



# **Care Managing Together:**

A Review of the Aetna and Area Agency on Aging  
MyCare Partnership in Ohio

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## EXECUTIVE SUMMARY

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. In response to these concerns, the Ohio Department of Medicaid (ODM) developed and implemented the MyCare Demonstration. MyCare was implemented in partnership with five health plans across the major urban areas of the state. ODM mandated that the health plans contract with the Area Agencies on Aging to continue their care management role as part of the home- and community-based services (HCBS) waiver program. However, each of the health plans were free to develop their own specific model of care management. Aetna and one other health plan of the five, used a unified care management model, where the care manager was responsible for all services delivered under the plan authority, both acute and long-term services.

Unfortunately, a lack of data about the implementation experience means it is impossible to assess whether differences in plan approaches had an impact on participants. The recently released evaluation by RTI of the Ohio MyCare program does not show results by plan or region and does not describe model variation by plan. This study is designed as a first step in gaining a better understanding of the care management plan models used in Ohio, focusing on the Aetna model being implemented in three regions of the state in partnership with three area agencies on aging (AAA).

To examine the Aetna model this evaluation uses both quantitative and qualitative methodological approaches. The quantitative study reviews the characteristics of Aetna MyCare participants and the use of long-term nursing home placement. The qualitative component of the study engaged more than 60 respondents through individual interviews and focus groups with key personnel employed by Aetna, the AAAs, and providers who work within the MyCare system. The purpose of the interviews was to understand and describe Aetna's unified care management model and to identify challenges, strengths, and areas for improvement.

All three of Aetna's Ohio regions utilize the unified care management model, designed to be a "one-stop shop" with care managers (CMs) serving as the primary point of contact for members. The care management staff were employed by the regional Area Agency on Aging, but were accountable to Aetna through a contractual relationship between the two organizations. Care managers have telephone and face-to-face contact with members, conduct assessments of member needs and services, and set up service providers. They monitor and respond to significant changes in members'



physical and cognitive abilities and make revisions to care plans and services as necessary to meet their health and psychosocial needs. CMs also are responsible for coordinating and monitoring member interactions with their community and inpatient health care providers. They are expected to follow members as they move through the continuum of care and assist them along the way with understanding and accessing their Aetna health benefits.

## **STUDY RECOMMENDATIONS**

This study represents a first step in understanding the processes involved in a managed care/care management model. Aetna and AAA staff and providers identified a number of benefits that are gained through the unified model. However, none of the existing research efforts have examined outcomes of the individual health plan models implemented across the state. It is critical for both Aetna and the state of Ohio to better understand the impacts of each care management model in such areas as member health and long-term services costs, program length of stay, use of nursing homes and hospitals, long-term services use, plan satisfaction, and survivorship. As we strive to make the health and long-term services system more effective, generating evidence-based data for innovations, such as the Aetna/AAA unified care management model, will be critical.

### **High involvement and communication**

The acute care and long-term services systems have dramatically different models and cultures. The Aetna MyCare model has shown that the two worlds can be unified under a common mission of serving members. The conviction of staff to provide quality service to members came through in our interviews with both Aetna and the AAA's. A priority of this partnership should be to engage those who have the most direct contact with members when making decisions and determining processes. AAA administrative staff expressed a desire to be more involved in developing procedures in response to state directives. In a unified model, open communication between entities and between different levels of staff needs to be an ongoing and never ending priority.

### **Intentional strategies for building behavioral health competencies**

The higher proportion of members with behavioral health challenges represents a change to AAA culture. Aetna's BH liaisons offer significant support to CMs as they work with individuals experiencing BH conditions. BH training is needed to help CMs gain more comfort and skill in working with members who have BH needs. The increased prevalence in BH conditions, and the wide range of member ages and circumstances within CM caseloads presents significant challenges to the MyCare model.

### **Unified data management systems**

Ensuring that all parties have access to good data to make the right decisions is always a challenge in health and long-term services organizations. Given the fluidity of both the health and long-term services systems, having timely and easily accessible information for CMs and staff at both organizations is now essential. Although efforts have been made to modify current systems and create solutions, development of a user friendly system that houses all the information needed by CMs and supervisors must be a core requirement of future data management systems.

### **Prioritized attention to home care shortages**

The current home care worker shortages are dramatic and could undermine the state's efforts of ensuring that individuals with disability can get services in the setting of their choice. These shortages are both a state and national problem and addressing it will require significant re-evaluation of current strategies and structures. AAA administrators shared that they are exploring solutions, but they will need the full and immediate support of Aetna and the state of Ohio.

### **Engagement of primary care physicians**

The Aetna/AAA model has dedicated considerable efforts to improve the involvement of and communication with the primary care physician. Despite these efforts, the cooperation has been mixed. While in some instances communication has been vastly improved, this area continues to present a challenge. Given the importance of the primary care physician in the lives of many of the Aetna MyCare members, figuring out how to better integrate physicians into the model is also critical to overall success.

## BACKGROUND

The expansion of managed long-term services has generated considerable interest over the last decade. More than 20 states are testing or exploring some type of managed long-term services system. Some states, such as Ohio, have implemented an integrated care program now being tested, while others have focused primarily on the Medicaid population with an opportunity to enroll members in a complementary Medicare Advantage plan, when possible. States 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.

In response to these concerns, the Ohio Department of Medicaid (ODM) developed and implemented the MyCare Demonstration. With approval from the Centers for Medicare and Medicaid Services (CMS), MyCare was implemented in partnership with five health plans across the major urban areas of the state. Health plans were allowed to bid on regions and Aetna became one of two providers in three regions in Ohio; central, southwest, and northwest (Columbus, Cincinnati, Toledo). The overall demonstration began in May 2014 and serves individuals who are eligible for both Medicare and Medicaid, with the program covering about 60% of those who are dually eligible in the state (115,000 Ohioans).<sup>1</sup> MyCare covers two distinct populations; individuals with severe disability who reside in a home or apartment community setting, in an assisted living residence (AL), or in a skilled nursing facility (SNF) and individuals with little or no disability who reside in the community. MyCare members with severe disability can receive in-home or AL waiver services and are assisted by care managers working in partnership with the health plans. It is these individuals with severe disability who will be the focus of this report. Prior to the MyCare demonstration, home and community-based services to individuals with physical and cognitive disabilities were provided through three separate waivers; PASSPORT (60 plus), Assisted Living Medicaid waiver (all ages in assisted living), and the Ohio Home care waiver (below age 60). After the beginning of the demonstration these programs continued in non-MyCare counties and for individuals eligible for Medicaid only.

Studies on the impact of efforts to integrate acute 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>2</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 2000's also found mixed results, including studies in Minnesota, Wisconsin, and Massachusetts. For example, an evaluation of Minnesota's MSHO program found reductions in hospital stays but no change in nursing home use.<sup>3</sup> Mixed results were also found in a recent study by Mathematica on Medicaid managed long-term services and supports (LTSS), reporting New York significantly lowering the rate of nursing home placement for managed care participants, and Tennessee not showing a statistically significant difference.<sup>4</sup> A newly released national 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>5</sup> However, impacts for MyCare 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>6</sup> The study also found an array of implementation problems during the early years of the demonstration.

Compounding the mixed results of these initial studies is the limited information about the care management models implemented. In fact, while a review of the five 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. The RTI analysis does not show results by plan or region and does not describe model variation by plan. Our study is designed as a first step in gaining a better understanding of the care management plan models being implemented in Ohio, focusing on the Aetna model being implemented in three regions of the state in partnership with three AAAs. Because of the growing interest in Medicaid managed long-term services and the recent expansion legislation which now allows Medicare Advantage plans to incorporate an array of community-based services into its benefit package, a review of the Aetna partnership model is quite timely.

## **STUDY APPROACH**

To examine the Aetna model being implemented in Ohio, this evaluation uses both quantitative and qualitative methodological approaches. The quantitative study reviews the characteristics of Aetna MyCare participants and compares them to a statewide sample of HCBS participants in non-MyCare counties. We also examined the length of stay in the community setting for MyCare members and the reasons for leaving the HCBS setting. A data file on Aetna MyCare members participating in the Integrated Care Delivery System (ICDS) Demonstration was provided to the research team by

Aetna for the analysis. Data received covered the time period from July 2014 to January 2018, with each enrollee followed for a 15 month time period.

The qualitative component of the study involved individual interviews and focus groups with more than 60 individuals employed by Aetna, the AAAs, and providers who work within the MyCare system. The purpose of the interviews was to understand and describe Aetna's integrated care management model and to identify challenges, strengths, and areas for improvement. To identify key personnel, the researchers conducted preliminary key informant interviews with Aetna and AAA administration. Providers were identified by either AAA administrative or care management staff. Individual interviews were conducted primarily in-person between November 2018 to January 2019. Focus groups occurred at three AAAs (Council on Aging in Aetna's southwest region, Central Ohio Area Agency on Aging in Aetna's central region, and Administration on Aging in Aetna's northwest region). Key Aetna personnel included administrators at the Aetna Ohio Columbus office (four), regional waiver managers (three), behavioral health liaisons (three), and one ICM (community well) care management supervisor.

Key AAA staff included administrators (12), care managers (CMs) working in Aetna MyCare (29), care management supervisors (five), and care management support staff (five) across each of the three Aetna Ohio regions. Of the 29 CMs who participated in focus groups, 21 had only worked as care managers under Aetna MyCare, while eight had prior experience in PASSPORT care management prior to their current assignment. Interviews and focus groups included questions regarding length of employment, previous care management experience, care management responsibilities, requirements, caseload size and composition, communication pathways (both formal and informal) and critical points of communication between Aetna, AAAs, and providers, care management core competencies, data sharing, technology platforms, care transitions between home, long-term, and acute care settings, efficiencies and inefficiencies within the model/system. CMs with prior PASSPORT experience were asked to identify differences between PASSPORT and Aetna's integrated case management.

Ten providers representing hospital case management, nursing home administration, Durable Medical Equipment (DME), nutrition services, and home health participated as well. Interviews and focus groups were audio-recorded and transcribed verbatim to assist in analysis. The research team analyzed the transcripts through a process of thematic analysis in which research team members conducted multiple reviews of the transcripts and used open coding to identify, review, and then define themes within the data. Interview and focus group data management and coding were aided by Dedoose analytic software.

While comparisons between the experiences of AAA CMs in Aetna MyCare and AAA care managers working with other plans would have provided helpful insights, such comparisons were not feasible due to rules which prohibit MyCare care managers from working for more than one plan simultaneously and non-disclosure agreements that prevented care managers from other plans being interviewed for this project.

## **DESCRIPTION OF THE AETNA/AAA MODEL**

The Ohio Department of Medicaid (ODM) mandated that the health plans contract with the Area Agencies on Aging to continue to be involved in the care management role as part of the home- and community-based services (HCBS) provided in MyCare. While the health plans were free to design their own care management model, Aetna and one other health plan of the five used a unified care management model, where the CM was responsible for all services delivered under the plan authority. In the other three plans the long-term services care management function for HCBS was separated from the other plan services under the demonstration.

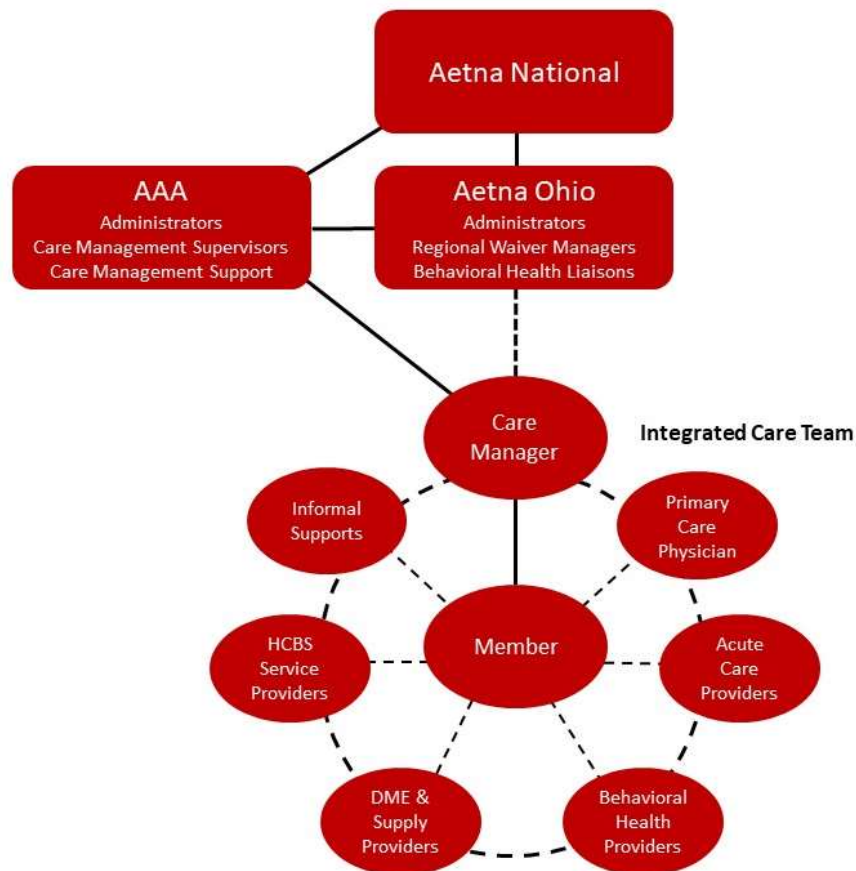
## **HOW IT WORKS**

All three of Aetna's Ohio regions utilize a unified care management model, with CMs employed by the AAAs responsible for coordinating the entire package of plan services, both acute and long-term. The role of a CM is designed to be a "one-stop shop"; they serve as the primary point of contact for members and many of their tasks overlap with what care managers do in the non-MyCare waiver programs. They have telephone and face-to-face contact with members (as dictated by the member's acuity level), conduct assessments of member needs and services, set up service providers (e.g., homemaking, personal care, home health care, home-delivered meals, transportation, home modifications, chore services, pest control), and secure durable medical equipment (e.g., walkers, wheelchairs, bedside commodes, hospital beds, lift chairs) and other supplies (e.g., incontinence, nutritional supplements). They monitor and respond to significant changes in members' physical and cognitive abilities and make revisions to care plans and services as necessary to meet their health and psychosocial needs.

The acute and behavioral health care responsibilities of the CM role are new to the AAAs. CMs are responsible for coordinating and monitoring member interactions with their community health care providers (e.g., primary care physician, behavioral health, dentist, optometrist, podiatrist, and physical, occupational, and respiratory therapy) as well as inpatient interactions (e.g., hospitals, behavioral health, skilled nursing rehabilitation facilities). They assist members with communicating, visiting, and following up with medical providers, even accompanying members to appointments, if necessary. They troubleshoot member issues with medication management and compliance. They

are expected to follow members as they move through the continuum of care and assist them along the way with understanding and accessing their Aetna health benefits. Figure 1 provides an overview of the Aetna unified care management model.

**Figure 1. Overview of Aetna Unified Care Management Model**



### *Integrating care*

Aetna's model is built upon interactions within an integrated care team which includes the member and their informal supports, the CM, the primary care physician, and other providers from whom the member receives his or her services. Within the model, there is more frequent and detailed communication with primary care physicians as an attempt to make the primary care physician a more active member of the team.

At the time of this study, there were 119 care managers in AAAs serving as Aetna MyCare CMs. The number of CMs varied by region, with the largest number working in the central region (60), followed by the southwest (37) and northwest (22) regions. The CM caseloads ranged from 53 to 92 for CMs working with community-dwelling members. For CMs serving the AL Waiver population, caseloads ranged from 54 to 100

members. CMs reported that their caseload membership is diverse with members ranging in age from 26 to 101. Program supervisory staff reported that the ideal caseload size for community dwelling members in this program would be 55-65.

### *Care manager support*

In all three AAA regions the CMs receive care management support within their agency. This support is not technically part of Aetna's model, but reflects adaptations by the AAAs to efficiently address the scope and requirements of CM responsibilities, particularly visit and contact requirements with members. AAAs reported staffing a nurse whose primary responsibility is to visit and follow-up with members after significant change events such as hospitalizations, falls, and other issues requiring immediate attention or intervention. Another support position reported by the AAAs is a dedicated assessor who visits with members within the three-day visit requirement after a new enrollment and completes the initial assessment before introducing the member to their care manager. One of the sites employed a consulting pharmacist to work with CMs.

All three AAAs reported the use of care management aides (CAs), which go by various titles (Care Manager Assistants in the northwest region, Outreach Workers in the central region, Care Coordination Specialists in the southwest region) and provide daily administrative support to CMs in a multitude of ways. They reported answering incoming phone calls and communicating with members if their CM is unavailable (e.g., in the field, ill, on vacation), sending out paperwork at the request of the CM (e.g., unable to contact letters), communicating with physician offices and hospitals (e.g., sending service plans for signature, requesting prescriptions for DME, requesting medical documentation such as discharge plans, medication lists), setting up services for members (e.g., personal care, home-delivered meals, emergency response system), keeping logs to ensure members get their services and receive the equipment they need in a timely manner; helping members find providers, assisting with the ordering of incontinence and other supplies, and linking member documentation in the Dynamo information system.

### *Care management supervision*

The care management supervisors, also employed by the AAA's, are involved with hiring and training new CMs and CAs and provide daily supervision and support to both groups. They manage the assignment of members to CMs so as to keep the caseloads balanced within the team. They offer assistance with clinical issues, providing guidance for CMs and even assisting with home visits in times of low staffing. Some supervisors identified themselves as "interpreters" in that their role requires taking Aetna directives and translating them to existing AAA policies and procedures, or writing new policies and procedures when necessary and communicating them to staff in ways that they can



understand and implement. They also reported playing a vital role in quality assurance, monitoring member emergency room visits and inpatient admissions, attending case rounds, and conducting chart reviews.

### *Behavioral health*

Behavioral health is a growing concern in Ohio and across the country. Aetna administrative staff reported that approximately 50% of their total membership has some type of diagnosed behavioral health issue, and AAA staff echoed this estimation within their CM caseloads. To address the behavioral health needs of its members, Aetna has employed behavioral health clinical liaisons (BH liaisons) in each region.

Aetna's BH liaisons are all licensed behavioral health practitioners and some have an additional certification as Licensed Independent Chemical Dependency Counselors (LICDCs). All three BH liaisons reported extensive previous clinical experience within their regions which has made them very knowledgeable about local resources and they prioritized provider outreach activities focused on maintaining their relationships with BH providers and adding new providers to Aetna's network. As part of their daily responsibilities, they review claims to ensure that members with new BH diagnoses are connected to providers and review all inpatient hospital admissions for opt-in members. In their interviews, BH liaison reported working with care management staff and helping them to assess the BH needs of members and connect them to the right resources as their primary role. They reported assisting CMs in multiple ways: locating members who they have not been able to reach (often by checking if the member has recently visited a BH provider), scheduling care team meetings at hospitals and attending those with or in place of the CM to help facilitate appropriate discharge planning and ensure that members are connected to and follow up with BH providers after discharge, and sometimes accompanying CMs on visits to members experiencing serious and complex BH issues. In addition, they staff a 24-hour crisis hotline, providing a direct resource for members.

Any staff member at any level within Aetna or the AAAs can directly contact a BH liaison. Most often, this contact comes in the form of emails and phone calls, but CMs can also submit consultation requests through the Dynamo information management system. BH liaisons regularly interact with the AAAs through case rounds, staff meetings, and monthly joint operating meetings. In two of the three regions, BH liaisons reported recently establishing office hours where they are on-site at the AAAs and available to AAA care management staff for consultation or training. However, whether or not a CM utilized them as a resource seemed to vary by individual rather than by region.

## **AETNA/AAA MYCARE INTEGRATED CARE DELIVERY SYSTEM**

### **MEMBERS**

To gain a better understanding of the Aetna/AAA partnership we looked at the characteristics of Aetna MyCare members receiving long-term services in the integrated care delivery system demonstration. Our data presented in this section cover two time periods. The first set of tables (Tables 1-3) presents a current snap shot of MyCare members and covers the time period between March and September of 2018. Tables 4 and 5 cover the time period 2015 through 2018 and are used to track members for a 15 month time period over that time frame.

As shown in Table 1, more than four in ten members were age 75 and older, but more than one-quarter were under age 65. Not unexpectedly, assisted living members were older, with 50% age 80 and above, compared to about one quarter of the home care members. Thirteen percent of the assisted living members were under 65, compared to almost 30% for the home care members. Less than 30% of ICDS members were men, with assisted living recording 23% of men as participants. Just under half of the ICDS members were non-white, but again there were big differences between home care and assisted living participants (51% vs 86% white). Finally, in looking at Aetna member distribution in Ohio, we find the central region accounting for 45% of the sample, southwest one-third, and northwest one-fifth. The southwest region did serve a higher proportion of members through assisted living (54% of all AL members).

**Table 1. Integrated Care Delivery System Member Demographic Characteristics (March – September 2018)**

	<b>Overall (%)</b>	<b>Home (%)</b>	<b>Assisted Living (%)</b>
<b>Age</b>			
Less than 60	16.9	18.1	5.5
60-64	10.9	11.3	7.8
65-69	15.1	15.7	10.3
70-74	15.8	16.1	12.6
75-79	13.6	13.6	14.1
80-84	10.7	10.3	14.6
85+	16.9	15.0	35.2
<b>Average Age</b>	<b>71.3</b>	<b>70.5</b>	<b>78.6</b>
<b>Gender</b>			
Male	27.9	28.4	22.9
Female	72.1	71.6	77.1
<b>Race</b>			
Caucasian	51.6	51.4	85.5
Black	47.7	48.4	14.5
Asian	.1	.1	
Alaskan/American Indian, Hawaiian	.1	.1	
<b>Region</b>			
Central	45.6	46.9	32.7
Northwest	20.8	21.5	13.8
Southwest	33.6	31.5	53.5
<b>Sample Size</b>	<b>4,141</b>	<b>3,743</b>	<b>398</b>

\*Some columns may not add to 100 due to rounding.

A comparison of member characteristics by region is presented in Table 2. The average age is relatively comparable by region, although central Ohio serves a higher proportion of members under age 60 (20%) and northwest serves the lowest proportion at 12%. The central Ohio region serves a higher proportion of non-white members at 54%, compared to 42% in southwest and 32% in northwest. In looking at functional status, central Ohio region members record just under three ADL impairments, northwest between two and three, and southwest at just over two. Central Ohio members recorded more falls in the last three months (26%, 23%, 20%). We have seen differences in HCBS levels of impairment by region and between the home care and assisted living participants in our previous work. In some instances such differences were attributed to variations in assessment procedures.

<b>Table 2. Integrated Care Delivery System Characteristics by Region (March – September 2018)</b>			
	<b>Central (%)</b>	<b>Northwest (%)</b>	<b>Southwest (%)</b>
<b>Age</b>			
Less Than 60	19.7	11.6	16.4
60-64	10.4	11.3	11.5
65-69	14.2	15.2	16.4
70-74	14.6	18.2	15.8
75-79	13.7	14.6	13.0
80-84	11.0	11.6	9.7
85+	16.5	17.4	17.2
<b>Average Age</b>	<b>70.7</b>	<b>72.7</b>	<b>71.2</b>
<b>Gender</b>			
Male	30.1	26.1	25.9
Female	69.9	73.9	74.1
<b>Race</b>			
Caucasian	45.9	67.6	57.9
Black	53.7	32.4	42.1
Asian	.2		
Alaskan/American Indian, Hawaiian	.2		.1
<b>Percentages with Impairment in Activities of Daily Living (ADL)</b>			
Bathing	83.0	85.5	74.8
Dressing	71.2	59.6	48.4
Mobility	34.0	24.0	23.6
Toileting	35.6	21.3	18.7
Eating	20.1	11.6	13.1
Grooming	52.8	46.4	35.5
<b>Number ADL Impairments</b>			
0	10.6	9.2	20.8
1	14.2	22.9	24.3
2	16.8	24.2	18.3
3	19.3	20.1	14.8
4 or More	39.2	23.6	22.0
<b>Average number of ADL Impairments</b>	<b>3.0</b>	<b>2.5</b>	<b>2.1</b>
<b>Dementia/Alzheimer's Disease</b>	<b>11.0</b>	<b>7.6</b>	<b>10.5</b>
<b>Fallen in Last 3 Months</b>	<b>25.9</b>	<b>22.9</b>	<b>20.3</b>
<b>Sample size</b>	<b>4,141</b>	<b>861</b>	<b>1,393</b>

In Table 3 we examine the services used by ICDS members who are receiving in-home care. Not surprisingly, given the functional impairments, four in five receive personal care assistance and are provided access to emergency response systems. More than half receive home-delivered meals. Three in ten receive specialty medical services. About 5% of members receive nursing services, adult day care, and a home modification. Chore, social work, and homemaker services are the remaining services provided, but all to a relatively small proportion of members (3.1%, 2.2%, 1.7%, respectively). The high use of personal care, emergency response systems, and home-delivered meals mirror the rates in the non-MyCare counties for HCBS and are comparable to national utilization rates as well (AARP, 2014). The higher number of participants are reflective of the overall number of HCBS participants in those regions.

**Table 3. Services Used by ICDS Aetna Members at Home**

<b>Percent Receiving Service</b>	<b>ICDS Home</b>	<b>Central</b>	<b>Northwest</b>	<b>Southwest</b>
Chore Services	3.1	3.8	2.5	2.6
Homemaker Services	1.7	.3	0	4.8
Companion Services	.1	.2	0	.2
Specialty Medical Services	31.2	28.3	31.8	35.1
Miscellaneous	1.5	1.6	2.0	1.0
Social Work Services	2.2	.3	5.2	2.8
Nutrition	.2	0.0	1.6	0.0
Home-Delivered Meals	55.4	49.4	66.3	56.7
Home Modification Services	4.8	3.7	4.5	6.5
Personal Care Services	77.2	78.1	80.0	73.9
Adult Day	4.6	5.9	2.1	4.2
Emergency Response Services	77.0	77.8	79.3	74.3
Nurse Services	5.5	4.2	2.6	9.4
<b>Sample Size</b>	<b>3,743</b>	<b>1,757</b>	<b>806</b>	<b>1,180</b>

Although the eligibility criteria for MyCare ICDS and the Medicaid waiver HCBS programs (PASSPORT and AL waiver) are universal across Ohio, because they cover different regions of the state we compare participants across the two programs. As shown in Table 4, participants are comparable on age between the two programs, with assisted living residents older than home care users in both programs (78 vs. 71). The gender balance is similar, although the Aetna members have slightly fewer males in both the home care and assisted living comparisons. Reflecting regional differences we do see large differences in race, with the Aetna programs having a much higher proportion of non-whites. As an example, almost half of the Aetna members are non-white, compared to 16% for the non-MyCare home care users. Finally, on the functional impairment activities of daily living measure, the home care program participants in the Aetna ICDS and the non-MyCare counties are similar, but the assisted living Aetna members reported lower levels of impairment. However, the Aetna group recorded higher rates of needing 24-hour supervision. Despite statewide criteria, the two programs used different measures and this could contribute to program differences.

**Table 4. Comparison of Aetna ICDS Members to Non-MyCare HCBS Participants**

LTSS HCBS	Average Age	Sex	Race	Average Impairment ADL (IADL)	Need for 24-hour Supervision*
		% Male	% White	Number	% Need
In-Home Services					
PASSPORT Home Care (Non-MyCare)	70.9	31.0	84.4	2.8	8.2
Aetna ICDS Home	70.5	28.4	51.4	2.7	8.6
Assisted Living					
AL Waiver (Non-MyCare)	78.1	26.6	94.2	2.4	16.1
Aetna ICDS AL	78.6	22.9	85.5	1.8	24.8

**Source:** PASSPORT Information Management System (PIMS). Aetna MIS

## Community transitions

One of the potential benefits of the Aetna MyCare demonstration was that the improved coordination of acute and long-term services could have an impact on participant outcomes. In Table 5 we examine whether participants continue to reside in an HCBS setting, either home care or assisted living. After 15 months, three in four home care recipients and seven in ten assisted living residents remained in the home and community-based setting. For MyCare members no longer in the community we find that for three in ten mortality was the termination reason (32% for home care, 26% for AL). Nursing home placement was also a major reason for leaving the community setting. The nursing home rates for those in AL were considerably higher (61%) compared to those in the home care program (30%). The AL termination rates to the nursing home setting are higher than expected and are consistent with previous state-wide findings. This trend could be attributable to the fact that the AL Medicaid rate has not increased since the program began in 2007, creating an incentive for AL facilities to recommend that higher care level residents, particularly those with dementia, could be better served in a skilled nursing facility. Finally, there were an array of other reasons individuals were no longer MyCare community members including losing Medicaid eligibility, moving out of the area, improvements in their functional ability, or changing health plans.

**Table 5. Rates of Community Residence for Aetna MyCare ICDS Members Over a 15 Month Time Period**

	<b>Aetna ICDS Aetna (HC)</b>	<b>Aetna ICDS Aetna (AL)</b>
Total Enrollment	3,320	296
Remain in community	2,523 (76.0%)	204 (68.9%)
Reason for Leaving Community		
Death	253 (31.7%)	24 (26.1%)
NH (30+ days)	240 (30.1)	56 (60.9%)
Other	304 (38.2%)	12 (13.0%)

\*Other— the category includes individuals who improved, moved out of the area, lost Medicaid eligibility, or withdrew from the program.

## PROCESS EVALUATION RESULTS

As noted, this study involved an extensive process evaluation of the current Aetna/AAA model. Our interviews with Aetna and AAA staff and providers identified multiple themes related to strengths of the model and to areas for improvement.

### What's working well?

Aetna and AAA staff and providers universally agreed that the main strength of Aetna's unified care management model is the ability of Aetna members to have one primary contact for all their needs, which reduces the number of people involved in their lives and coming into their homes. They reported that having one care manager who deeply knows the member and understands their needs improves members' continuity of care. They also reported reduced confusion about where the responsibility lies for certain functions, with some AAA administrative staff citing communication problems between AAA waiver service coordination staff and the other MyCare plans. Some providers also stated that they appreciate having one point of contact they can call to resolve issues, whereas with other health plans it is more difficult to know who to contact regarding service authorizations and billing.

### *Acknowledgment of complementary expertise and knowledge*

By fully partnering with the AAAs, Aetna has been able to access the wealth of knowledge and experience the AAAs have in working with individuals who require long-term services and supports. As one Aetna administrator shared,

“The biggest strength is the AAAs have been doing it, and they continue to do it, so you've got that knowledge base that I think the other plans missed out...by not taking advantage of that.”

CMs who have face-to-face interaction with members in their home environments provide a “boots on the ground” perspective to care management that both AAA and Aetna staff feel is a benefit. An AAA administrator described the strengths of CMs' relationships with their members and plans,

“I find that relationship much stronger, more effective and efficient, because our care managers have the opportunity to really work closely with the member, and the member's family or caregiver, and carve out a plan and stay with that plan to make sure things happen.”

At the same time, the AAAs reported that the partnership with Aetna has been beneficial as Aetna is able to lend their weight to helping the AAAs find resources when needed. One AAA administrator shared,



“...when I’ve said, ‘We don’t have enough resources to do something.’ They look for other resources. They look for alternatives. And they are a real partner, which I really appreciate.”

### *Opportunities for communication*

Aetna and the AAAs have established multiple opportunities for communication and collaboration and both Aetna and AAA staff made reference to this “open communication.” Better communication is something that has occurred over time and has required significant investment and work on the part of both organizations. Formal opportunities for communication exist through monthly waiver meetings and WebEx calls, joint operating meetings, and case rounds. These formal communication pathways are used as opportunities for Aetna to provide the AAAs with training related to new processes, responsibilities, and regulations as they are handed down by ODM. AAA staff reported that the meetings also provide an opportunity to talk with each other about best practices and challenges. The AAAs also expressed appreciation at being involved in Aetna’s audit process so they can respond quickly by adjusting internal processes to meet requirements.

Informal communication pathways also appear to be frequently used. AAA staff and providers across all three regions reported that Aetna is accessible to them in a way that the other plans they work with are not. Waiver managers make regular visits to the AAAs and are accessible by phone and email. Several respondents reported that communication is aided by the fact that Aetna provides personal contacts to the AAAs for multiple levels within the organization. In most cases, they have the name of someone they can contact to address a concern, rather than just sending an email to a group mailbox.

“I think it’s nice to know who the person is on the other side of the email or the phone and feel like you can call somebody up or they can call you and you can problem solve, or deal with issues together.”

“I know who I can go to if we have provider issues, or whatever. But with the other health plan we work with we don’t have a direct contact person. So we’re a kind of a step removed with the other plan than we are with Aetna. We do have a kind of a contractual obligation that we don’t have with the other plan, and that is that, we keep Aetna informed as we add providers to our network, ODA certified providers, or as providers drop off for whatever reason, contract termination, or whatever.”

The ability to communicate directly with Aetna medical directors through the case rounds process was also reported as a benefit by the AAAs. Respondents from the AAA's provided examples of how communication with a medical director helped to create and maintain service plans that take into account the overall well-being of the member. One respondent relayed an instance where Aetna approved paying a higher rate for an RN to provide personal care services in a rural area because there were no personal care services available in that area. AAA staff reported that many members who were previously on the Ohio Home Care Waiver have high care plan costs as a result of receiving 24-hour care. Case rounds discussions have provided CMs with a forum to be proactive in thinking through next steps and back-up plans in complex situations that could result in crisis for the member if their primary caregiver was suddenly unavailable (e.g., the hospitalization or death of an aging parent caregiver).

The involvement of Aetna data management/IT personnel in meetings with the AAAs has also provided an important communication opportunity. While significant challenges still exist in data sharing and technology platforms, AAA staff were complimentary of Aetna's efforts to address these challenges and improve ease of use and access for the AAAs through the case management dashboard in Dynamo and the creation of the SSRS system.

“[Aetna IT personnel] really has done a nice job of trying to listen to see what the needs are and develop good reporting mechanisms that are consistent and accurate. That part has worked well and has been nice.”

Aetna staff reported that efforts to address data sharing remain a high priority and that they are committed to continued work in this area.

### *Increased autonomy*

Both Aetna and AAA staff reported that the early phases of building their partnership were admittedly fraught with difficulties (trust issues, territorial arguments, not acknowledging each other expertise) that still exist to some degree. However, they also reported that a more trusting relationship has developed between the two organizations over time, leading to increased autonomy for the AAAs and, ultimately, improved service for members. An example of this increased autonomy frequently cited by AAA staff is the ability of CMs to authorize certain services such as personal care and home-delivered meals without additional approval from Aetna. One CA described it this way,

“There were periods where [care managers] had to ask Aetna for approval for absolutely everything...and they have really since given care managers autonomy to make those decisions within parameters which has really sped up members getting their services.”

### *Care management support*

The AAAs' use of care management support staff to help with the administrative portion of their work was reported as a key factor in the ability to be more responsive to members' concerns and to deliver more expedited service. The CAs who were interviewed expressed a strong commitment to customer service and willingness to spend extra time and go above and beyond to assist members in navigating complex issues, even making attempts to assist members in reaching Aetna personnel through member services. These CAs serve an important function for the AAAs, and for Aetna, in that they are often the first people to whom members speak if they have concerns about services or providers. Because CMs are often in the field on visits and not immediately available by telephone, CAs help ensure that members are able to speak with a live person, rather than voicemail. They also report fielding calls from providers and helping them get connected to the right department or person at Aetna when they have concerns and questions. In one region, CAs reported receiving an average of about 300 calls per week, most of those from members.

Some administrative aspects of care management are very time-intensive and the CAs interviewed described innovative methods to ensure efficiency. In one AAA region, a CA has been given responsibility for dealing with all new enrollments; assigning them to CM caseloads per zip code and ensuring that caseloads are as evenly distributed as possible. This CA also sets up the schedule for the assessor. In another AAA region, a CA has taken on coordinating the process for managing bids for home modifications. CAs reported spending a great deal of time documenting and journaling in various locations (Dynamo, AAA process logs) to keep CMs updated on their activities and to promote clear communication.

### **Areas for improvement**

Interviews with Aetna and AAA staff and providers also revealed ideas for improvement in model design or implementation.

### *Information sharing and technology*

Day-to-day process and quality assurance challenges caused by separate information systems and differential access for Aetna and AAA staff were repeatedly mentioned by both organizations during interviews and pose significant barriers to efficiency and the realization of the goals of MyCare. One AAA supervisor shared the frustration of not having access to all the information needed to effectively address the member needs across the continuum,

“If we are gonna look at a person in a holistic way, all that data needs to go into a central data system so that we can manage care.”

AAA staff reported that while Dynamo is designed to provide CMs with the information necessary to do their jobs, it is not always user-friendly or reliable (at times “glitching” and “freezing”), causing frustration and delays. Care management supervisors also expressed the need for the ability to pull out management reports more frequently and at a more detailed level. Aetna has tried to be responsive to these concerns through the creation of the SSRS system to facilitate report creation. Whether the issue is that SSRS cannot generate the desired reports, or that AAA staff at varying levels need more training on how to work within SSRS, it is clear that this is an area that requires improvement.

### *Communication surrounding changing processes and tasks*

Both Aetna and AAA staff reported frustration with the frequency of new initiatives and shifting priorities to which they must respond. One care management supervisor explained this challenge,

“So you need the care manager to really keep up with reading policies and understanding the changes, because while you’re doing one thing one week, the next week it changes. You need to be very quickly on the move, being able to adapt quickly to changes.”

This ever-changing environment presents challenges in recruiting and retaining care management staff. When turnover results in higher caseloads for CMs, the ability to incorporate additional tasks into their daily practice becomes even more of a challenge. While CMs seemed to attribute most new initiatives to Aetna, the AAA administrative staff acknowledged that Aetna is often responding to directives from ODM,

“Some of it, Aetna has no control over. ODM has an HSAG audit, and they get results back and they say, ‘Well, as a result of this one, we need to change, and here’s our focus.’ Then three months later, the results of the next audit come in and they wanna focus on a different area... There’s just a lot more hands involved in the process anymore...I do think we probably need to do a better job educating our staff so that they know what’s an ODM rule, what’s an Aetna rule, what’s an AAA rule.”

AAA staff reported that they desire more input and opportunity to assist in determining how new initiatives and training are presented/provided to AAA staff. Because they are more familiar with the daily operations of their organizations, they described being in a better position to consider how to frame and communicate the initiatives to their staff and how to best incorporate new tasks and procedures.

“We know the stress that our care management staff are under on a day-to-day basis. You get a sense and a feel for the environment or the culture that you’re working in...If we’re part of the development of the draft process, we can kinda give people a heads-up so that it's not so disruptive back in the office.”

This administrator went on to discuss the importance of including not only the AAAs in developing new procedures, but also soliciting input from staff who work directly with members.

“We might have some really good ideas, and I’d like to involve the care managers. The care managers, they’re the ones doing it...We need their input. There’s nobody better to ask than the person that's doing it...You don't know until you’re out there doing it.”

AAAs also acknowledged the pressure that Aetna is under to respond quickly to ODM corrective plans and the challenge of getting all the AAAs together to discuss how to respond.

### *Process for Durable Medical Equipment (DME)*

AAA staff reported significant issues with securing DME and other supplies for members in a timely manner and expressed concerns with the process for authorizing these items. There are several areas where this process tends to break down: waiting for a physician prescription or signature, confusion over what is covered by Medicare versus Medicaid, hesitancy on the part of the DME provider to submit claims for something they know will be denied, and waiting on a response from Aetna’s Waiver Authorization Team (WAT).

While CMs are able to authorize some services such as personal care and home-delivered meals, CMs report that requests for items like walkers, wheelchairs, incontinence supplies, and nutritional supplements must be submitted to the WAT and approved before they can be received by the member. One CM described a delay in securing diabetic socks for a member,

“It took me six weeks to get my client diabetic socks...I talked to the woman at the pharmacy [who said] ‘That’s not covered under Medicaid or Medicare.’ I said, ‘Okay, send me a bid and I’ll submit it to the waiver team.’ So I did that, submitted it to the waiver team. They said, ‘No, it has to go through Medicaid and Medicare.’ And I said, ‘No, the pharmacy says they’re not going to do that, because they get dinged when they have to submit things that aren’t eligible...’”

Another CM described it this way,

“It seems to be a battle between the provider and Aetna and who’s paying for it....the DME providers are the experts, and they know what the coverage guidelines are....it just seems like Aetna wants the providers unfortunately, to spend a lot more time to get to the same decision, where they already knew what the outcome was gonna be, but they’re kind of making them go through that extra step all the time....that kind of delays the member getting the piece of equipment that they need....”

There was some confusion about why this was occurring given the capitation model design of MyCare, but AAA respondents consistently reported that they were unclear as to how the financial model actually worked in this area.

Some CMs felt that when the process gets held up at the physician level, it might be due to the fact that physician offices are receiving so many different types of communication from care managers, with such frequency, that they stop responding, or their offices are just too busy to respond.

“Sometimes we fax the doctor two, three, four times, call the doctor. It’s trying to get that signature. The member keeps calling us saying, ‘Hey, you said you’d get us a hospital bed or you’d get us a walker.’...A lot of times I’ll tell the member, ‘Make an appointment, go in and see the doctor, and ask for a prescription.’ Then we can get it faster. That is a huge holdup with the DMEs...it waits at the doctor’s office. I know, I understand they’re overloaded too. I get that, but the member is the one who suffers.”

It is clear that continued efforts are needed to educate physicians about MyCare requirements and engage them in discussions about how to streamline processes.

Providers describe that delays on their part of the process are sometimes caused by the quality and timeliness of the information they receive from care managers. They report that receiving the demographic information required to process DME requests varied widely by CM, particularly in regards to member demographic information. One provider shared, “I’ve seen that same demographic sheet come from both Passport Medicaid and from Aetna MyCare. I know they have access to it. They just don’t send it.” While some providers expressed appreciation for having one point of contact at the AAAs, other providers expressed a lack of understanding of how care management was structured at the AAA level (unified care management vs. waiver service coordination only),

“...so it’s confusing sometimes as to who I’m speaking with and what particular agency they work for. That, I think, is confusing because I don’t have a guidebook or anything like that as far as how the [AAA] is

structured, so if I do have a question, I don't always know who to contact.”

Again, it appears that more education about the ICDS model is needed. Interviews with DME providers also echoed challenges with information systems and difficulties caused by having to access multiple systems to find the information necessary to bill for equipment. One DME provider explained,

“As far as I know, there is no way of checking if a patient is eligible for an item, other than checking an item's billing code via Medicaid, either through the MITS portal or by calling Medicaid. A user friendly provider portal would be very handy to check member eligibility, to verify when a member joined the Aetna MyCare program and if they have any other active insurances. Right now we acquire that information from the Medicaid MITS portal or by calling Medicare, but once a person has switched to the Aetna MyCare program, we have no verifiable source to document eligibility for referrals.”

### *Documentation requirements and processes*

While concerns about the volume of documentation required to meet state regulations are not new to the waiver system, CMs expressed frustration about documentation that feels unnecessarily duplicative and repetitive. One example provided by a CM describes the process that follows creating an incident report,

“...you send the email to like six different people. Then you put the note in Dynamo. Then after like a week or two, you get an email back from Aetna. And then you have to insert your prevention plan. And then you have to call the doctor, and put the prevention plan in a note on your care plan, and then you share your care plan with the doctor and the providers, and the members, and all that, and then document.”

Prevention plans appeared to be a particularly frustrating process for CMs who reported that in some cases, they are required to submit prevention plans for issues over which they have no control,

“And not all prevention plans make sense. For example, my member was a passenger in a car, and they got rear ended. I can't prevent that from happening. Like if it's called a prevention plan, what is my prevention plan with them? There is no prevention plan. They wore their seat belt. They were in a car with someone that had a legal driver's license. It's very confusing and time consuming if I don't have a true prevention plan, and neither does my client.”

CMs discussed a multitude of assessments related to issues such as hypertension, flu shots, and pain that are intended to address areas of priority related to quality measures. Here again, CMs seemed to attribute these assessments to Aetna policy, although some assessments may be state-mandated. Although the assessments may be significant for some members, for other members CMs described them as an exercise in just “checking a box” that does not allow CMs to use their judgment. And in some cases, there is no option available that is relevant to the member. One CM shared,

“...some of the assessments just don’t work, like the pain assessment we are required to do if they’re a certain age. But my client, what if they don’t have pain? ...there’s no answer for me to say, “Member doesn’t have pain.”

Concern was expressed by some AAA staff that while meeting quality measures is certainly important, a primary focus on HSAG results does not necessarily translate to quality care or service for members. One AAA staff member shared their concern that a narrow focus on compliance with quality measures may result in a limited view of what members need for actual quality of life,

“I do think that we’ve lost the holistic part of the care, and everybody’s kind of ... It’s like the school systems. You’re teaching to the test. I think sometimes when we try to educate and train our staff, we’re teaching to the test on this one. ‘This is what you’re gonna be graded on, so these are the things that you must meet.’ I’m not sure, even if you met 100% of those requirements, whether you were actually providing good-quality care to the person that you’re sitting across the kitchen table from....I really do think we’re focused on compliance more than care or making sure people receive everything we can do that they need.”

### *Behavioral health competency of AAA staff*

Both Aetna and AAA staff shared concerns about the increase in the proportion of members with behavioral health needs and the additional skills and care management time needed to serve these members. Issues related to behavioral health, and particularly substance use disorders, involve more visits, phone calls, and follow-up to ensure that members’ needs are met and to address health and safety issues; often resulting in incident reports and prevention plans. CMs reported dealing with members who leave treatment against medical advice or are not taking prescribed medications, contacting adult and child protective services agencies, and trying to track down members who are not responding to attempted contacts. They also discussed health



and safety issues that arise when members are put at risk by family members who have substance use problems.

While all CMs expressed concern about the amount of additional time required, some also shared that at times they do not feel confident or equipped to provide care management in the face of complex BH issues. BH liaisons echoed these concerns and recommended required and increased training on BH issues for AAA staff, at all levels, on areas of general BH knowledge, local resources, follow-up, assessment of risk, and motivational interviewing techniques. The ability of AAAs to attract and retain independently licensed staff was also raised as a concern. Focused efforts are needed in this area and AAAs would do well to more fully utilize BH liaisons for training and consultation. Because few CMs reported in-depth experience in behavioral health, the BH liaisons can provide vital access to and knowledge of community resources and a wealth of experience in dealing with the complex issues related to behavioral health issues such as substance use disorders.

### *Reporting of care transitions between settings*

CMs reported challenges with trying to follow members and track their activities across care settings. Communication problems with hospital discharge planners were mentioned frequently during interviews. CMs related a frequent lack of response from hospital discharge planners when reaching out to them to discuss members' discharge plans and difficulty securing discharge paperwork. While some discharge planners do extend invitations to care and discharge planning meetings, CMs reported that they are often not given very much notice and could not always rearrange their schedules quickly enough to participate. In addition, some members were not able to communicate to hospital staff the name of their CM, so the hospital was not always aware that a CM was involved.

Another barrier to continuity of care reported by Aetna staff is the willingness of some acute providers, such as hospital systems, to work with MyCare health plans, "We do have those barriers where certain hospital systems just will not work with us. We've brought this to ODM's attention. We're hoping to get a little push through that." This is certainly something that needs to be addressed at the state level if the goals of an integrated care delivery system are to be fully realized.

Finally, while not unique to Aetna's model, if a member has not opted in to Aetna for their Medicare coverage, this presents a barrier to the goal of care continuity across settings. At the time of these interviews, about 70% of Aetna MyCare members had opted in to Aetna Medicare coverage. As one Aetna administrative staff member related, members not enrolled in an Aetna Medicare plan present a number of coordination challenges, particularly when a member is hospitalized,

“I would say, as far as that, the transition of care in and out of the hospital, a barrier would be sometimes we don’t know someone is in the hospital or discharged until a claim hits, especially if they don’t have their Medicare through Aetna. We would be the secondary payer....We won’t, sometimes, find out at all, because it’s all going through their primary, unless the care manager happens to try and call on that day and they’re not there and they find out from the home health agency that they’re in the hospital.”

### *Provider issues*

AAA staff and provider agencies identified a number of issues, particularly in regard to responding to current challenges in the home health arena. In all three regions we heard a consistent theme of in-home care worker shortages, which in some instances resulted in members not receiving all of the services that are prescribed in their plan of care. Although this is a state-wide issue impacting all of the plans and the PASSPORT and AL programs, respondents identified specific MyCare model areas of concern. One AAA administrator predicted that these shortages will derail the primary objectives of the ICDS model,

“But just the lack of home health aides is just crushing the ability for us to really provide the services that we think we need. Unless the state decides to pay more in that area, I just don’t know how we’re gonna resolve that. I think that’s just gonna become a bigger and bigger hole. I think we’ll get to ... The rebalancing, at some point it’s gonna stop, because you’re not gonna be able to ... Or may even reverse, because you’re gonna end up with more people in a nursing home ‘cause there’s just no way to properly serve them at home.”

AAA staff pointed out that in the current model, they have less flexibility to work with providers to try and mitigate issues that may result in service disruptions to members. One AAA administrator related,

“The whole provider relations aspect of it seemed to work better when you have control over payment systems. We have a lot of mom-and-pop programs in our area. We don’t have a lot of national providers, other than meal providers, in our area. We could have a little bit more flexibility in the old days. If they called us up and they were having trouble meeting payroll, we might be able to run them a check earlier than what we might otherwise have been able to do that, just to help them and provide a relations aspect of it.”

Another critical provider area identified is CM interactions with members' primary care physicians (PCPs). The Aetna model includes considerable care management communication requirements between CMs and primary physicians and CMs reported that PCPs have embraced this increased interaction at varying levels. Some PCPs, particularly in the early days of the demonstration, did not understand why CMs were contacting them regarding care plans. However, CMs related that there are PCPs who appreciate the additional information and believe it helps them better treat their patients. Because CMs report that the majority of their contact with PCPs is through their office nurses, offering more education about the model and documentation requirements to physicians and their office staff may reduce confusion and delays. It is evident that for care to be truly integrated across the long-term services and acute care arenas, PCPs must understand and embrace the model of care.

A final provider issue identified was a reported difficulty in getting skilled rehabilitation approved by Aetna after a three-day qualifying stay. Respondents reported that members were required to use their Medicaid nursing home benefit and then receive therapy under Medicare Part B. Respondents felt that in many cases, members needed more intense therapy than what was provided under Part B and this policy actually resulted in members spending longer time in a nursing home. There was also some concern regarding the member's right to appeal skilled rehabilitation denial and the role CMs can play in the appeals process as they are the member's advocate and at the same time an extension of Aetna.

### *Turnover and job challenges*

Respondents discussed concerns that the unified care management model, particularly when implemented during a demonstration phase where the model is still being developed, is stressful. AAAs reported higher care management turnover rates for the MyCare program overall compared to the more well-established and routinized PASSPORT program. One universal job challenge mentioned by CMs, as noted earlier, is the frequent and unexpected changes in priorities and tasks that result in a continually shifting work environment for CMs. One care management supervisor described the effects of turnover on caseload size,

“There's just so many things to try to keep track of, I think it gets very overwhelming for some people, very stressful. And then unfortunately, it gets kind of a domino effect. Once somebody leaves, we have to absorb that case load, and it takes so long to get a new person trained and up to speed, that then in addition to having all these things, you have to track now, you have 10 more people on your case load that you have to do, and I think it just gets very overwhelming and frustrating, and I think that's part of some of the high turnover that we have.”

An AAA administrator also relayed how the shifting environment poses challenges for orienting and training new staff and that efforts to keep up with changing processes need to involve Aetna and the AAAs,

“I think part of that’s on Aetna, part of that’s on us. They do tend to have a lot of changes in their processes, so it’s kinda hard ... Once you get something, you couldn’t possibly keep a printed manual up to date, as fast as changes occur. We need to do a better job on that ourselves.”

Care managers in all three regions also highlighted the job challenges related to caseload size. The size of CM caseloads is determined by AAA administrative staff and there was some variation across the regions as to the ideal caseload size. While supervisors indicated a goal for caseloads to include approximately 55 - 65 members, they reported that efforts to reach this goal are affected by high turnover among CMs and budget limitations that hinder their ability to offer competitive salaries.

Another area identified by AAA staff as a job challenge is the acuity level of members. The ICDS MyCare members have high levels of functional and/or cognitive impairment and in many instances also have major health conditions as well. Large caseloads, difficulties in securing providers, and the increased contact and follow-up associated with high member health care needs were all reported to contribute to making MyCare care management a high pressure position. Another contributing factor is the large and growing proportion of members with behavioral health needs. Highly developed time management skills appear to be critical to success as a CM. One care management supervisor described the combination of traits that seems to be needed for success,

“Once we get them on staff, it’s pretty clear within the first couple of months, you can tell those people that are a little bit more scattered in how they do things, or those people that are very rigid in how they get things done. If you can find that staff person that’s really rigid but still has that sense of compassion for the people they’re dealing with ... Those are the ones that are gonna do really well.”

Care management supervisors also related that CMs must balance time pressures with their desire to give members the time and attention needed to provide comprehensive service,

“We have those other folks that are really dedicated to the care of their members, which is a wonderful thing. But you can’t spend so much time on one member to the detriment of the rest of your case load.”

Finally, respondents talked about the stress of having “responsibility without control” as an additional job challenge. CMs related that an important value underlying the program is member autonomy to “live their lives.” And while CMs expressed strong support of that principle, they also felt that they are being asked to ensure that those choices did not have any negative impacts on the consumer. An AAA administrator echoed these sentiments and acknowledged the paradox of safety vs. autonomy,

“We have this value of autonomy and making that choice, but never do we want people to fail. So whether it’s nursing home or assisted living or home care, you can’t quite have high levels of autonomy with no failure...”

The job of care manager in long-term services and supports has always been considered a high pressure position. Care managers work with consumers who are experiencing high levels of disability, often with stressful family circumstances and high health care needs. As Medicaid recipients, these individuals also have limited economic resources. Combining responsibilities for health services in addition to long-term services and factoring in the high proportion of members with behavioral health needs means that a tough job is now even more difficult under the Aetna MyCare model. While there are some important benefits to the unified model, it will be critical to use the information related by Aetna and AAA staff and providers to develop support mechanisms for all personnel working in this complex system of care.

### *Unintended consequences*

The final theme addresses unintended consequences. In today’s health care arena, where cost pressures are high, it is easy to make decisions that could cause an organization to miss their desired outcome. Respondents provided several examples where short-term decisions could have longer term impacts that were not being considered. One example provided by CMs and providers was the denial of skilled rehabilitation benefits. There was concern expressed that such denials could lead to longer nursing home stay for members and could eventually result in higher costs and negative outcomes. Processes that result in delays to securing DME equipment, as well as the growing problem of home care shortages, also have the potential to contribute to increased health and safety risks for members. It is often difficult to factor in the many potential outcomes that can occur, but respondents highlighted that it is critical that long-term consequences be factored in to the decision making processes of the model.

## RECOMMENDATIONS

This study represents a first step in understanding the processes involved in the Aetna/AAA managed care/care management model. Aetna and AAA staff and providers identified a number of benefits that are gained through the unified model. However, none of the existing research efforts, including the large RTI evaluation of MyCare, have examined outcomes of the individual health plan models implemented across the state. It is critical for both Aetna and the State of Ohio to better understand the impacts of each care management model in such areas as member health and long-term services costs, program length of stay, use of nursing homes and hospitals, long-term services use, plan satisfaction, and survivorship. As we strive to make the health and long-term services system more effective, it will be critical to generate evidence-based data for innovations, such as the Aetna/AAA care management model. Given the expected increase in Ohio's older population with severe disability, it is essential that good data be generated to address these types of questions and assist policy makers in decision-making.

### High involvement and communication

The acute care and long-term services systems have dramatically different models and cultures. The earliest efforts to integrate these two areas, the Social Health Maintenance Organizations, highlighted the difficulties in bringing separate entities together even within the same organization. The Aetna MyCare care management model has shown that, while it is not easy, the two worlds can be unified under a common mission of serving members. The conviction of staff to provide quality service to members came through in our interviews with both Aetna and the AAA's. A priority of this partnership should be to engage those who have the most direct contact with members when making decisions and determining processes. AAA administrative staff expressed a desire to be more involved in developing procedures in response to state directives. At the same time, AAAs also need to engage and solicit input from CMs and CAs when developing those procedures. The CMs and CAs who participated in interviews were highly motivated to help improve processes and tasks in order to achieve good outcomes for members. In a unified model, open communication between entities and between different levels of staff needs to be an ongoing and never ending priority. Although communication between Aetna and the AAAs appears generally pretty good, our interviews identified a number of examples where improved communication could enhance the partnership and ultimately result in improved member experiences.

### Intentional strategies for building behavioral health competencies

The higher proportion of members with behavioral health challenges represents a change to AAA culture. The BH liaisons offer significant support to CMs as they work with individuals experiencing BH conditions and could be more fully utilized as a

resource. In some instances more in-depth and specialized BH training is needed to help CMs in working with members with BH needs. The increased prevalence in BH conditions, and the complexity of circumstances within CM caseloads presents significant challenges to the MyCare model. A 45-year-old member with severe behavioral health challenges and limited family contact faces a very different set of circumstances from an 85-year-old member with dementia living with an adult relative. AAAs should pay particular attention to BH issues when determining caseload size, supervision, and team structures.

### **Unified data management systems**

Ensuring that all parties have access to good data to make the right decisions is always a challenge in health and long-term services organizations. Given the fluidity of both the health and long-term services systems, having timely and easily accessible information for care managers and staff at both organizations is now essential. Although efforts have been made to modify current systems and create solutions, development of a user friendly system that houses all the information needed by care managers and supervisors must be a core requirement of future data management systems. Much progress has been made in how to share information across organizations, but a better system will be necessary to efficiently and effectively serve the increase in the number of members enrolled and growing complexity of their needs.

### **Prioritized attention to home care shortages**

The current home care worker shortages are dramatic and could undermine the state's efforts of ensuring that individuals with disability can get services in the setting of their choice. These shortages are both a state and national problem and addressing it will require significant re-evaluation of current strategies and structures. AAA administrators shared that they are exploring solutions, but they will need the full and immediate support of Aetna and the State of Ohio. The scope of worker challenges is extensive and the solutions will require an array of strategies. Some solutions may be technology based, some may be partnerships with high schools and community colleges, some may involve changes in wage and benefit structures, and some are yet to be identified. Reliance on in-home care is a core strategy of this model and the number of individuals who desire to remain in their communities will continue to grow. If in-home care is to remain a viable and safe option for members, bold and innovative plans and partnerships will be required.

### **Engagement of primary care physicians**

The Aetna/AAA model has dedicated considerable efforts to improve the involvement of and communication with the primary care physician. Despite these efforts, cooperation has been mixed. While in some instances communication has been vastly improved, this

area continues to present a challenge. Given the importance of the primary care physician in the lives of many Aetna MyCare members, figuring out how to better integrate physicians into the model is also critical to overall success. Given the changes in the health care delivery system and the current pressures on physicians, solving this problem is no small task. However, without the buy-in and involvement of the primary care physician, the opportunity to provide high quality acute and long-term services at the right time in the right place is severely compromised. While this is a universal problem facing integrated care programs, the Aetna/AAA unified model provides the foundation for addressing this challenge.

## **CONCLUSION**

The process evaluation results have identified important issues to consider as the model continues to evolve. If these results can be paired with a comprehensive impact evaluation, Aetna, AAA's, and Ohio Departments of Aging and Medicaid will be in a better position to serve individuals across the state with long-term service and support needs.



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