties after the implementation of MyCare. Medicare monthly expenditures were \$85 lower, and Medicaid \$233 lower compared to the non-MyCare counties.
- For the LTSS subgroup, total adjusted expenditures were \$146 per month lower for the MyCare counties **compared** to the non-MyCare counties, but the results for Medicare (\$212 higher for MyCare) and for Medicaid (\$358 lower for MyCare) when compared to the non-MyCare counties were mixed. Of the \$146 in reduced expenditures for MyCare, one-third of this difference (\$47) was achieved through lower HCBS expenditures.
- Expenditures in this study represent money paid to providers. The differences in expenditures for the MyCare and non-MyCare counties does not mean that the state spent less money on dually eligible individuals in MyCare counties. To compare actual state costs, the capitated rate for MyCare members, plus any carve-out expenditures, would need to be compared to the service and administrative expenditures for the non-MyCare counties. That comparison was outside of the scope of this study.

### Service Use and Level of Care

- The proportion of individuals in MyCare counties that were categorized as LTSS increased from 34.6% before the implementation of the MyCare program to 40.2% after the implementation of MyCare. In non-MyCare counties for the same period, the proportion of LTSS individuals was nearly flat (39.5% vs 38.8%). The MyCare counties saw a 5.3 percentage point increase in the LTSS population after adjusting for differences in individual characteristics, which represents a 16% increase in the proportion of LTSS individuals in the MyCare counties.
- For the full analysis group, and both the CW and LTSS subgroups, when **compared** to non-MyCare counties, MyCare counties had lower inpatient

hospital use after the implementation of MyCare, and this accounted for a sizable portion of the expenditure differences described earlier (10.5% lower use).

- After the implementation of MyCare, the LTSS subgroup in MyCare counties saw lower Medicaid-supported nursing facility use **compared** to the non-MyCare counties (by 8 percentage points, a 19% increase) but comparatively higher Medicare nursing facility use (by 10.3 percentage points, a 198% increase).
- The implementation of MyCare is associated with a large increase in the use of hospice in the LTSS subgroup compared to the non-MyCare sample, increasing from 2.1% to 6.6% and recording a 200% (4.2 percentage point) regression-adjusted increase. For the LTSS subgroup not using a nursing facility, hospice use increased from 2.5% to 6.9% and had a regression adjusted increase of 144% (3.6 percentage points). (Note: hospice is a Medicare primary service.)
- For the LTSS subgroup who did not reside in a nursing facility, the service use analysis found reductions in an array of HCBS for the MyCare counties compared to the non-MyCare counties after the implementation of MyCare. These included: assisted living (56%), transportation (53%), adult day care (33%), emergency response (19%), home care (13%), and home delivered meals (12%).
- One in five MyCare LTSS subgroup members (21%) not residing in a nursing facility did not have HCBS expenditures after the implementation of MyCare, compared to the non-MyCare counties proportion of 9%. However, the hospice use for the MyCare counties was substantially higher (6.9% for MyCare vs. 2.4% for non-MyCare counties).

### Implementation Results

- While the impact analysis was not able to analyze findings by plan, the process evaluation did identify variation in MyCare implementation. Two of the MCOPs (CareSource and Aetna) use a fully-delegated care management model, where one care manager employed by the contracted AAA is responsible for all the member's MyCare services. This model is applicable for these plans' members of

all ages who are enrolled in the MyCare waiver. The other three plans employ a waiver service coordination model in which a MCOP care manager coordinates medical and behavioral health services, and an AAA waiver service coordinator coordinates HCBS services for members who are aged 60 and older. The waiver services are coordinated plans' waiver members who are under the age of 60. There is also variation by plan in the processes and personnel configurations used to address transitions between care settings and care management for members with behavioral health needs.

- Four in ten MyCare members opted out of the Medicare managed care component of the demonstration, and AAA and MCOP interview respondents reported that this makes it more difficult to coordinate services across the Medicare and Medicaid programs. Process interviews also revealed that there is significant confusion among members and their families regarding opt-in/opt-out status and that members may be making the choice to opt-out without full understanding of the implications. LTSS MyCare members reported that they had been actively counseled to opt-out by health care providers, particularly physicians.
- Almost half of MyCare members are under age 65 and many have behavioral health needs, including severe mental illness (21%), depression (33%) anxiety (24%) and PTSD (2.5%). This was unanticipated at the outset of the demonstration and interview respondents reported that these members have a considerable impact on program operations, requiring more intensive and time-consuming care management, initial and ongoing education on behavioral health issues for care management staff, and knowledge of, and close coordination with, community behavioral health service providers.
- MCOP interview respondents were consistently positive about the benefits that MyCare affords to CW members, particularly care management and incentives for taking preventative health actions such as routine screenings and immunizations. Impact findings suggest comparative expenditure reductions for these individuals.

- Hospice coverage is a “carve-out” service in the three-way contract between ODM, CMS, and the MyCare Ohio plans. This means that hospice is paid for outside of the plan’s Medicare and Medicaid capitated rates and could be a factor explaining the increase in hospice use rates for MyCare opt-in members. Providers bill original Medicare, also known as traditional Medicare, for hospice services.

## Discussion

The impact on expenditures of the MyCare CW subgroup for both Medicare and Medicaid is consistent with the earlier RTI study results limited to Medicare. The findings on the CW subgroup are consistent with process analysis results, which reported the importance of care management activities with CW members. Interview respondents consistently mentioned that many of those individuals easily fell through the cracks in the pre-MyCare system. Descriptive data showed that the MyCare CW subgroup members were a vulnerable population, and it appears that being able to direct resources to coordinate and monitor services and conditions has an effect on utilization and expenditures. As ODM considers revisions to MyCare, it is important to recognize the vulnerability of this subgroup and the importance of coordinating care for these individuals. In particular, the high proportion of CW members with behavioral health needs indicates the importance of coordinated care management activities to make sure that these individuals have access to needed services.

Results for the LTSS subgroup are a bit more difficult to interpret. Individuals in MyCare counties experienced reductions in overall costs relative to non-MyCare counties, driven by a drop in hospital use and Medicaid supported nursing facility use. The drop in in-patient hospital use is an important finding and efforts to understand how this outcome was achieved could have implications for future practice and policy decisions. However, Medicare nursing facility use and hospice use increased for the MyCare sample. Because hospice coverage was carved-out of the initial three-way agreement, the 200% increase among LTSS individuals requires further study. Additionally, the 16% increase in the LTSS subgroup in the MyCare counties requires further review to better understand what is driving differences in the MyCare and non-MyCare counties. Some

of this increase in LTSS members could be tied to increase in hospice use. Individuals classified as LTSS in MyCare counties received fewer HCBS services, with one-in-five MyCare members residing in the community not receiving any HCBS, although a higher proportion received hospice care. More study of the home care service use within the LTSS community group to better understand these utilization patterns would be an important quality review.

## INTRODUCTION

In May 2014, Ohio began implementation of the Financial Alignment Initiative (FAI) in partnership with the Centers for Medicare and Medicaid Services (CMS). The FAI capitated models, which were implemented in ten states, were based on a concern that the Medicaid and Medicare programs were not well integrated, and each program had an incentive to shift costs to the other. The motivation for the initiative was that the lack of coordination resulted in poor quality outcomes for individuals and high expenditures for both the states and the federal government. The demonstration was rooted in a belief that enrolling dual eligible individuals in a managed care plan that included both Medicare and Medicaid would improve outcomes for plan members and lower expenditures for the states and the federal government. CMS contracted out with a national evaluator, the Research Triangle Institute (RTI), to evaluate the state initiatives. The report for Ohio was released in November of 2018 and, on average, results were positive for the demonstration overall but mixed for the population enrolled in the long-term services component of the demonstration.<sup>1</sup> Unfortunately, the evaluation did not include Medicaid expenditures, an issue of paramount importance to state policy makers.

With no other evaluation data available for Ohio's MyCare program, the Ohio Department of Medicaid (ODM) funded the Scripps Gerontology Center at Miami University (Scripps) and the Ohio Colleges of Medicine Government Resource Center at the Ohio State University (GRC) to conduct an independent evaluation of the demonstration. The evaluation includes both an impact evaluation and a process evaluation, which are presented in this report. The impact analysis addresses the critical question about whether the demonstration impacted service utilization and costs and the process analysis focuses on the implementation and administrative aspects of MyCare and provides important context for better understanding the impact analysis. Select process evaluation findings are referenced in this report; the full process findings are presented in a separate companion report.

## BACKGROUND

The expansion of managed long-term services has generated considerable interest over the last decade. In addition to the capitated FAI programs, additional states are testing or exploring some type of managed long-term services system. For example, Colorado and Washington are testing an integrated model using the fee-for-service system, while others have focused primarily on the Medicaid population with an opportunity to enroll members in a complementary Medicare Advantage plan, when possible.<sup>2</sup> In states implementing these efforts, policy makers believe that better integration of Medicare and Medicaid services can lower cost and improve quality. There has been a long-standing criticism that the Medicare and Medicaid programs have not worked in concert and that state and federal policy incentives have not been aligned. The increasing older population, the cost pressures from both Medicare and Medicaid, and health and long-term services quality concerns, highlight the need for new models of service delivery. Additionally, a shift to a managed care strategy is attractive to states, to the extent that it can provide more stability of expenditures from year to year.

The strong push to integrate Medicare and Medicaid services has been driven by the federal government, through CMS, and by the states themselves in response to two major system concerns: quality and cost. Professionals, researchers, and consumers are well aware of the lack of coordination between hospitals, nursing facilities, home health and home-and community-based service (HCBS) providers. The silos result in organizations typically being well versed in their own part of the system, but less so for the other components. Critics of the current approach cite such negative outcomes as potentially inappropriate hospital re-admissions, unnecessary nursing facility placement, or a lack of communication across in-home providers as examples of this fragmentation. The argument is that these instances can result in poor quality and a higher cost delivery system. Because the dual eligible group is such a large part of Medicaid expenditures and Medicaid is about one-quarter of most state budgets, efforts to both control costs and make expenditures predictable each year are paramount to the states.<sup>3</sup> A growing older population compounds these problems today and tomorrow

and many of the states participating in the FAI are the largest states in the nation including New York, California, Texas, Illinois, Michigan, and Ohio.<sup>4,5</sup>

The hypothesis for the FAI demonstrations was that an integrated care delivery system could have a positive impact on individuals in several ways. First, the incentives to better coordinate care could help to create a more cost-effective system. For example, since the 1970s critics have argued that the long-term care system has been out of balance with Medicaid favoring the more expensive institutional care over home and community-based services (HCBS). Often HCBS options have been restricted, while access to nursing facility care has not. While most states, including Ohio have made major changes that have already altered the balance between nursing facilities and HCBS, an integrated care delivery system could enhance these efforts since the funding stream would be more integrated.

The fragmentation and misaligned incentives that have existed between the Medicare and Medicaid funding sources have also been identified as a major contributor to poor quality and high costs of care. States have had strong incentives to shift costs to Medicare and away from Medicaid and this can result in inappropriate transfers of individuals across settings. One common example is the coordination between the home, hospital, and nursing facility, which has been heavily criticized for not being driven by consumer needs. Because Medicare and Medicaid have different funding approaches and reimbursement rates, the lack of coordination has also had an impact on provider behaviors across settings. A well implemented integrated care system could help to ensure that older individuals get the right care, in the right place, at the right time. While many of these issues have been the object of numerous strategic initiatives, system change has been slow and inconsistent across the nation. Proponents of integrated care argue that the demographic and cost challenges must be addressed as America ages.

In response to these concerns, the Ohio Department of Medicaid (ODM) developed and implemented the MyCare Demonstration. The demonstration is regulated by a three-way contract between ODM, CMS and five managed health plans, called MyCare Ohio Plans (MCOP's). The health plans were allowed to bid on regions, which covered the



major urban areas of the state. The overall demonstration began in May 2014 and serves individuals who are dually eligible for both Medicare and Medicaid, with the program covering 57% of those who are dually eligible in the state (as of November 2021 MyCare served 144,000 Ohioans). MyCare covers two distinct populations referred to by the MyCare program as community well (CW) and long-term services and supports (LTSS). The CW population includes individuals with moderate, little, or no disability who reside in the community. The LTSS population includes individuals who have severe disability who reside in a home or apartment community setting, in an assisted living residence (AL), or in a skilled nursing facility (SNF). LTSS MyCare members in the community may receive in-home or AL waiver services (HCBS) and receive care management to coordinate their acute and long-term care needs. This report focuses on both of the CW and LTSS target populations.

Studies on the impact of efforts to integrate acute medical and long-term services began more than 30 years ago. Overall, the results of these efforts have been mixed. The initial Social/Health Maintenance Organization four-site demonstration (S/HMO) did not find major impacts, but noted considerable cultural barriers between the acute and long-term sides of the programs.<sup>6</sup> The lessons of this early demonstration continue to have implications for the integration efforts now underway. A series of studies on individual state programs conducted in the 2000s also found mixed results, including studies in Minnesota, Wisconsin, and Massachusetts. For example, an evaluation of Minnesota's Senior Options Program (MSHO) found reductions in hospital stays but no change in nursing facility use.<sup>7</sup> A recent study, which examined the implementation of Medicaid managed long-term services and supports (MLTSS) found that there was no change in the proportion of residents that were considered low care in nursing facilities.<sup>8</sup>

Mixed results were also found in a study by Mathematica of MLTSS, with New York significantly lowering the rate of nursing facility placement for managed care participants, but Tennessee not showing a statistically significant difference.<sup>9</sup> As noted, the evaluation study conducted by RTI reported Ohio specific results for MyCare and found lower inpatient hospital admissions, lower probability of care sensitive admissions, lower skilled nursing admissions, lower probability of long stay admissions,

lower physician management, but higher emergency room (ER) visits for demonstration participants overall.<sup>10</sup> However, impacts for MyCare long-term services and supports (LTSS) users were mixed, showing higher ER visits, higher skilled nursing facility admissions, higher care-sensitive admissions, but lower inpatient hospital admissions, and lower all cause 30-day hospital readmissions.<sup>11</sup> The study also found an array of implementation problems during the early years of the demonstration. However, this study did not include Medicaid utilization or expenditure data, limiting interpretation of study results.

The most recent round of studies on integrated care just released also found mixed results. State projects in Illinois and Virginia reported higher Medicare expenditures for the demonstration members, and California reported slightly lower Medicare expenditures, but again Medicaid expenditures were not included in these studies.<sup>12</sup> Evaluation data from New York found an increase in outpatient visits for demonstration members, but also found higher use of the emergency rooms for demonstration members.<sup>13</sup> Several of these demonstrations, such as Virginia and Illinois, have ended.

Compounding the mixed results of these studies is the limited information about the care management models implemented. In fact, while a review of the five separate health plan approaches in Ohio indicate very different strategies to managing health and long-term services for MyCare participants with disability, a lack of data about the implementation experience means it is impossible to assess whether differences in plan approaches have an impact on participants. Our process evaluation is designed to help gain a better understanding of the MyCare model being implemented in Ohio. Because of the growing interest in Medicaid managed long-term services and the recent expansion federal legislation, which now allows Medicare Advantage plans to incorporate an array of community-based services into its benefit package, it is critical for the state to have good information about the FAI model.

## MYCARE PROGRAM DESCRIPTION

The process evaluation companion report provides detail about the MyCare program and its implementation. In this section, we include a brief description to provide context for understanding impact findings.

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

*MyCare Ohio Plans (MCOP)*—The five MCOPs—Buckeye Health Plan (Buckeye), CareSource, Molina Healthcare of Ohio (Molina), Aetna Better Health of Ohio (Aetna), and UnitedHealthcare (United)—provide integrated Medicare and Medicaid services across 29 counties grouped into seven regions which were centered around the main urban areas of the state. Each region is served by two MCOPs, except for the Northeast region, which is served by three MCOPs.

*Enrollment*—Individuals who are dually eligible, over 18 years of age, and live in one of the covered geographic regions must enroll into MyCare. They have the option to voluntarily enroll in any of the MCOPs available in their region. If they do not choose a plan, they are automatically enrolled by ODM into a MCOP for both their Medicaid and Medicare benefits. Beneficiaries can select to have the MCOP continue to coordinate both their Medicaid and Medicare benefits (called “opt-in”) or they may choose to “opt-out” from the Medicare portion of the demonstration and choose either fee-for-service Medicare or pick from an array of Medicare Advantage plans. Beneficiaries who opt-in to the Medicare portion of MyCare have the right to opt-out at any time after enrollment

and return to fee-for-service or enroll in a different Medicare Advantage plan for Medicare services.

*Care management*—Under the rules of the demonstration, MCOPs must provide care management services to all enrolled members that promotes their ability to live independently and that coordinates the full set of Medicare and Medicaid benefits across the continuum of care, regardless if they are opt-in or opt-outs. Additionally, the MCOPs are required to contract with the Area Agencies on Aging (AAAs) within each region to provide coordination of HCBS waiver services for beneficiaries age 60 and older with long-term services needs. The three-way contract allows waiver service coordination for individuals under age 60 to be conducted by the MCOP's or other entities that have experience working with people with disabilities. Primary care physicians and other providers are included in the transdisciplinary care teams to assist in development of service plans, communicate with members about their care, and work with the care manager or waiver service coordinator on updates with significant changes to the member's health or services.

Outside of these requirements, the MCOPs were given considerable flexibility in designing their care management models. Two distinct models of HCBS waiver care management are used in the demonstration: waiver service coordination and fully-delegated waiver care management. Three of the MCOPs (Buckeye, Molina, and United) chose to operate using the waiver service coordination model, where HCBS waiver service coordinators employed by the AAAs coordinate services for members that needed long term services in such areas as personal care, home-delivered meals, durable medical equipment, and transportation. A MCOP care manager assigned to each member is responsible for creating and implementing a care plan for the member with input from the AAA waiver service coordinator that also addresses medical and behavioral health needs. The AAA waiver service coordinator is responsible for conducting the required monitoring visits and providing the information necessary to inform the care plan. Two MCOPs (Aetna and CareSource) elected to operate within a fully-delegated model in which care managers employed at the AAAs serve as the care

manager of record and are responsible for care management of all members receiving HCBS waiver services, including their LTSS, medical and behavioral health needs.

Prior to the MyCare demonstration, HCBS was provided to individuals with physical and cognitive disabilities through three separate waivers; PASSPORT (60 plus), Assisted Living Medicaid Waiver Program (ages 18 and older in assisted living), and the Ohio Home care waiver (below age 60). These programs continue in non-MyCare counties and for individuals eligible for Medicaid only.

## **STUDY METHODS**

### **IMPACT EVALUATION RESEARCH DESIGN OVERVIEW**

The goal of this study is to understand how the implementation of MyCare is associated with Medicare and Medicaid expenditure and utilization patterns for individuals who are eligible for both programs. To study the effect on an intervention, it is necessary to examine what occurred before and after program implementation. However, only examining individuals in MyCare counties would not identify the true effect of the intervention, as other factors independent of the MyCare intervention may cause changes in expenditures and utilization over time. To address this methodological challenge, the study compares individuals in the MyCare “treatment group” to a “comparison group” of individuals that did not participate in MyCare and were not subject to the MyCare intervention. The idea is that the outcome trends for the MyCare “treatment” and comparison groups would have been equivalent over time, except for the receipt of the intervention. The comparison group in this study is dually eligible Ohioans in non-MyCare counties. By comparing the trends in expenditure and utilization for individuals in MyCare and non-MyCare counties before and after the implementation of MyCare, the effect of the implementation of MyCare on these interventions can be identified.

### **IMPACT EVALUATION EMPIRICAL METHOD**

In evaluation research, the gold standard would be to randomly assign individuals, or in some large-scale studies, even counties, into treatment and comparison groups.

Because MyCare has been implemented in the demonstration counties since 2014, random assignment is not possible. The MyCare counties were not selected at random and are located primarily in the urban areas of the state with very different demographic profiles, so our evaluation design had to account for such differences.

The MyCare impact evaluation uses a method designed for this type of scenario called a difference-in-differences analysis which compares the treatment group (individuals in MyCare counties) to a comparison group (individuals in non-MyCare counties) before and after the implementation of MyCare. A difference-in-differences analysis essentially contains two steps to identify the effect of the MyCare program. The first step is to calculate study outcomes for a period before and after the implementation of the intervention (MyCare) and calculate the difference in the outcomes in the before and after periods separately for the treatment and comparison groups. The second step is to calculate the difference between the treatment and comparison groups using the before and after period differences calculated in the first step. The resulting value from the second step identifies the effect of the intervention, or in this case, the effect of the implementation of the MyCare program on study outcomes.

A difference-in-differences analysis can be done by calculating summary statistics of outcome variables or by using regression analysis that also adjusts for other characteristics of the individual, such as demographics and medical conditions. In the statistical analysis, the following regression model is estimated where coefficients have been suppressed and the subscripts  $i$  and  $t$  represent individual and month:

$$Outcome_{it} = After_{it} + MyCare_{it} + After_{it} * MyCare_{it} + Controls_{it}.$$

The variable  $Outcome_{it}$  is an outcome variable (e.g. expenditure or utilization) for an individual in a month. The variable  $After_{it}$  is an indicator variable that identifies whether the individual's observation is before or after the implementation of MyCare, and  $MyCare_{it}$  is an indicator for whether the individual is in a MyCare county (treatment group) or in a non-MyCare county (comparison group). The variable  $Controls_{it}$  is a set of control variables that identify the demographics and the health conditions of the

individual. The coefficient estimate for the variable  $After_{it} * MyCare_{it}$  identifies the effect of the MyCare intervention on the outcome variables.

### **Definition of the Impact Study Sample and Study Period**

The unit of observation used in the impact evaluation is a person-month. For each person-month, an observation was considered eligible to be included in the study if the following criteria were met:

1. The individual was at least 18 years of age.
2. The individual was dually eligible for Medicare and Medicaid.
3. The individual was not enrolled in the Program of All-Inclusive Care for the Elderly (PACE).
4. The individual did not reside in an Intermediate Care Facility (ICF) or was not on a developmental disability waiver.
5. The individual was not in one of the MyCare exclusion categories by being in the Qualified Medicare Beneficiary program or in the Medicare Premium Assistance program and thus are not eligible to participate in MyCare.
6. Individuals in a MyCare Medicaid plan, who were enrolled in a MyCare Medicare Advantage plan (i.e., opt-in) or were enrolled in Medicare fee-for-service.
7. The individual lived solely in a MyCare or non-MyCare county for all months in which they were dually eligible.

Claims information was only available for individuals for the MyCare Medicare Advantage plan connected to the Medicaid health plan or if the member was in fee-for-service Medicare. Medicare Advantage claims were not available for MyCare members who enrolled in a different Medicare Advantage plan or for non-MyCare sample members who enrolled in a Medicare Advantage option available to them in their individual communities, as those data were not accessible. Finally, the sample was restricted to those that lived in MyCare or non-MyCare counties during the entire study period.

The study relies on data from 2011 through 2018 (See Table 1). While data from 2011 through 2018 are used to construct the study sample and control variables, the period before MyCare's implementation, the "before period," is defined as January 2012



through April 2014. Additionally, the period after MyCare's implementation, the "after period," is defined as January 2015 to December 2018. We exclude person-months observations in the period of May through December 2014, referred to as a donut hole, because of large variation in expenditure and utilization patterns that appeared to be the result of the transition to MyCare and not the actual policy intervention. This variation in expenditures and utilization largely dissipated by January 2015. Excluding the person-month observations in the donut hole eliminates any confounding results that may be caused by this transition period.

This resulting sample used in this analysis was 11,291,298 person-months, reflecting 390,096 individuals based on Medicaid identification numbers. The most significant reason a person-month was not included in the analysis was because of enrollment in Medicare Advantage. Use and expenditure data for non-MyCare Medicare Advantage plans were not available for this research effort. Medicare Advantage accounted for about 10% of dually eligible individuals in non-MyCare counties and about 20% of individuals in MyCare counties before the implementation of MyCare. Additionally, 30% of individuals enrolled in MyCare, but who opted-out of the Medicare component of MyCare, joined a different Medicare Advantage plan.

**Table 1. Analysis Time Periods**

<b>Year</b>	<b>Period</b>	<b>Description</b>
2011	Reference	Period used to construct control variables.
January 2012- April 2014	Before Period	Period when entire state utilized fee for service Medicaid
May 2014 – December 2014	Donut Hole	Period of transition. These observations were not included.
January 2015 – December 2018	After Period	Period of intervention

### **Defining the MyCare and Non-MyCare Groups**

This study sample was broken into the MyCare treatment and non-MyCare comparison groups. The MyCare group is defined as individuals who lived in a MyCare demonstration county for all months in which they are dually eligible. The non-MyCare



group is defined as individuals who lived in a non-MyCare demonstration county for all months in which they are dually eligible.

### **Defining Full Analysis Group, the CW and LTSS Subgroups**

To fully understand the effect of MyCare, analyses are performed for (1) the “full analysis group” which includes those who are CW and LTSS; (2) the CW subgroup; and (3) the LTSS subgroup.

To define individuals who are CW and LTSS, medical claims data and waiver enrollment information was utilized for each month. For individuals enrolled in a MyCare plan, LTSS was based on whether the plan was paid a LTSS capitated payment (formally referenced in three-way contract as being Nursing Facility Level of Care (NFLOC) and the individual could be in a nursing facility or receiving long-term services in the community). All other individuals were identified as being LTSS if they were enrolled in a HCBS waiver (Choices, Transitions, PASSPORT, AL waiver) or were defined as requiring a LTSS because they were a long-stay nursing facility resident. Dually eligible individuals in the non-MyCare counties that were not identified as having LTSS were considered as CW.

### **Defining Outcome Measures and Control Variables**

*Outcome measures:* The main outcome measures are expenditure and utilization of various services (Table 2) that can be calculated from paid claims data. In general, these outcomes are examined for the full analysis group and the CW and LTSS subgroups. When services are generally only provided to individuals of LTSS, such as HCBS services, the analysis is restricted to individuals who are in the LTSS subgroup.

Outcomes are broken into expenditures attributable to Medicare and Medicaid when possible, while utilization is generally examined irrespective of payer. Expenditures include all services related to medical, long-term services, and durable medical equipment paid in the claims data. Prescription drug claims were not available for the comparison group and thus were not examined in the study. For individuals not enrolled in MyCare, claims can easily be distinguished between Medicare and Medicaid. Claims data from MyCare had a category for whether the expenditure was attributed to

Medicare or Medicaid, but there is no guarantee that this would have been recorded the same way as in fee-for-service claims data. For example, Medicare may cover most of the cost with Medicaid covering only the copayment or deductible. The MyCare data did not include Medicare cross-over expenditures, so it is possible that some Medicaid expenditures were allocated to the Medicare program.

Total expenditures on all medical, long-term services, and durable medical equipment (DME) were calculated for all individuals, regardless of where the service was provided or if the individual was CW or LTSS. For the full analysis group and each subgroup, expenditures for the following group of paid claims were also calculated: expenditures on inpatient hospital care, expenditures on outpatient evaluation and management (E/M) services, expenditures in a nursing facility (including post-acute care and long-stay), expenditures paid to a home health agency, expenditures on durable medical equipment, and expenditures on hospice care. Two measures of outpatient E/M services captures the spending on the primary reason for an outpatient visit. The first measure focuses on emergency department use (ED) and the second measure focuses on visits to a physician (which includes urgent care). Both of these measures do not include the additional costs of testing and ancillary services as the purpose of both measures is to examine the general level of outpatient visits. Nursing facility care includes both post-acute care and long-stay care, as Medicaid covers the full cost of long-stays, but also covers copayments if the stay is for post-acute care and Medicare is covering the majority of the nursing facility stay cost.

For the LTSS subgroup, expenditures for the following HCBS services were calculated: assisted living, home care (including personal care, homemaker and chore services), in-home meal services (home-delivered meals and nutrition services), adult day services (adult care and adult day transportation), emergency response, social work counseling, non-emergency medical transportation, and waiver nursing.

<b>Table 2. Outcome Variables Examined</b>				
	<b>Expenditures Examined</b>		<b>Utilization Examined</b>	<b>Group and Subgroups Examined</b>
	<b>Medicare</b>	<b>Medicaid</b>		
<b>Total Service Expenditures</b>	X	X		Full, CW, LTSS
<b>Type of Services by Locations</b>				
Inpatient Hospital	X	X	X	Full, CW, LTSS
Outpatient ED E/M	X	X	X	Full, CW, LTSS
Outpatient Physician E/M	X	X	X	Full, CW, LTSS
Nursing facility	X	X	X	Full, CW, LTSS
Home Health Agency	X	X	X	Full, CW, LTSS
Durable Medical Equipment	X	X		Full, CW, LTSS
Hospice	X	X	X	Full, CW, LTSS
<b>HCBS Services</b>				
Assisted Living		X	X	LTSS
Home Care		X	X	LTSS
Home Meals Services		X	X	LTSS
Adult Day Services		X	X	LTSS
Emergency Response		X	X	LTSS
Social Work Counseling		X	X	LTSS
Non-Emergency Medical		X	X	LTSS
Transportation		X	X	LTSS
Waiver Nursing		X	X	LTSS

Notes: ED = emergency department; E/M = Evaluation and Management; Full = full analysis group; CW = Community Well subgroup; LTSS = long-term services and supports

To measure utilization, for each person-month it was determined whether the individual had any paid claims for the service. These services include having a claim for an inpatient hospital stay, outpatient visit, nursing facility, home health agency, and hospice. For individuals with LTSS, we also examined if any of the following services were used in the month: assisted living, home care, home-delivered meal services, adult day services, emergency response, social work counseling, non-emergency transportation, and waiver nursing.

*Control variables:* Control variables are demographic characteristics and health conditions that effect expenditure and utilization. These control variables adjust for differences in individuals across time and between the MyCare and non-MyCare counties. Demographics are based on what is reported for the individual at the time of the person-month observation. Health conditions for individuals were identified by diagnosis codes obtained from Medicare and Medicaid claims records in ambulatory clinical settings or inpatient hospitals (e.g., physician's office, urgent care, emergency department, hospital). The specific diagnoses codes were based on the CMS Chronic Condition Warehouse. For each person-month, a person was considered to have the condition if they had any claim with the diagnosis over a one-year period. Health conditions were broken into disability, physical health, and behavioral health conditions. The specific control variables are shown in Table 3.

<b>Table 3. Control Variables</b>		
<b>Type of Variable</b>	<b>Control variables</b>	<b>Description/Notes</b>
Subgroup	<ul style="list-style-type: none"> <li>CW vs. LTSS</li> </ul>	Used only in the full group analysis to distinguish between the two subgroups
Demographics	<ul style="list-style-type: none"> <li>Age</li> <li>Gender</li> <li>Race/ethnicity: Black, Indigenous, and People of Color (BIPOC)</li> <li>Married</li> </ul>	Obtained from Medicaid enrollment files
Disability	<ul style="list-style-type: none"> <li>Impaired Vision</li> <li>Impaired Hearing</li> <li>Impaired Mobility</li> <li>Disease associated with impairment</li> <li>Dementia</li> </ul>	All variables are defined as indicators for having the health condition and were obtained from medical claims. Disease associated with impairment includes items such as multiple sclerosis and spinal cord injuries.
Health Conditions	<ul style="list-style-type: none"> <li>Arthritis</li> <li>Asthma/Chronic obstructive pulmonary disease (COPD)</li> <li>Cancer</li> <li>Chronic Pain</li> <li>Diabetes</li> <li>Hip Fracture</li> <li>Migraine</li> <li>Obesity</li> <li>Stroke/Transient ischemic attack (TIA)</li> <li>Tobacco Use</li> <li>Number of Heart Disease Diagnoses</li> </ul>	All variables are defined as indicators for having the health condition and were obtained from medical claims. The number of heart disease conditions include, heart attack, heart failure, high cholesterol, high blood pressure, ischemic heart disease, and peripheral vascular disorder.
Behavioral Health Conditions	<ul style="list-style-type: none"> <li>Severe Mental Illness (SMI)</li> <li>Anxiety</li> <li>Depression</li> <li>Post-Traumatic Stress Disorder</li> <li>Abuse of Alcohol, Drugs, or Opioids</li> </ul>	All variables are defined as indicators for having the health condition and were obtained from medical claims. SMI includes bipolar disorder, personality disorder, and schizophrenia.

## Impact Evaluation Methodological Limitations

In this study, the MyCare treatment group is identified as all dually eligible individuals in a MyCare county. Because Medicare is a social insurance and not a social welfare program, Medicare beneficiaries cannot be required to enroll in a managed care plan in the same way as Medicaid enrollees. As a result, currently about four in ten individuals in MyCare counties opt-out of the Medicare Advantage component of MyCare. This means that a sizable proportion of individuals do not have both Medicaid and Medicare coordinated by the health plans as intended in the design of the intervention. While individual enrollment data contains whether a person opted-in or opted-out of the Medicare-side of the MyCare program, this information is not available in the before period for any individual, and in the after period for individuals in non-MyCare counties. The primary results include the opt-outs MyCare members, but to gain a better understanding of who opts-in and opts-out of MyCare, additional analyses are also conducted that compare the characteristics, expenditures, and utilization of opt-in and opt-out MyCare members in the after period.

A second limitation faced in the study is that some dually eligible individuals who should have been in the research sample were excluded from the study. This is because the study did not have Medicare Advantage claims data and hence expenditure data for individuals enrolled in a non-MyCare Medicare Advantage Plan. Medicare Advantage accounts for about 10% of the individuals in non-MyCare counties who are dually eligible, and about 30% of the individuals in MyCare counties who opted-out.

A final limitation is that there are individuals who appear to meet all of the dual eligible requirements for MyCare participation but are not enrolled. Similarly, to the MyCare opt-outs, these individuals are included in the sample because we are unable to remove these individuals from the non-MyCare comparison counties sample and from the before period data. This encompasses about 10% of the entire analytic sample and this limitation could exert attenuation bias on the estimated effect of the intervention.

In summary, our main analysis, which compares individuals in MyCare to non-MyCare counties, examines the effect on the group the intervention intended to target, or more formally, an intent-to-treat analysis. Under this approach, the evaluation results

compare the outcomes of all dual eligible individuals in the MyCare counties who meet eligibility criteria for MyCare, to all individuals with dual eligibility meeting program criteria who live in the non-MyCare counties. This means that the difference-in-differences results presented in this report include those who opt-out and those not enrolled in MyCare.

## **PROCESS EVALUATION DESIGN**

The process evaluation data collection was conducted in two phases. The first phase occurred from March – December 2020 and included two main components: (1) interviews and focus groups with key stakeholders at state and regional levels and (2) a review of MyCare descriptive data. The second phase, between June 2021 and November 2021, involved interviews with MyCare members and interviews with additional nursing facility and assisted living facility providers. The full process evaluation report is available in an accompanying report.<sup>14</sup>

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

### **Process Interviews**

To understand the administration and day-to-day implementation of care management with MyCare Ohio, the research team conducted 75 interviews/focus groups with a total of 331 respondents between September 1 – October 31, 2020. These respondents were comprised of personnel from the four focus AAAs and all five MCOPs. The process research team also conducted 40 interviews with organizations providing LTSS or acute care services to MyCare members. Provider respondents represented home care, durable medical equipment (DME), transportation, SNFs, AL, senior housing, hospice, hospital discharge planning and case management, physician, and case

management organizations. Finally, to ensure feedback from both CW and LTSS members from all five MCOPs, the process team interviewed 40 members (37 members and 3 family members) across the four focus regions.

### Description of Current MyCare Members

Although our impact evaluation results focus on the time period 2012- 2018 we present data on the current program to provide context to the current study. Any differences in program structure or policy will be highlighted in our presentation of results and our subsequent discussion of research and policy issues. This section presents ODM reported enrollment data for October and November 2021. As shown in Table 4, total MyCare enrollment in November 2021 was 144,000 members. Enrollment varied slightly across the five plans, with CareSource having the highest proportion of members (23%). While the majority of members (52%) were over the age of 65, a sizeable proportion (48%) were under age 65, including 15% under age 45. Four in ten (41%) of the MyCare members were reported to be classified as Black, Indigenous, and People of Color (BIPOC), and six in ten were women (62%) (See Table 6).

<b>Table 4. MyCare Enrollment by Plan, Age, and Gender, November 2021*</b>					
<b>MyCare Plans</b>	<b>Total MyCare Enrollment November 2021</b>	<b>Distribution by Plan (%)</b>	<b>Distribution by Age Under 65 %</b>	<b>Distribution by Age 65+ %</b>	<b>Distribution by Gender Female %</b>
Aetna	28,018	19.5	46.6	53.4	62.8
Buckeye	27,458	19.1	51.7	49.3	59.7
CareSource	32,742	22.7	48.4	51.6	62.6
Molina	27,865	19.3	50.6	49.4	59.8
United Healthcare	27,956	19.4	44.1	55.9	62.3
<b>MyCare Total</b>	<b>144,039*</b>	<b>100.0</b>	<b>48.1</b>	<b>51.9</b>	<b>61.5</b>

\*Source: Ohio Department of Medicaid, Reports and Research, Enrollment, Demographic and Expenditures Dashboard <sup>15</sup>



Tables 5 and 6 show MyCare members who opt-in or opt-out of the integrated Medicare Advantage component of the demonstration. Overall, four in ten (42%) members opt-out of the Medicare Advantage portion of MyCare. The opt-in/opt-out rates vary by plan, with United recording an opt-out rate of 54%, in contrast to 37% for CareSource. While opt-out members receive the same care management services as those that opt-in, care managers have less opportunity to manage and coordinate the Medicare services used by the opt-out members.

As shown in Table 6, there is some variation by age with older members having an opt-out rate of 46% and those under age 45 recording a 29% opt-out rate. There are differences by race/ethnicity, with white members (38% vs. 45%) reporting lower opt-out rates than BIPOC members. We see bigger differences by type of membership. CW members have a 39% opt-out rate compared to over for 45% for those with LTSS. For those with LTSS and receiving HCBS waiver services, the opt-out rate was 45%, compared to 51% for those having LTSS and residing in a nursing facility. As shown in Table 4, United, which had a higher opt-out rate overall compared to the other MCOPs, recorded a higher proportion of those age 65 as members than the other plans (56% vs. 51%).

**Table 5. Opt-in and Opt-out MyCare Enrollment Total and by Plan, November 2021**

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

\*Total number of members fluctuates daily.<sup>16</sup>

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

\*Data on race is missing in some cases

Notes: BIPOC = Black, Indigenous, and People of Color; HCBS= home and community-based services.<sup>17</sup>

## IMPACT FINDINGS

### DESCRIPTION OF THE FULL ANALYSIS GROUP

This study uses a difference-in-differences analysis in which the trajectories of individuals who are dually eligible in MyCare and non-MyCare counties are compared before and after the implementation of the MyCare program. Summary statistics are presented, which report the average values for each variable for MyCare counties and non-MyCare counties for both the before and after periods. These results provide a general understanding of the trajectories, but they do not account for differences in the demographics and health conditions of individuals in the four groups, which may affect the outcomes examined in the study. Therefore, all outcomes are regression-adjusted to account for these differences in demographic and health conditions.

To understand the differences in the characteristics of the individuals in the four groups, Table 7 presents descriptive data for the “full analysis sample” (n = 11,291,298). To generate these data, individual claims were examined each month and averaged for each group and time period. For example, we took the mean age of all dually eligible individuals in the sample each month and then averaged them across all of the before MyCare implementation months to calculate the average age in the before period (63.4 years for MyCare and 64.1 years for non-MyCare). In Table 8, we present similar characteristics for the CW and LTSS subgroups.

Our presentation of the MyCare evaluation sample has two objectives: (1) to compare the sample members in MyCare counties to those in non-MyCare counties in the before and after periods of the implementation of the MyCare demonstration, and (2) to paint a portrait of those individuals who comprise the group eligible for both the Medicare and Medicaid programs. Our comparison of before and after periods in the MyCare and non-MyCare counties provides the groundwork for our analysis of program outcomes. As noted, areas of differences between the MyCare and non-MyCare county samples will need to be addressed through the study regression analysis. We present the summary statistics in Table 7 for the full analysis group broken down by four categories of descriptors which will serve as control variables in the regression analysis: demographics, disability, health conditions, and behavioral health conditions.

The full analysis group included a sizable proportion of sample members (35-40%) classified as LTSS. These individuals were eligible to receive long-term services in the community through a Medicaid waiver, are long-term nursing facility residents, and a MyCare plan was paid a LTSS capitated payment. In the MyCare counties, the proportion in LTSS increased from 34.6% to 40.2% between the before and after periods. In comparison, the proportion in non-MyCare LTSS remained flat in the before and after periods (39.5% to 38.8%). This means that the MyCare counties saw a 6.3 percentage point increase in the proportion classified as LTSS in the after period compared to the before period relative to non-MyCare counties.

**Table 7. Select Characteristics of Dually Eligibles in the MyCare Impact Evaluation: Full Analysis Group Before and After Implementation of MyCare**

Characteristics	MyCare Counties		Non-MyCare Counties	
	Before Period	After Period	Before Period	After Period
<b>Subgroup</b>				
LTSS (%)	34.6	40.2	39.5	38.8
<b>Demographics</b>				
Age (mean)	63.4	64.1	64.1	63.7
Female (%)	65.5	64.2	64.5	63.3
Married (%)	15.8	15.3	21.0	20.1
BIPOC Race/ethnicity (%)	36.3	38.3	5.5	5.7
<b>Disability</b>				
Impaired vision (%)	1.1	1.3	1.3	1.1
Impaired hearing (%)	6.4	6.0	6.3	6.9
Impaired mobility (%)	8.3	8.6	7.5	7.6
Disease associated w/ impairment (%)	4.2	4.4	3.8	4.7
Dementia (%)	24.0	22.3	22.3	20.1
<b>Health Conditions</b>				
Diabetes (%)	35.5	34.8	38.9	38.0
Stroke/TIA (%)	10.0	8.7	9.9	9.4
Obesity (%)	17.0	22.4	18.0	25.4
Arthritis (%)	37.6	37.5	38.5	42.0
Tobacco use (%)	22.7	23.4	22.5	27.0
Chronic pain (%)	19.8	28.2	20.0	29.5
Number of Heart Conditions	1.7	1.7	1.9	1.9
<b>Behavioral Health Conditions</b>				
Severe mental illness (%)	21.4	20.7	21.2	21.1
Depression (%)	32.5	32.8	35.0	38.2
Anxiety (%)	24.0	27.9	29.2	36.4
PTSD (%)	2.5	3.9	2.1	3.7
<b>Sample Sizes</b>	2,614,471	5,191,702	1,271,228	2,213,897

Notes: LTSS = long-term services and support user; BIPOC = Black, Indigenous, and People of Color; PTSD = post-traumatic stress disorder; TIA = transient ischemic attack. The before period is defined as 2012-April 2014 and the after period is 2015 through 2018. The unit of observation is a person-month.

In looking at the demographic characteristics, age and gender are quite similar in the the comparative increase in the MyCare counties was 5.3 percentage points, or a 16% increase, when regressions were used to adjust for the other demographic and health conditions listed in Table 7.

MyCare and non-MyCare counties samples (mean before period age of 63.4 vs. 64.1 and percent female 65.5% vs 64.5%). A further breakdown of age found that 47% of the full analysis group is below the age of 65 (not shown). With the MyCare counties located in the urban areas of the state, the racial/ethnic composition was expected to be different between the MyCare and non-MyCare counties. During the before period, the MyCare counties were more racially and ethnically diverse (36.3% vs. 5.5% BIPOC individuals). The MyCare counties also had fewer married individuals (15.8% vs. 21%). These differences indicate the need to account for demographic characteristics through regression-adjustment.

Previous research finds that individuals who are eligible for both Medicare and Medicaid generally have higher expenditures. For example, individuals with dual eligibility represented 15% of Medicaid beneficiaries, but accounted for 35% of total Medicaid expenditures, and accounted for 20% of Medicare recipients, but 35% of Medicare expenditures.<sup>18,19</sup> Using medical claim diagnosis information, the study sample has high prevalence of impairment, health, and behavioral health conditions which are associated with higher expenditures and affirm the vulnerability of Ohio's dual eligible population (See Table 7).

There is general comparability across the disability measures in the before period in terms of the proportion of the sample with impairment in vision, hearing, mobility, and diseases associated with impairments. The proportion with dementia was slightly higher in the MyCare counties (24% vs. 22%) in the before period, but the trends in the after period were similar. In the before period, the MyCare counties sample included 35.5% with diabetes, compared to 38.9% for the non-MyCare counties; stroke/TIA, (10% vs. 9.9%), obesity (17% vs. 18%), arthritis (37.6% vs. 38.5%), and chronic pain (19.8% vs. 20%). The high levels of chronic illness in such areas as diabetes, arthritis, and chronic pain, reinforce the high health needs of this population.

In looking at behavioral health conditions, again the high risks experienced by the evaluation sample are evident. More than one in five have a diagnosis of severe mental illness (21.4% in MyCare and 21.2% non-MyCare counties) and one-third have a depression diagnosis (32.5% MyCare vs. 35% non MyCare). An anxiety diagnosis was also common, but slightly lower in the MyCare counties (24.0% vs. 29.2%).

## **COMPARING CW AND LTSS SUBGROUPS**

The CW subgroup, while including many individuals with chronic illness, differs from the LTSS subgroup in that these individuals are not in need of long-term services funded through the Medicaid program. Individuals classified as LTSS have significant functional or cognitive impairments and need long-term care services, either in the community, in an assisted living, or a nursing facility. Each observation in the full analysis group was identified as being CW or LTSS as described in the methods section of this report. Our presentation of these evaluation subgroups emphasizes two sets of comparisons: one that focuses on the differences between the CW and LTSS subgroups, and a second that compares the MyCare and non-MyCare counties within the two subgroups.

As shown in Table 8, the CW and LTSS subgroups differ widely across the data categories of demographics, disability, health and behavioral health conditions. The CW subgroup is younger (age mean 57 vs. 75) and more likely to be men (percent female 60% vs. 72%). The CW has a higher proportion of BIPOC individuals than the LTSS subgroup. Despite the age and gender differences, the CW and LTSS samples are more similar on marital status.

As expected, the CW subgroup has fewer disabilities than the LTSS subgroup. The largest difference was in the diagnosis of dementia. Dementia was less prevalent in the CW subgroup (less than 13%), but four in ten in the LTSS subgroup had a dementia diagnosis. Comparisons between the CW and LTSS subgroups for health conditions presents more of a mixed picture. Diabetes, stroke, and arthritis were less prevalent in the CW subgroup than the LTSS subgroup (diabetes 32% vs. 45%; stroke 7% vs. 14%; and arthritis 34% vs. 44%). Obesity was similar across the two subgroups, but tobacco use and chronic pain was higher for the CW subgroup (tobacco 28% vs. 12%; chronic

pain 21% vs. 17%). Behavioral health conditions were clearly more prevalent in the CW subgroup than the LTSS subgroup. The CW subgroup had higher prevalence of severe mental illness (23% vs. 18%), anxiety (28% vs. 23%) and PTSD (3% vs. 1%), with depression being comparable across CW and LTSS subgroups.

While there were differences across the CW and LTSS subgroups, comparing MyCare and non-MyCare counties within the CW and LTSS subgroups finds similar trends to the analysis of the full analysis group. Those trends were that the before period characteristics of the CW and LTSS subgroups were generally similar except in terms of racial/ethnic composition and marital status. The CW subgroup is comprised of 40% BIPOC individuals in the MyCare counties compared to 6% in the non-MyCare counties. The BIPOC composition of the LTSS group was 30.3% and 4.6% in the MyCare and non-MyCare counties. For both the CW and LTSS subgroups the non-MyCare counties had a higher proportion of married individuals.

The comparison of the MyCare and non-MyCare counties in the before period show small differences across the disability measures, except for the dementia diagnosis, where the MyCare counties have a higher proportion of individuals with dementia (44% vs. 36.5%) in the LTSS subgroup. The health conditions comparison between the MyCare and non-MyCare subgroups in the before period showed little difference. A comparison of the MyCare and non-MyCare samples finds comparable proportions of individuals with behavioral health conditions, except for anxiety, which in both CW (25.5% vs. 30.9%) and LTSS (21.2% vs. 26.4%) subgroups is lower for the MyCare counties.

<b>Table 8. Select Characteristics of Dually Eligibles in the MyCare Impact Evaluation: CW and LTSS Subgroups Before and After Implementation of MyCare</b>								
<b>Characteristics</b>	<b>Community Well Subgroup</b>				<b>Long-term Services and Supports Subgroup</b>			
	<b>MyCare Counties</b>		<b>Non-MyCare Counties</b>		<b>MyCare Counties</b>		<b>Non-MyCare Counties</b>	
	<b>Before Period</b>	<b>After Period</b>	<b>Before Period</b>	<b>After Period</b>	<b>Before Period</b>	<b>After Period</b>	<b>Before Period</b>	<b>After Period</b>
<b>Demographics</b>								
Age (mean)	57.4	57.1	57.2	56.7	74.7	74.5	74.6	74.6
Female (%)	61.6	59.7	59.2	58.3	73.1	70.8	72.6	71.2
Married (%)	16.0	14.9	23.8	21.5	15.3	16.0	16.6	18.0
BIPOC Race/ethnicity (%)	39.5	42.1	6.1	6.3	30.3	32.6	4.6	4.7
<b>Disability</b>								
Impaired vision (%)	.09	.07	.07	.07	2.1	2.1	1.7	1.7
Impaired hearing (%)	5.0	4.6	4.6	5.6	9.1	7.4	8.8	9.1
Impaired mobility (%)	4.4	3.9	3.9	3.4	15.7	16.6	12.9	14.2
Dementia (%)	13.4	13.0	13.0	8.6	44.0	46.7	36.5	39.6
<b>Health Conditions</b>								
Diabetes (%)	31.0	30.1	33.3	32.3	43.8	41.7	47.5	47.0
Stroke/TIA (%)	7.2	5.5	6.9	6.0	15.3	14.9	14.5	13.4
Obesity (%)	17.2	23.1	17.9	25.6	16.6	21.4	18.1	25.0
Arthritis (%)	34.3	34.6	34.7	38.1	43.8	41.7	44.3	48.1
Tobacco use (%)	28.4	30.0	28.6	33.8	11.9	13.8	13.3	16.2
Chronic pain (%)	21.2	30.5	21.7	31.5	17.0	24.6	17.3	26.4
Number of Heart Conditions	1.5	1.5	1.6	1.6	2.1	2.0	2.3	2.3
<b>Behavioral Health Conditions</b>								
Severe mental illness (%)	23.6	24.1	22.3	22.8	17.1	15.5	19.5	18.4
Depression (%)	32.8	33.3	35.4	37.8	32.1	32.0	34.5	38.8
Anxiety (%)	25.5	29.9	30.9	38.0	21.2	24.9	26.4	33.9
PTSD(%)	3.2	5.3	3.5	5.1	0.9	1.7	.07	1.4
<b>Sample Sizes</b>	1,710,679	3,107,051	768,829	1,354,506	903,792	2,084,651	502,399	859,391

Notes: CW = community well; LTSS = long-term services and supports; BIPOC = Black, Indigenous, and People of Color; PTSD = post-traumatic stress disorder; TIA = transient ischemic attack. The before period is defined as 2012-April 2014 and the after period is 2015 through 2018. The unit of observation is a person-month.



## **COMPARISON OF MEDICARE AND MEDICAID EXPENDITURES BETWEEN DUALY ELIGIBLES IN MYCARE AND NON-MYCARE COUNTIES**

Using information from the Medicare and Medicaid claims data, expenditures on all medical, HCBS and nursing facility services, and durable medical equipment were calculated for each dually eligible individual for each month. These expenditures are presented per member, per month (PMPM). The average PMPM expenditure is reported for the MyCare and non-MyCare counties for the before and after periods. These average PMPM expenditures are unadjusted and reflect actual expenditures incurred. However, as has already been shown, there can be differences in demographics, level of impairment, and other health characteristics over time and by MyCare and non-MyCare counties. To statistically account for these differences the regression-adjusted effect is also reported. When adjusting for these characteristics, the results are generally in the same direction as the average unadjusted PMPM expenditures, but do not match. When examining the unadjusted and regression-adjusted effects, it is important to note that the effect of the MyCare intervention is relative to non-MyCare. Therefore, even if both MyCare and non-MyCare counties experienced increases in PMPM, MyCare can have relative expenditure reductions if the PMPM in MyCare counties increased less than non-MyCare counties. Furthermore, the expenditures examined are paid medical claims by Medicare, Medicaid, and MyCare plans to providers. Therefore, these expenditures do not reflect the actual cost to the state, as it does not include capitated payments or carve-outs.

### **Full Analysis Group**

Table 9 reports the average PMPM expenditures for the MyCare and non-MyCare counties in the before and after periods in actual dollars. It also reports the unadjusted and regression-adjusted effect of the MyCare intervention. While the unadjusted effect represents the actual changes in PMPM expenditures, the regression-adjusted effect should be given more weight because it accounts for differences in individual demographic and health characteristics.

For total expenditures, both Medicare and Medicaid combined, the average PMPM in before period was \$3,278 in the MyCare counties and \$3,023 in the non-MyCare counties. In the after period, the average PMPM expenditures in the MyCare and non-MyCare counties were nearly equal (\$2,943 vs. \$2,953). These results show the unadjusted effect of the MyCare program was a reduction in average PMPM expenditure for the MyCare counties of \$264. The regression-adjusted effect found a \$274 overall reduction. In looking at Medicare and Medicaid expenditures separately, the unadjusted results show a larger relative reduction for Medicare than Medicaid (\$179 vs. \$85 PMPM), yet the adjusted-regression effect finds a smaller relative expenditure decline in Medicare and a large one for Medicaid (\$78 for Medicare vs. \$196 PMPM for Medicaid).

In reviewing the individual expenditure categories, two services with the largest decline in PMPM expenditure between the before and after time periods were inpatient hospital care and nursing facility care. Inpatient hospital spending by Medicare had a regression-adjusted decline in PMPM spending (\$105) in the MyCare counties compared to the non-MyCare counties. For nursing facility services, the regression-adjusted results showed increased PMPM expenditure for Medicare (\$90) and a decrease in PMPM expenditure of \$125 for Medicaid. Outpatient expenditures for both emergency department and physician care showed little or no differences between groups except for physician services under Medicare, with the MyCare counties lower by \$9 PMPM. Home health expenditures also demonstrated a mixed outcome, with MyCare counties having lower Medicare expenditures (\$10 PMPM) and higher Medicaid expenditures (\$20 PMPM). Medicare hospice expenditures were higher by \$7 PMPM and Medicaid hospice expenditures were \$13 PMPM lower in MyCare counties compared to non-MyCare counties.

<b>Table 9. Average Per Member Per Month (PMPM) Expenditures for Medicare and Medicaid in Nominal Dollars: Full Analysis Group</b>						
	<b>Actual PMPM Expenditures (\$)</b>				<b>Effect of MyCare Intervention Identified by Difference-in-Differences Analysis (Negative Values Indicate MyCare Counties are Lower)</b>	
	<b>MyCare Counties</b>		<b>Non-MyCare Counties</b>		<b>Unadjusted</b>	<b>Regression-Adjusted</b>
<b>Expenditure Type (dollars)</b>	<b>Before Period</b>	<b>After Period</b>	<b>Before Period</b>	<b>After Period</b>		
Total Expenditures	3,278	2,943	3,023	2,953	-264	-274
Medicaid	1,544	1,352	1,459	1,352	-85	-196
Medicare	1,734	1,592	1,564	1,601	-179	-78
<b>Inpatient Hospital Expenditures</b>						
Medicaid	41	37	17	17	-4	-1
Medicare	683	522	563	569	-167	-105
<b>Outpatient ED E/M Expenditures</b>						
Medicaid	4	4	4	1	+2	+2
Medicare	54	58	60	68	-5	+1
<b>Outpatient Physician E/M Expenditures</b>						
Medicaid	14	7	14	6	-1	+2
Medicare	61	39	64	54	-12	-9
<b>Nursing facility Expenditures</b>						
Medicaid	873	777	883	834	-47	-125
Medicare	212	275	200	184	+79	+90
<b>Home Health Agency Expenditures</b>						
Medicaid	152	173	95	80	+36	+20
Medicare	70	61	63	64	-10	-10
<b>DME Expenditures</b>						
Medicaid	39	39	33	42	+17	+18
Medicare	46	46	55	47	-4	-4
<b>Hospice Expenditures</b>						
Medicaid	81	66	62	62	-16	-13
Medicare	113	117	89	85	+7	+7

Notes: E/M = evaluation and management; ED = Emergency department; DME = durable medical equipment. All expenditures are reported in nominal dollars. The unadjusted effect may not equal the values reported in the actual PDPM columns due to rounding. Regression-adjustments controlled for all control variables described in the Method section.

## Community Well Subgroup Analysis

While the CW subgroup did not include individuals that require long-term services, the characteristics of this group presented earlier indicate areas of high need. A review of subgroup members found that total PMPM expenditures in the period prior to MyCare implementation was \$2,490 for MyCare counties and \$2,231 for non-MyCare counties (See Table 10). In the after period, the average PMPM in the MyCare counties dropped to \$1,627 PMPM and dropped to \$1,878 PMPM in the non-MyCare counties. While the average PMPM declined between the before and after period, the regression-adjusted results find the relative decline was larger in the MyCare counties (\$318 PMPM). The decline in expenditures for both the MyCare and non-MyCare counties occurred in Medicare and Medicaid, but the larger decline occurred on the Medicare side. The relative decline in expenditures is a regression-adjusted \$233 PMPM for Medicare compared to \$85 PMPM for Medicaid.

A review of the individual service categories showed a general pattern of lower expenditures (regression-adjusted differences) for the MyCare counties relative to the non-MyCare counties for both Medicare and Medicaid. The exception is outpatient emergency department E/M expenditures, which was unchanged for Medicare and increased slightly for Medicaid in the MyCare sample (\$2 PMPM). The largest relative differences occurred in two expenditure categories: inpatient hospital and hospice expenditures. Medicare (regression adjusted difference was lower for MyCare counties relative to non-MyCare counties of \$123 PMPM for inpatient hospital services and \$54 PMPM for hospice. Medicaid hospice expenditures were also lower by \$56 PMPM

**Table 10. Average Per Member Per Month (PMPM) Expenditures for Medicare and Medicaid in Nominal Dollars: Community Well Subgroup**

Expenditure Type (dollars)	Actual PMPM Expenditures (\$)				Effect of MyCare Intervention Identified by Difference-in-Differences Analysis (Negative Values Indicate Counties are Lower)	
	MyCare Counties		Non-MyCare Counties		Unadjusted	Regression-Adjusted
	Before Period	After Period	Before Period	After Period		
Total Expenditures	2,490	1,627	2,231	1,887	-519	-318
Medicaid	837	416	768	488	-141	-85
Medicare	1,653	1,212	1,462	1,399	-378	-233
Inpatient Hospital Expenditures						
Medicaid	47	32	17	17	-14	-11
Medicare	682	461	540	511	-192	-123
Outpatient ED E/M Expenditures						
Medicaid	5	4	5	1	+2	+2
Medicare	56	58	58	65	-5	0
Outpatient Physician E/M Expenditures						
Medicaid	15	8	15	7	+1	-9
Medicare	62	42	65	55	-11	-8
Nursing facility Expenditures						
Medicaid	433	161	480	254	+205	-6
Medicare	199	119	193	152	+167	-15
Home Health Agency Expenditures						
Medicaid	63	42	18	13	-15	-17
Medicare	32	30	22	26	-5	-2
Home Health Agency Expenditures						
Medicaid	63	42	18	13	-15	-17
Medicare	32	30	22	26	-5	-2
DME Expenditures						
Medicaid	25	13	19	19	-12	-11
Medicare	34	22	43	39	-8	-7
Hospice Expenditures						
Medicaid	114	44	93	88	-65	-56
Medicare	137	58	114	100	-64	-54

Notes: E/M = evaluation and management; ED = Emergency department; DME = durable medical equipment. All expenditures are reported in nominal dollars. The unadjusted effect may not equal the values reported in the actual PMPM columns due to rounding. Regression-adjustments controlled for all control variables described in the Method section except subgroup.

## The LTSS Subgroup

Table 11 provides a breakdown of the Medicare and Medicaid expenditures for the LTSS subgroup. With high levels of need, the MyCare counties had total Medicare and Medicaid expenditures of \$4,770 PMPM in the before period compared to \$4,237 PMPM for the non-MyCare counties. Total expenditures increased for both the MyCare (\$4,905 PMPM) and non-MyCare counties (\$4,634 PMPM). There were increases in both Medicare and Medicaid expenditures. Evaluating the relative effect for the MyCare counties, the regression-adjustment finds that total expenditure increased less in the MyCare counties (\$146), with most of the reductions coming from Medicaid (\$358). Medicare spending increased by \$212 PMPM more in the MyCare counties relative to the non-MyCare counties in the regression-adjusted results.

In many of the service categories, results were mixed and often went in different directions. As an example, for nursing facility expenditures, the MyCare counties saw a relative regression-adjusted increase of \$270 PMPM for nursing facility services paid for by Medicare, while there was a \$314 PMPM relative decrease for nursing facility services paid for by Medicaid. On the other hand, Medicare inpatient hospital expenditures were lower (\$66 PMPM lower) but higher for Medicaid (\$15 PMPM) in MyCare counties relative to non-MyCare counties. Emergency room expenditures saw no differences between MyCare and non-MyCare counties, but lower physician care PMPM expenditures for MyCare counties (Medicare \$9, Medicaid \$10). Medicare home health care was lower for MyCare counties compared to the non-MyCare counties (\$21 PMPM), but higher for Medicaid home health care (\$76 PMPM). A large difference was found for hospice, which was \$120 PMPM higher for the MyCare counties for Medicare and \$69 PMPM higher for Medicaid.

The last part of the table reports HCBS expenditures that are typically paid for by Medicaid. These were not included in the full analysis group and CW subgroup tables. These services, such as assisted living, home care, meals, and transportation are funded through one of Ohio's Medicaid waivers, (PASSPORT, the Assisted Living Waiver Program, or the Ohio Home Care Waiver) in the non-MyCare counties, or as part of the MyCare waiver. Only LTSS individuals are eligible for these services. The

three largest HCBS expenditures are assisted living, home care, and home-delivered meal services. With the exception of meals, the average PMPM between the before and after periods declined in the MyCare and non-MyCare counties. For example, the average PMPM for assisted living services went from \$80 to \$35 PMPM in the MyCare counties and from \$73 to \$63 in the non-MyCare counties. On a regression-adjusted basis, assisted living (\$34), transportation (\$9), home care (\$7), and adult day services (\$5), had lower PMPM expenditures in the after period for the MyCare counties compared to non-MyCare counties. Waiver nursing services were \$8 PMPM higher for the MyCare counties (mostly due to the decline in waiver nursing services in non-MyCare counties). Overall expenditures on HCBS services were \$47 lower for the MyCare counties in comparison to the non-MyCare counties.

## **SERVICE UTILIZATION COMPARISONS BETWEEN DUALY ELIGIBLES IN MYCARE AND NON-MYCARE COUNTIES**

To supplement the expenditure analysis, service utilization is examined to determine if the differences in expenditures are driven by changes in the quantity of services provided to each member or through some other mechanism. The utilization measure is defined as having a billed claim for the services in the month. Similar to the expenditure analysis, unadjusted utilization rates are reported for the MyCare and non-MyCare counties for the before and after periods. Unadjusted and regression-adjusted difference-in-differences effects were also calculated. Positive values indicate that relative service utilization increased in the MyCare counties relative to the non-MyCare counties, whereas negative values indicate a relative decrease in utilization. The use data support the expenditure findings.

**Table 11. Average Per Member Per Month (PDPM) Expenditures for Medicare and Medicaid in Nominal Dollars: LTSS Subgroup**

Expenditure Type (dollars)	Actual PDPM Expenditures (\$)				Effect of MyCare Intervention Identified by Difference-in-Differences Analysis (Negative Values Indicate Counties are Lower)	
	MyCare Counties		Non-MyCare Counties		Unadjusted	Regression-Adjusted
	Before Period	After Period	Before Period	After Period		
Total Expenditures	4,770	4,905	4,237	4,634	-262	-146
Medicaid	2,883	2,747	2,517	2,715	-333	-358
Medicare	1,887	2,157	1,720	1,919	+72	+212
Inpatient Hospital Expenditures						
Medicaid	31	44	15	17	+12	+15
Medicare	685	613	598	661	-135	-66
Outpatient ED E/M Expenditures						
Medicaid	3	3	3	1	+3	+3
Medicare	51	58	62	72	-3	+3
Outpatient Physician E/M Expenditures						
Medicaid	11	5	12	5	+1	-10
Medicare	59	35	62	52	-13	-9
Nursing facility Expenditures						
Medicaid	1,708	1,694	1,500	1,749	-263	-314
Medicare	237	508	211	233	+248	+270
Home Health Agency Expenditures						
Medicaid	322	368	213	185	+73	+76
Medicare	141	108	125	125	-32	-21
DME Expenditures						
Medicaid	65	58	55	77	-29	-28
Medicare	68	50	74	60	-4	-2
Hospice Expenditures						
Medicaid	20	99	14	22	++70	+69
Medicare	68	205	50	63	+123	+120
Medicaid HCBS						
Assisted Living	80	34	73	62	-35	-34
Home Care	507	487	478	475	-17	-7
Home Meal Services	52	55	53	55	+1	+3
Adult Day Services	25	19	7	7	-6	-5
Emergency Response	10	9	11	11	-2	-2
Social Work Counseling	1	0	2	2	-1	-1
Non-Emergency Transportation	34	31	22	29	-10	-9
Waiver Nursing	17	18	16	8	+9	+8

Notes: E/M = evaluation and management; ED = Emergency department; DME = durable medical equipment; HCBS = home and community-based services; LTSS = long-term services and supports. All expenditures are reported in nominal dollars. The unadjusted effect may not equal the values reported in the actual PDPM columns due to rounding. Regression-adjustments controlled for all control variables described in the Method section except subgroup.



## Full Analysis Group Utilization Comparisons

Table 12 reports service utilization for the full analysis group. Inpatient hospital care dropped in both the MyCare and non-MyCare counties, but the MyCare counties saw a bigger change, going from 5.7% to 4.3%, compared to the non-MyCare counties which changed from 4.9% to 4.5%. The regression-adjusted difference was 0.6 percentage points lower for MyCare counties. Outpatient emergency department and physician E/M utilization, which captures whether an individual used the emergency department or physician's office (or urgent care), saw a decrease in utilization in the MyCare counties compared to remaining flat or a slight increase in the non-MyCare counties. After adjusting for individual characteristics, the utilization of the emergency department increased in the MyCare counties by 0.5 percentage points and physician visits utilization declined by 1.1 percentage points compared to the non-MyCare sample. Small changes are found for the use of home health agencies, but there is an increase in the use of hospice among the MyCare counties (3.0% to 3.8%) compared to almost no change in the non-MyCare counties. The regression-adjusted difference is 0.9 percentage points higher for the MyCare counties.

The utilization of nursing facility services decreased in both the MyCare (24.0% to 21.1%) and non-MyCare counties (25.9% to 22.4%), resulting in a regression-adjusted decline that was 1.0 percentage points larger for the MyCare counties. However, to better understand nursing facility results, nursing facility utilization further examined by whether Medicare paid for part of the stay and if Medicaid paid any portion of the room and board charge in the month. This could result in some double counting if Medicaid covered the copayment associated with a Medicare post-acute care stay. The MyCare counties saw an increase in the use of Medicare-paid nursing facility care (4.3% to 7.2%) compared to a decline in the non-MyCare counties (4.8% to 3.8%). The net regression-adjusted effect is an increase in the MyCare counties of 4.0 percentage points. This is in contrast to the Medicaid paid nursing services, which saw declines in both samples, with the regression-adjusted results finding larger declines in utilization in the MyCare counties (2.7 percentage points).

**Table 12. Monthly Proportion of Dually Eligibles Using Various Services: Full Analysis Group**

	Proportion Billed for Service (%)				Effect of MyCare Intervention Identified by Difference-in-Differences Analysis (Negative Values Indicate Counties are Lower)	
	MyCare Counties		Non-MyCare Counties		Unadjusted	Regression-Adjusted
Service Type	Before Period	After Period	Before Period	After Period		
Inpatient Hospital	5.7	4.3	4.9	4.5	-1.0	-0.6
Outpatient ED E/M	11.3	10.7	11.4	11.2	-0.4	+0.5
Outpatient Physician E/M	39.7	38.4	42.4	43.9	-2.9	-1.1
Nursing Facility Services	24.0	21.1	25.9	22.4	+0.6	-1.0
Medicaid	21.2	15.3	23.1	19.6	-2.4	-2.7
Medicare	4.3	7.2	4.8	3.8	+4.0	+4.0
Home Health Agency	14.5	14.8	11.9	11.3	+0.9	-0.2
Hospice	3.0	3.8	2.5	2.4	+0.9	+0.9

Notes: E/M = evaluation and management; ED = Emergency department; Utilization is defined as having a paid claim for the services by Medicare or Medicaid (except in the case of Medicare and Medicaid nursing facility services) in the person-month. Regression-adjusted results account for controls listed in the methods section.

## Community Well Subgroup Utilization Comparisons

Data for the CW subgroup are presented in Table 13. Similar to the full analysis group, the regression-adjusted utilization rates among MyCare counties were lower for the inpatient hospital use and outpatient physician E/M services, and higher for outpatient emergency department utilization. Unlike the full analysis group, which saw increased Medicare nursing facility utilization in the MyCare counties, the use of nursing facilities declined between the before and after periods for any nursing facility use and those paid for by Medicare or Medicaid in both the MyCare and non-MyCare counties. The regression-adjusted results find relative increases in the use of nursing facilities in the MyCare counties, but the overall size of the effects are small. The CW subgroup also saw declines in the use of hospice.

**Table 13. Monthly Proportion of Dually Eligibles Using Services: Community Well Subgroup**

	Proportion Billed for Service (%)				Effect of MyCare Intervention Identified by Difference-in-Differences Analysis (Negative Values Indicate Counties are Lower)	
	MyCare Counties		Non-MyCare Counties		Unadjusted	Regression-Adjusted
Service Type	Before Period	After Period	Before Period	After Period		
Inpatient Hospital	5.4	3.7	4.4	3.8	-1.2	-0.7
Outpatient ED E/M	11.9	11.1	11.6	11.1	-0.3	+0.6
Outpatient Physician E/M	42.1	42.6	44.1	46.6	-2.1	-1.3
Nursing Facility Services	13.2	5.3	15.2	8.1	-0.8	+0.5
Medicaid	10.6	3.5	12.6	5.9	-0.4	+0.5
Medicare	3.8	2.2	4.2	2.9	-0.2	+0.2
Home Health Agency	6.9	5.8	3.0	2.7	-0.8	-0.8
Hospice	3.5	1.9	3.0	2.7	-1.2	-1.0

Notes: E/M = evaluation and management; ED = Emergency department; Utilization is defined as having a paid claim for the services by Medicare or Medicaid (except in the case of Medicare and Medicaid nursing facility services) in the person-month. Regression-adjusted results account for controls listed in the methods section.

## LTSS Subgroup Utilization Comparisons

The service utilization findings for the LTSS subgroup are shown in Table 14. In line with the expenditure findings, the nursing facility use patterns present a mixed picture. The MyCare counties saw declines in inpatient utilization (6.2% to 5.2%) while the non-MyCare counties stayed relatively flat (5.8% to 5.7%), with a regression-adjusted relative decline in utilization of 0.3 percentage points for the MyCare counties. The utilization of the outpatient emergency department and physician services followed similar trends to the full analysis group. There is little change in the use of home health agencies, while the use of hospice services increased significantly in the MyCare counties. The use of hospice in the MyCare counties increased from 2.1% to 6.6%, compared to 1.6% to 2.0% in the non-MyCare counties. The regression-adjusted relative increase in the MyCare counties comes to 4.1 percentage points.

In the LTSS subgroup, the overall use of nursing facilities remains relatively flat in the MyCare counties (44%), though the non-MyCare counties experienced an increase (42.2% to 45%). The regression-adjusted effect finds MyCare counties relative change in utilization to non-MyCare counties is 3.3 percentage points lower. The results for nursing facility utilization vary by payer. MyCare counties saw significant increases in Medicare nursing facility use (5.2% to 14.6%) compared to a decline in non-MyCare counties (5.8% to 5.2%), with a regression-adjusted relative difference of 10.3 percentage points. In contrast, Medicaid nursing facility utilization declined in the MyCare counties (41.6% to 35.5%) and increased in the non-MyCare counties (39.3% to 41.8%). The regression-adjustment finds that MyCare counties had an 8.0 percentage point relative decline in Medicaid nursing facility utilization.

A review of the array of Medicaid HCBS finds consistently lower utilization associated with MyCare counties relative to the non-MyCare counties for the regression-adjusted effects, except for waiver nursing. While there were relative decreases in the MyCare counties, these effects may be impacted by the fact that many of the individuals in the LTSS subgroup were in nursing facilities. The next analysis examines the utilization of Medicaid HCBS in the LTSS subgroup for individuals that did not utilize a nursing facility in that month to get a better understanding of the HCBS utilization patterns.

<b>Table 14. Monthly Proportion of Dually Eligibles Using Services: LTSS Subgroup</b>						
	<b>Proportion Billed for Service (%)</b>				<b>Effect of MyCare Intervention Identified by Difference-in-Differences Analysis (Negative Values Indicate Counties are Lower)</b>	
	<b>MyCare Counties</b>		<b>Non-MyCare Counties</b>		<b>Unadjusted</b>	<b>Regression-Adjusted</b>
<b>Service Type</b>	<b>Before Period</b>	<b>After Period</b>	<b>Before Period</b>	<b>After Period</b>		
Inpatient Hospital	6.2	5.2	5.8	5.7	-0.9	-0.3
Outpatient ED E/M	10.1	10.2	11.0	11.4	-0.3	+0.6
Outpatient Physician E/M	35.2	32.2	39.8	39.7	-3.0	-1.1
Nursing Facility Services	44.4	44.7	42.2	45.0	-2.5	-3.3
Medicaid	41.6	35.5	39.3	41.8	-8.5	-8.0
Medicare	5.2	14.6	5.8	5.2	+10.0	+10.3
Home Health Agency	28.9	28.3	25.6	24.9	+0.1	+1.0
Hospice	2.1	6.6	1.6	2.0	+4.1	+4.2
<b>Medicaid HCBS</b>						
Assisted Living	5.3	3.3	4.7	4.3	-1.6	-1.6
Home Care	45.4	35.4	49.3	45.3	-6.0	-5.0
Home Meals Services	25.8	24.2	27.8	28.7	-2.4	-1.6
Adult Day Services	3.8	3.0	0.9	0.9	-0.7	-0.6
Emergency Response	34.0	30.3	36.5	38.0	-5.2	-4.1
Social Work Counseling	0.9	0.5	1.4	1.2	-0.3	-0.2
Non-Emergency Transportation	14.9	14.3	10.9	16.4	-6.0	-5.2
Waiver Nursing	1.5	1.8	1.6	0.7	+1.1	+1.1
Any Home Care Service	53.7	52.0	56.3	59.3	-4.6	-3.2

Notes: E/M = evaluation and management; ED = Emergency department; HCBS = home and community-based services; LTSS = long-term services and supports; Utilization is defined as having a paid claim for the services by Medicare or Medicaid (except in the case of Medicare and Medicaid nursing facility services and Medicaid HCBS) in the person-month. Regression-adjusted results account for controls listed in the methods section.

## **MEDICAID HCBS UTILIZATION COMPARISONS FOR LTSS INDIVIDUALS NOT IN A NURSING FACILITY**

This section presents the Medicaid HCBS utilization for LTSS subgroup members who were not in a nursing facility during the month (referred to in the process evaluation report as LTSS waiver). In both the MyCare and non-MyCare counties, utilization of assisted living services decreased, but the regression-adjusted decrease in the MyCare counties was larger (3.4 percentage points). For all home care services, there is generally a decrease in utilization in the MyCare counties, with the only exception being waiver nursing. In the non-MyCare counties, two services saw increases in utilization:

home meal services, and emergency response. Most other services remained relative flat or declined slightly.

Of particular interest is the use of any home care service. LTSS subgroup members not in a nursing facility saw a decrease in the use of any home care service (90.3% vs. 79.1%) in MyCare counties. In contrast, the use of any home care service remained relatively flat for non-MyCare counties (91.7% vs. 91.2%). The regression-adjusted relative difference is a 12.8 percentage point reduction in the MyCare counties. This might suggest that MyCare is cutting HCBS services, but there is also a 3.6 percentage point regression-adjusted relative increase in the use of hospice in the MyCare counties, which does provide some home care services.

<b>Table 15. Monthly Proportion of Sample Using Medicaid HCBS: LTSS Subgroup Not Using a Nursing facility</b>						
Service Type	Proportion Billed for Service (%)				Effect of MyCare Intervention Identified by Difference-in-Differences Analysis (Negative Values Indicate MyCare is Lower)	
	MyCare Counties		Non-MyCare Counties		Unadjusted	Regression-Adjusted
	Before Period	After Period	Before Period	After Period		
<b>HCBS Services</b>						
Assisted Living	8.1	4.6	7.2	6.6	-2.9	-3.4
Home Care	79.0	62.1	82.7	79.8	-14.0	-9.4
Home Meals Services	45.1	42.5	46.7	50.5	-6.4	-5.2
Adult Day Services	6.5	5.2	1.4	1.5	-1.3	-1.4
Emergency Response	58.6	51.6	60.6	66.2	-12.6	-10.9
Social Work Counseling	1.7	0.9	2.4	2.2	-0.6	-0.5
Non-Emergency Transportation	22.6	13.2	15.2	14.8	-9.1	-8.4
Waiver Nursing	2.7	3.1	2.7	1.2	+1.9	+1.9
Any Home Care Service	90.3	79.1	91.7	91.2	-10.7	-12.8
Hospice	2.5	6.9	1.9	2.4	+3.9	+3.6

Notes: HCBS = home and community-based services; LTSS = long-term services and supports Utilization is defined as having a paid claim for the services by Medicare or Medicaid for hospice and Medicaid for HCBS services in the person-month. Regression-adjusted results account for controls listed in the methods section.

## **ANALYSIS OF OPT-IN AND OPT-OUT MYCARE MEMBERS**

One of the challenges faced in evaluating the MyCare demonstration is that currently four in ten members opt-out of the Medicare portion of the integrated care model. As described in the companion process evaluation, care managers working in the contracted AAAs and in the MyCare plans discussed the difficulties associated with only managing Medicaid services. It is more difficult to manage and coordinate services when your organization is not the payer. This means that a sizable proportion of members do not receive the full MyCare intervention of integrating Medicare and Medicaid.

Table 16 presents a comparison of the opt-in and opt-out members enrolled in MyCare in the after period. The proportion of this sample that is LTSS is 39.5% among opt-in and 60.8% among opt-out members. This is consistent with findings reported in Table 6, which showed opt-out rates to be higher among those with LTSS, but highest among those with LTSS and staying in a nursing facility. Another indicator of a higher need for long-term services was that the opt-out members generally had greater prevalence of medical diagnoses associated with disability. For example, the opt-out members had higher prevalence of impaired mobility (12.1% vs. 8.1%), a diagnosis associated with impairment (5.9% vs. 4.1%) and dementia (30.4% vs. 24.0%) than the opt-in members. Opt-out members are older and more likely to be white.

Given these differences, it was expected that opt-in members would have lower expenditures than opt-out members. This is indeed the case, with opt-in members recording total Medicare and Medicaid expenditure of \$2,470 PMPM, compared to \$3,807 PMPM for the opt-out group. This pattern is also found for the CW and LTSS subgroups.

While we recognize that it is more difficult to impact service use for the opt-out members, the Medicare choice requirement will not likely change given the rules of the program. Programmatically it is important to consider the effects on all individuals enrolled in MyCare, both opt-ins and opt outs. Because our pre-post design compares all dual eligible individuals in the MyCare and non-MyCare counties, our analysis is based on the full analysis group and reflects an intent-to-treat research design.

<b>Table 16. Select Characteristics of Dually Eligibles Enrolled in the Medicaid-Side of MyCare During the After Period: Opt-in Versus Opt-out of Medicare</b>		
<b>Characteristics</b>	<b>Enrolled in MyCare</b>	
	<b>Opt-in Medicare</b>	<b>Opt-out Medicare</b>
<b>Subgroup</b>		
LTSS (%)	39.5	60.8
<b>Demographics</b>		
Age (mean)	62.8	67.0
Female (%)	64.0	67.7
Married (%)	14.4	16.1
BIPOC Race/ethnicity (%)	41.8	33.0
<b>Disability</b>		
Impaired vision (%)	1.3	1.6
Impaired hearing (%)	5.8	7.0
Impaired mobility (%)	8.1	12.1
Disease associated w/ impairment (%)	4.1	5.9
Dementia (%)	24.0	30.4
<b>Health Conditions</b>		
Diabetes (%)	34.0	38.5
Stroke/TIA (%)	7.7	10.4
Obesity (%)	22.3	23.6
Arthritis (%)	35.5	42.7
Tobacco use (%)	24.8	19.3
Chronic pain (%)	28.0	30.2
Number of Heart Conditions	1.6	1.8
<b>Behavioral Health Conditions</b>		
Severe Mental Illness (%)	19.6	21.1
Depression (%)	31.4	35.5
Anxiety (%)	26.4	31.3
PTSD (%)	3.8	3.8
<b>Expenditures</b>		
Total Expenditures (\$)	2,470	3,807
Total Medicaid (\$)	1,113	2,032
Total Medicare (\$)	1,358	1,775

Notes: LTSS = long-term services and supports; BIPOC = Black, Indigenous, and People of Color; PTSD = post-traumatic stress disorder; TIA = transient ischemic attack. The before period is defined as 2012-April 2014 and the after period is 2015 through 2018.



## SUMMARY OF FINDINGS

This evaluation provides Ohio with its first comprehensive study of the MyCare Demonstration. In this section major study findings are summarized and issues for policy and practice are discussed.

### MAJOR FINDINGS

#### Expenditures on Health and Long-Term Services

- Overall results find that dually eligible in MyCare counties had higher unadjusted total Medicare and Medicaid expenditures relative to individuals in the non-MyCare counties in the years before the implementation of MyCare, for the full analysis group as well as for the CW and LTSS subgroups. After the implementation of MyCare, the unadjusted total Medicare and Medicaid expenditures in MyCare and non-MyCare counties were similar, though the MyCare counties had lower Medicare and Medicaid expenditures in the CW subgroup and higher expenditures in the LTSS subgroup.
- For the full analysis group, on a per person basis, total Medicare and Medicaid adjusted expenditures were \$274 per month lower in MyCare counties **compared** to the non-MyCare counties after the implementation of MyCare, with \$78 attributed to Medicare and \$196 to Medicaid.
- For the CW subgroup, the total Medicare and Medicaid adjusted expenditures were \$318 per month lower for MyCare counties in **comparison** to the non-MyCare counties after the implementation of MyCare. Medicare monthly expenditures were \$85 lower, and Medicaid \$233 lower compared to the non-MyCare counties.
- For the LTSS subgroup, total adjusted expenditures were \$146 per month lower for the MyCare counties **compared** to the non-MyCare counties, but the results for Medicare (\$212 higher for MyCare) and for Medicaid (\$358 lower for MyCare) when compared to the non-MyCare counties were mixed.

- Expenditures in this study represent money paid to providers. The differences in expenditures for the MyCare and non-MyCare counties does not mean that the state spent less money on dually eligible individuals in MyCare counties. To compare actual state costs, the capitated rate for MyCare members, plus any carve-out expenditures, would need to be compared to the service and administrative expenditures for the non-MyCare counties. That comparison was outside of the scope of this study.

### **Service Use and Level of Care**

- The proportion of individuals in MyCare counties that were categorized as LTSS increased from 34.6% before the implementation of the MyCare program to 40.2% after the implementation of MyCare. In non-MyCare counties for the same period, the proportion of LTSS individuals was nearly flat (39.5% vs 38.8%). The MyCare counties saw a 5.3 percentage point increase in the LTSS population after accounting for differences in individual characteristics, which represents a 16% increase in the proportion of LTSS individuals in the MyCare counties.
- For the full analysis group, and both the CW and LTSS subgroups, when compared to non-MyCare counties, MyCare counties had lower inpatient hospital use after the implementation of MyCare, which accounted for a sizable portion of the expenditure differences described earlier (10.5% lower use).
- After the implementation of MyCare, the LTSS subgroup in MyCare counties saw lower Medicaid-supported nursing facility use (by 8 percentage points, a 19% increase), but higher Medicare nursing facility use (by 10.3 percentage points, a 198% increase).
- The implementation of MyCare is associated with a large increase in the use of hospice in the LTSS subgroup compared to the non-MyCare sample, increasing from 2.1% to 6.6% and recording a 200% (4.2 percentage point) regression-adjusted increase. For the LTSS subgroup not using a nursing facility, hospice use increased from 2.5% to 6.9% and had a regression adjusted increase of 144% (3.6 percentage points).

- For the LTSS subgroup who did not reside in nursing facilities, the service use analysis found reductions in an array of home and HCBS for the MyCare counties compared to the non-MyCare counties after the implementation of MyCare. These included: assisted living (56%), transportation (53%), adult day care (33%), emergency response (19%), home care (13%), and home delivered meals (12%).
- One in five MyCare LTSS subgroup members (21%) not residing in a nursing facility did not have HCBS expenditures after the implementation of MyCare, compared to the non-MyCare counties proportion of 9%. However, the hospice use for the MyCare counties was substantially higher (6.9% for MyCare vs. 2.4% for non-MyCare counties) and hospice does provide some in-home services.

## Implementation Results

- While the impact analysis was not able to analyze findings by plan, the process evaluation did identify variation in MyCare implementation. Two of the MCOPs (CareSource and Aetna) use a fully-delegated care management model, where one care manager employed by the contracted AAA is responsible for all the member's MyCare services. The other three plans employed a waiver service coordination model in which an MCOP care manager coordinates medical and behavioral health services, and a AAA waiver service coordinator coordinates HCBS services. There is also variation by plan in the processes and personnel configurations used to address transitions between care settings and care management for members with behavioral health needs.
- Four in ten MyCare members opted out of the Medicare Advantage component of the demonstration, and AAA and MCOP interview respondents reported that this makes it more difficult to coordinate services across the Medicare and Medicaid programs. Process interviews also revealed that there is significant confusion among members and their families regarding opt-in/opt-out status and that members may be making the choice to opt-out without full understanding of the implications. LTSS MyCare members reported that they had been actively counseled to opt-out by health care providers, particularly physicians.

- Almost half of MyCare members are under age 65 and many have behavioral health needs, including severe mental illness (21%), depression (33%) anxiety (24%) and PTSD (2.5%). This was unanticipated at the outset of the demonstration and interview respondents reported that these members have a considerable impact on program operations, requiring more intensive and time-consuming care management; initial and ongoing education on behavioral health issues for care management staff; and knowledge of, and close coordination with, community behavioral health service providers.
- MCOP interview respondents were consistently positive about the benefits that MyCare affords to CW members, particularly care management and incentives for taking preventative health actions such as routine screenings and immunizations. Impact findings suggest comparative expenditure reductions for these individuals.
- Medicare hospice coverage is a “carve-out” service in the three-way contract between ODM, CMS, and the MyCare Ohio plans. This means that hospice is paid for outside of the plan’s Medicare and Medicaid capitated rates and this could be a factor explaining the increase in hospice use rates for MyCare opt-in members.

## THE PATH FORWARD

The impact on expenditures of the MyCare CW subgroup for both Medicare and Medicaid is consistent with the earlier RTI study results limited to Medicare. The findings on the CW subgroup are consistent with process analysis results, which reported the importance of care management coordination activities with CW members. Interview respondents consistently mentioned that many of those individuals easily fell through the cracks in the pre-MyCare system. Descriptive data showed that the CW MyCare sample members are a vulnerable population, and it appears that being able to direct resources to coordinate and monitor services and conditions influences utilization and expenditures. As ODM considers revisions to MyCare, it is important to recognize the vulnerability of the CW subgroup and the importance of coordinating care for these individuals. In particular, the high proportion of CW members with behavioral health

needs indicates the importance of coordinated care management activities to make sure that these individuals have access to needed services.

Results for the LTSS subgroup are a bit more difficult to interpret. Individuals in MyCare counties experienced reductions in overall costs relative to non-MyCare counties, driven by a drop in hospital use and Medicaid-supported nursing facility use. The drop in in-patient hospital use is an important finding and efforts to understand how this outcome was achieved could have implications for future practice and policy decisions. However, Medicare nursing facility use and Medicare hospice use increased for the MyCare sample. Because hospice coverage was carved-out of the initial three-way agreement, the 200% increase among LTSS individuals requires further study. This increase occurred for both nursing facility residents and HCBS recipients. Additionally, the 16% increase in the number of individuals classified as needing LTSS in the MyCare counties requires further review to better understand what is driving differences in the MyCare and non-MyCare counties. Some of this increase in LTSS can be tied to the hospice carve-out. Individuals classified as LTSS in MyCare counties received fewer HCBS services and one-in five sample members residing in the community did not receive any HCBS, although some received in-home care through hospice. More study of the home care service use within the LTSS community sample to better understand these utilization patterns would be an important quality review.

As the Department of Medicaid moves forward with their review of MyCare, the evaluation has identified a number of areas for further exploration. In this section we identify those areas.

- Given the implementation variations across MyCare, a breakdown of results by plan, region, or MCOP model would be important to better understand the impacts of the demonstration.
- A more detailed analysis by age, type of diagnosis, subgroup, level of functional ability, and long-term services setting would assist in better understanding demonstration outcomes. The high proportion of individual below age 65 and even below age 45 indicates that there are two very different populations being served in MyCare and a better understanding of these groups is important.

- The high proportion of MyCare members with behavioral health needs documented in the data analysis and reinforced in the process evaluation requires further attention from a program design perspective. As with the age question raised above, these findings indicate that MyCare serves an array of individuals with very different needs and circumstances and program design needs to reflect those differences.
- Examination of the impact on quality of life and quality of care of individuals in the MyCare and non-MyCare counties is necessary to gain a better understanding of demonstration impacts. While the process evaluation did include interviews with a small sample of MyCare members, it did not include large-scale direct data collection with MyCare and non-MyCare members.
- A mechanism to review and interpret MyCare plan findings needs to be incorporated into ongoing practice. Specific findings, such as increase in LTSS, high use of hospice, and lower use of HCBS in MyCare counties should be systematically reviewed on a regular basis.
- Given the increasing proportion of MyCare members opting out of the Medicare component of the demonstration, a careful look at program design is important. In particular, the root cause and impact of the high opt-out rate for the individuals who are LTSS needs to be reviewed, particularly those who are long-term nursing facility residents.
- Continued review of the MyCare impact on providers will be important. Process interviews identified high administrative burden for providers and a number of instances where providers reported delayed payments or denied payments.
- The mixed nursing facility impact results require further examination. Is this finding related to how the plans report nursing facility use or is the result driven by a change in practice?
- A “cost to the state analysis” should be completed to assess how the demonstration impacts overall state expenditures for dual eligible beneficiaries.

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