MyCare Ohio Report

Submitted June 30, 2016

The Ohio Department of Medicaid

John R. Kasich, Governor John B. McCarthy, Director

MEMORANDUM

TO: Ohio House Speaker, the Honorable Cliff Rosenberger
Ohio Senate President, the Honorable Keith Faber
Ohio House Minority Leader, the Honorable Fred Strahorn
Ohio Senate Minority Leader, the Honorable Joe Schiavoni
Joint Medicaid Oversight Committee, Susan Ackerman, Executive Director
Legislative Service Commission Director, Mark Flanders

FROM: Director John B. McCarthy

SUBJECT: Ohio Department of Medicaid Annual Report on MyCare Ohio

DATE: June 30, 2016

Section 5164.134 of the Ohio Revised Code requires the Ohio Department of Medicaid to report annually on the administration of MyCare Ohio – Ohio Medicaid's demonstration program to coordinate the benefits made available to individuals served by both Medicaid and Medicare. I hope that this report provides valuable insight on our agency's efforts to implement a truly innovative program aimed at serving residents with complex health care needs.

I look forward to continued collaboration between our agency and members of the Ohio General Assembly.

Sincerely,

John B. McCarthy
Director
Ohio Department of Medicaid

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Introduction

In accordance with Ohio Revised Code sections 5162.134 and 5164.911, on an annual basis, the Ohio Department of Medicaid (ODM or Ohio Medicaid) must submit a report to the General Assembly evaluating the administration of the MyCare Ohio program.

MyCare Ohio is a demonstration project aimed at coordinating health care delivery for individuals served by both Medicare and Medicaid. The demonstration is a collaborative effort between Ohio Medicaid, Centers for Medicare and Medicaid Services (CMS), and five private managed care plans. MyCare Ohio is a fully capitated program that provides comprehensive services to Medicare-Medicaid enrollees.

The demonstration integrates and coordinates health care delivery by:

- Utilizing managed care to improve continuity and coordination of care that is patient centered;
- Providing a primary of contact for beneficiaries;
- Focusing on individual choice and control of care delivery;
- Coordinating long-term care, behavioral health, and physical health services;
- Encouraging and supporting an individual's right to live independently;
- Reducing the overall cost of care for the individual, Medicare, and Medicaid; and
- Providing seamless transition between settings and programs.

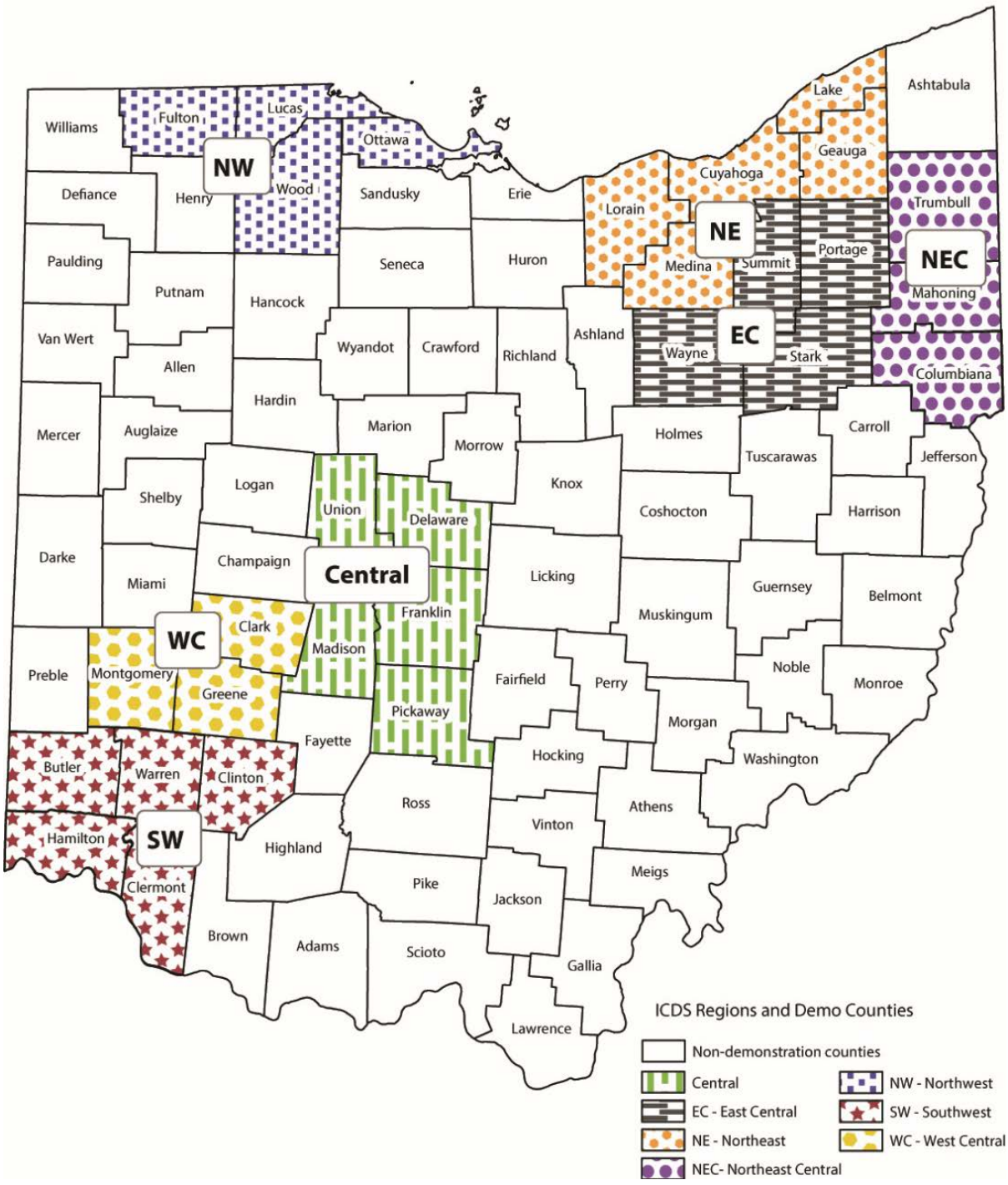
Initial Medicaid enrollment began on May 1, 2014 and continued, by region, through July 1, 2014. The Medicare passive enrollment period began on January 1, 2015, and beneficiaries maintain the freedom to 'opt-out' of receiving their Medicare benefits through a MyCare Ohio Plan, if they choose. The first full year of the Medicare passive enrollment is now complete, and the average monthly enrollment for MyCare Ohio is approximately 93,000 individuals.

Ohio Medicaid continues to work closely with CMS through bi-weekly update calls and also facilitates monthly meetings involving the managed care plans. CMS approved ODM's request for a two year extension of the demonstration to December 2019. The additional time will allow for more accurate measuring of the health outcomes for Ohioans who participate in MyCare Ohio and the potential state resources saved. Additionally, forums were held at AAAs to collect stakeholder feedback and identify areas of strength in the program, as well as areas in need of improvement.

Provider Panel Requirements

Since MyCare Ohio is a Medicare-Medicaid integrated program, the Medicare panel requirements are commonly used for most provider types throughout the demonstration. Medicaid provider types include dentists, nursing facilities, and waiver services providers.

Figure 1: MyCare Ohio Regions and Demonstration Counties



Enrollment Data

The tables below contain enrollment data as of December 2015. Table 1 compares enrollment numbers for MyCare Ohio dual members to Medicaid-only members, by plan in each region. Table 2 shows the types of enrollment by plan.

Table 1: Comparison of Dual Members to Medicaid-Only Members, by Plan per Region – December 2015

Plan	Community Well Dual Benefit	Community Well - Medicaid Only	Total Community Well	% Total Community Well	Waiver - Dual Benefit	Waiver - Medicaid Only	Total Waiver	% Total Waiver	NF 100+ Days - Dual Benefit	NF 100+ Days - Medicaid Only	Total NF 100+ Days	% NF 100+ Days	Total MyCare*
Aetna	8,139	2,981	11,120	55.4%	3,194	1,775	4,969	24.8%	1,815	2,116	3,981	19.8%	20,070
Buckeye	5,518	1,987	7,505	50.1%	2,702	1,984	4,686	31.3%	1,513	1,287	2,800	18.7%	14,991
CareSource	9,845	2,418	12,263	54.4%	3,747	2,345	6,092	27.0%	1,765	2,407	4,172	18.5%	22,527
Molina	6,247	2,235	8,482	55.7%	2,090	1,413	3,503	23.0%	1,536	1,702	3,238	21.3%	15,223
United Healthcare	6,753	2,455	9,208	50.4%	3,056	1,635	4,691	25.7%	2,466	1,887	4,353	23.8%	18,252
TOTAL	**36,502**	**12,076**	**48,578**	**53.3%**	**14,789**	**9,152**	**23,941**	**26.3%**	**9,095**	**9,449**	**18,544**	**20.4%**	**91,063**

Table 2: MyCare Ohio Enrollment, by Plan and Type – December 2015

MyCare Region	Managed Care Plans										Total		Overall MyCare	% of Duals to MyCare
	Aetna		Buckeye		CareSource		Molina		UnitedHealth Care					
	MCD Only Benefits	Dual Benefits	MCD Only Benefits	Dual Benefits	MCD Only Benefits	Dual Benefits	MCD Only Benefits	Dual Benefits	MCD Only Benefits	Dual Benefits	MCD Only Benefits	Dual Benefits		
Central	2,478	4,983	1	0	0	1	1,617	3,662	1	2	4,097	8,608	12,705	67.8%
East Central	1	0	0	0	1,968	3,961	0	0	2,473	4,551	4,442	8,512	12,954	65.7%
Northeast	0	0	1,179	3,237	4,209	8,656	0	0	2,565	5,445	7,953	17,338	25,291	68.6%
Northeast Central	0	0	0	1	1,000	2,761	1	0	1,057	2,445	2,058	5,207	7,265	71.7%
Northwest	1,182	3,033	919	2,826	0	0	0	0	0	0	2,101	5,859	7,960	73.6%
Southwest	3,288	5,219	1	0	0	0	2,478	4,089	0	1	5,767	9,309	15,076	61.7%
West Central	1	0	3,235	3,777	0	0	1,314	2,246	0	0	4,550	6,023	10,573	57.0%
Total	6,950	13,195	5,335	9,841	7,177	15,379	5,410	9,997	6,096	12,444	30,968	60,856	91,824	66.3%
Total/Opt-in (%)	**20,145**	**65.5%**	**15,176**	**64.8%**	**22,556**	**68.2%**	**15,407**	**64.9%**	**18,540**	**67.1%**	**91,824**	**66.3%**		

Prior Authorization

MyCare Ohio plans must provide timely access to all medically necessary covered services. Additionally, plans may require prior authorization (PA) for services - except for emergency services, certain urgent care services, family planning services and out-of-area renal dialysis services. All MyCare Ohio plans must:

- Have written policies and procedures for processing PA requests;
- Allow members to initiate requests for services;

» Maintain mechanisms to ensure consistent application of review criteria for PA decisions; and

» Provide consultation with requesting providers when appropriate.

Review guidelines must be consistent with Medicare standards for acute services and prescription drugs and must also be consistent with Medicaid standards for Medicaid services not covered by Medicare. Guidelines for integrated services must provide for review, authorization and payment using both Medicare and Medicaid criteria in that order. Plans must make PA decisions within the required time frames and must offer appeal rights to members for denied requests.

Table 3: Total Number of Prior Authorization Requests Received by MyCare Ohio Plans between January 1, 2015 and December 31, 2015

Total Prior Authorization Requests	Total Prior Authorization Requests Per 1000 Member Months	Approval Percentage	Denial Percentage
277,911	248.44	92.86%	7.14%

Calculation based on ODM member month data: Total Prior Authorizations Requests per 1000 Member Months = Total Prior Authorization Requests x 1000 divided by member months.

Appeals Process

Appeal processes vary at the state and federal levels. As a result, significant negotiation occurred between Ohio Medicaid and CMS during MyCare planning stages to reach agreement on an appeals process that aligns with state and federal requirements, while also satisfying the expectations of various advocates and stakeholders. Ohio Medicaid also had to be sure that the Ohio Department of Job and Family Services Bureau of State Hearings had the capacity to handle the additional workload resulting from MyCare Ohio hearing requests. While Ohio Medicaid and CMS established the parameters associated with the appeal process, the MyCare Ohio plans are primarily responsible for executing the appeals process. Current Ohio Department of Job and Family Services Bureau of State Hearings processes are maintained.

When a denial or limited authorization is issued by a MyCare Ohio plan, members have the opportunity to submit an appeal to that plan.

Table 4: Number of Appeals Received by the MyCare Ohio plans from January 1, 2015 to December 31, 2015

Total Number of Appeals	Number of Appeals per 1,000 Members Months*	Number of Appeals Sustained**	Number of Appeals Overruled***
1228	1.10	408	820

* Calculation based on ODM member month data: Total Appeal Requests per 1000 Member Months = Total Appeal Requests x 1000 divided by member months.

** Appeal Sustained – means the *MyCare Ohio* plan's action is overturned and the Plan must reverse their original decision.

*** Appeal Overruled – means the *MyCare Ohio* plan's action is upheld or stands.

In most cases, when a MyCare Ohio plan makes a decision on appeal to sustain or overturn their original denial, it is due to the receipt of additional supporting medical documentation submitted by the requesting physician or provider.

Claims Processing

The table below describes MyCare Ohio plans' reported number of claims, amount paid, and percent rejected and percent paid within 30 days as of December 31, 2015.

Table 5: Claims Processing within 30 days by the *MyCare Ohio* plans from May 1, 2014 to December 31, 2015

Region	Counties	Enrollment Begins	Health Plans	Number of Enrollees	Number of Claims*	Amount of Claims Paid*	% of Claims Rejected	% Paid within 30 Days
Northeast	Lorain, Cuyahoga, Lake, Medina, Geauga	May 1, 2014	Buckeye	4,416	471,574	$110,065,415	22.4%	92.4%
			CareSource	17,359	3,366,531	$586,360,756	9.3%	93.3%
			United	7,786	1,013,702	$352,412,906	9.1%	99.6%
Northeast Central	Trumbull, Mahoning, Columbiana	June 1, 2014	CareSource	5,179	877,551	$145,569,676	8.8%	93.8%
			United	3,400	387,000	$131,597,667	10.6%	99.7%
Northwest	Fulton, Lucas, Wood, Ottawa	June 1, 2014	Aetna	4,209	366,388	$93,306,633	16.8%	93.0%
			Buckeye	3,735	406,533	$86,277,965	21.7%	92.3%
Southwest	Butler, Warren, Clinton, Hamilton, Clermont	June 1, 2014	Aetna	8,522	721,012	$257,990,783	18.3%	92.8%
			Molina	6,909	646,173	$268,734,851	11.2%	96.6%
East Central	Wayne, Summit, Stark, Portage	July 1, 2014	CareSource	9,604	1,557,255	$261,269,546	9.5%	94.0%
			United	6,903	753,482	$238,190,050	9.6%	99.8%
Central	Franklin, Union, Delaware, Madison, Pickaway	July 1, 2014	Aetna	7,388	808,998	$206,502,915	12.5%	95.2%
			Molina	5,564	593,480	$204,852,656	11.8%	95.9%
West Central	Montgomery, Clark, Greene	July 1, 2014	Buckeye	7,029	864,160	$205,816,015	21.6%	93.5%
			Molina	3,739	397,553	$118,996,574	12.6%	96.4%
TOTAL				**101,742**	**13,231,392**	**$3,267,944,409**		

*Includes cumulative number of claims and amount of claims paid from the date enrollment began in that region.

Demonstration Measurement and Evaluation Design

Evaluation is an essential part of MyCare Ohio. In addition to requirements specified in the Ohio Revised Code, CMS contracted with an independent evaluator, RTI International, to assess the impact of the MyCare Ohio demonstration. RTI's evaluation will focus on:

- Health outcomes;
- Access to care;
- Enrollment;
- Quality of care;
- Beneficiary satisfaction and experience;
- Overall costs/savings for Ohio Medicaid, Medicare;
- Long-term care rebalancing and diversion effectiveness;
- Marketing; and
- Appeals and grievances.

Full cooperation from the State, CMS, and the managed care plans is essential in completing a comprehensive assessment. In the three-way contract, the State and the MyCare Ohio plans agreed to submit all necessary data to RTI for its report. There are more than a hundred different performance measures, both quantitative and qualitative, that will be used.

Conclusion

The information contained in this report documents programmatic activity related to the MyCare Ohio demonstration over its first full year of implementation since the Medicare passive enrollment began in January 2015. Managed care processes have been successfully implemented across the Medicare and Medicaid services, resulting in collaborations with both traditional and newly involved provider communities.

The effectiveness of these interventions and care coordination activities require further experience and evaluation. Over the next several years, outcomes of these care coordination processes are expected to produce positive and measureable results.

ODM looks forward to sharing those results with the General Assembly in future annual reports.