Ohio
Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

July 1, 2014

SFY 2014 Annual Report on MyCare Ohio

Honorable Members of the General Assembly, Joint Medicaid Oversight Committee, and Legislative Service Commission:

Section 5164.134 of the Revised Code requires the Ohio Department of Medicaid to report annually, on the administration of *MyCare Ohio* – Ohio Medicaid's three-year 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 recent success in implementing a truly innovative program aimed at serving residents with complex health care needs.

As we move ahead with this truly unique endeavor, I look forward to a continued collaboration between our agency and members of the Ohio General Assembly.

Sincerely,

John B. McCarthy
Director

CC: Ohio House Speaker Bill Batchelder
Ohio Senate President Keith Faber
Ohio House Minority Leader Tracy Maxwell Heard
Ohio Senate Minority Leader Joe Schiavoni
Joint Medicaid Oversight Committee Executive Director Susan Ackerman
Legislative Service Commission Director Mark Flanders

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MyCare Ohio:

Annual Report on Integrated Care Delivery System Evaluation

July 1, 2014

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Introduction

December 2012 saw Ohio become just the third state in the nation to receive federal approval for its plan to coordinate benefits for individuals covered by both Medicare and Medicaid. This population, often times referred to as "dual eligibles," makes up only 14 percent of the total Medicaid population but accounts for roughly 34 percent of all costs.

Implementation efforts for the three-year MyCare Ohio demonstration unfolded throughout State fiscal year (SFY) 2014. Discussions with managed care plans and the Centers for Medicare and Medicaid Services (CMS) were held simultaneously with regular stakeholder meetings in order to ensure a seamless and efficient launch.

The Medicaid benefits portion of MyCare Ohio went live on May 1, 2014 with the enrollment of individuals in the Northeast Region (Cuyahoga, Medina, Lorain, Geauga and Lake counties). Beneficiaries were given 60 days to choose a MyCare Ohio managed care plan. Individuals failing to select a plan at the end of 60 days had a plan selected for them. Beneficiaries will have until the close of calendar year (CY) 2014 to choose a MyCare Ohio plan for their Medicare benefits.

The six remaining MyCare Ohio regions went live on June 1 and July 1 of 2014. Of the roughly 182,000 Ohioans covered by both Medicare and Medicaid, as many as 114,000 individuals are expected to be served through the demonstration.[1]

Ohio Revised Code sections 5162.134 and 5164.911 require the Ohio Department of Medicaid (ODM) to submit an annual report to the General Assembly evaluating the effectiveness of MyCare Ohio (formerly the Integrated Care Delivery System or ICDS). MyCare Ohio did not begin enrollment until May 1, 2014, therefore data is limited or not available. However, MyCare Ohio managed care plans have provided some data from the initial enrollment phase.[2] The following report includes an overview of how MyCare Ohio was designed and implemented, an update on integration progress, enrollment data/feedback and further explanation as to how MyCare Ohio will be measured and evaluated in the future.

MyCare Ohio is a program in which Ohio Medicaid and CMS have partnered to coordinate service delivery through a managed care approach. The demonstration is a fully capitated program that creates organized systems of care that provide comprehensive services to Medicare-Medicaid enrollees. MyCare Ohio integrates and coordinates healthcare delivery by:

- utilizing managed care to improve care coordination that is patient-centered;
- providing one point of contact for beneficiaries;
- emphasizing individual choice and control in care delivery;
- providing coordination of long-term care services, behavioral health services and physical health services;

[1] A complete map of participating counties and the implementation timeline can be found in Appendix 1.
[2] Data from the managed care plans can be found in Appendices 6, 7, and 8.

- supporting an individual's right to live independently;
- reducing the overall cost of care for the beneficiary, Medicaid and Medicare; and
- providing a seamless transition between settings and programs.

Ohio Medicaid and CMS will closely monitor MyCare Ohio throughout the duration of the demonstration. In addition, CMS has contracted with an independent evaluator, RTI International (RTI) to do a formal evaluation of the demonstration. Enrollees will be participating in assessing the program's effectiveness through public meetings, surveys, and focus groups. MyCare Ohio will be assessed for its overall success towards providing accessible and cost effective health care. The demonstration will allow the state to measure if an approach of this kind can improve health outcomes while concomitantly having a positive influence on spending, without the commitment of state-wide implementation. As a result of this critical evaluation, recommendations can be made for further improvement and expansion.

Initial Community Engagement

Ohio Medicaid engaged stakeholders from the very beginning, and maintained an open dialogue throughout the planning phases of MyCare Ohio. These meetings were beneficial to both Ohio Medicaid and its partners. The associations contributed diverse perspectives which proved valuable in designing MyCare Ohio. In the process, the associations gained a better understanding of how MyCare Ohio was going to work.

Associations that met with Ohio Medicaid included:

- Ohio Health Care Association
- The Academy of Senior Health Science
- LeadingAge Ohio
- Ohio Council for Home Care and Hospice
- Midwest Care Alliance
- Ohio Department of Transportation
- The Ohio Council of Behavioral Health and Family Services Providers
- Ohio Optometric Association
- Ohio Bar Association
- Ohio Hospital Association
- Ohio Association of Health Plans
- Ohio Association of Area Agencies on Aging
- The Pharmaceutical Research and Manufacturers of America
- Public Retirement Systems
- Medicare Advantage Plans
- County Department of Job and Family Services
- Ohio Association of Medical Equipment Services

Starting in 2012 and through the demonstration's launch, Ohio Medicaid convened an Enrollment Workgroup to help beneficiaries transition to MyCare Ohio. Consumer and provider stakeholders assisted in developing processes and educational resources related to MyCare Ohio. Additionally, the interested parties offered assistance in the enrollment process. Ohio Medicaid continues to engage with and incorporate feedback from stakeholders through ongoing meetings, focus groups and surveys.

Partnership with CMS

- On **April 24, 2012**, Ohio Medicaid issued a Request for Applications (RFA) to contract with qualified health plans to manage a comprehensive benefit package for the MyCare Ohio program. The RFA process assured that selected applicants had the experience necessary to meet the needs of the dual-eligible population. Selected applicants would be expected to operate in accordance with the provider agreements that they signed. The deadline for applications was set for May 25, 2012. With the exception of the Northeast region of the state, Ohio Medicaid planned to have two managed care plans per region. Because of the number of potential beneficiaries, the Northeast region would have three managed care plans. Scoring of the applicants was based on criteria determined in the RFA. Score sheets, provided in the appendix of the RFA, were used to calculate and compare applicants. Final scoring results were announced on August 20, 2012 and the plan selection of service regions was announced on August 27, 2012. Five MyCare Ohio plans were selected: Aetna, Buckeye, CareSource, Molina and United Healthcare.
- In **December 2012**, a Memorandum of Understanding (MOU) was signed between CMS and the State of Ohio. The MOU established the intent for a Federal-State partnership to implement the MyCare Ohio demonstration proposal. It details the principles that CMS and Ohio Medicaid would follow in order to implement the MyCare Ohio demonstration.
- On **February 11, 2014**, Ohio Medicaid, CMS and the selected MyCare Ohio plans executed the three-way contract. This contract assures that MyCare Ohio plans will provide beneficiaries all covered Medicaid and Medicare benefits through an integrated care delivery model that is designed to improve quality, outcomes, choice and independence.
- The Ohio Department of Aging applied for, and was granted, CMS funding to implement the MyCare Ohio Ombudsman program. CMS awarded approximately $270,000 for the first year.
- Beginning on **May 1, 2014**, beneficiaries began mandatory MyCare Ohio enrollment for Medicaid and voluntary enrollment into MyCare Ohio for Medicare. By **January 1, 2015**, any individual who has not yet selected a MyCare Ohio plan for their Medicare benefits will be automatically enrolled in their current MyCare Ohio plan for those benefits, in addition to the Medicaid benefits they receive from the plan. This will maximize the positive results that come with integrated care. Beneficiaries have the option of declining this enrollment and continuing to receive their Medicare benefits through

traditional Medicare fee-for-service (FFS) or through a Medicare Advantage Plan. Beneficiaries choosing not to receive their Medicare benefits through a MyCare Ohio plan will continue to receive their Medicaid benefits through a MyCare Ohio plan.

Ohio Administrative Components Implemented

Because enrollment for Medicaid services is mandatory in MyCare Ohio, a provider agreement was executed between Ohio Medicaid and participating MyCare Ohio plans in February 2014. In this agreement, the MyCare Ohio plans agree to provide comprehensive Medicaid services as provided in Chapter 5160-58 of the Ohio Administrative Code (OAC). The MyCare Ohio plans also agree to assume the risk of loss, while complying with federal and state laws. The agreement defines a number of different requirements, including:

- Call Center requirements
- Staffing requirements
- Information submission requirements
- Financial reporting requirements
- Provider contracting requirements
- Documentation requirements
- Training requirements
- Marketing requirements
- Benefit requirements and limitations
- Communication requirements
- Ethical requirements
- Privacy compliance requirements
- Measurement requirements
- Website requirements
- Payment requirements
- Quality requirements

The provider agreement also specifies actuarially sound capitation rates. Lastly, the agreement consists of certain components aimed at incentivizing plans that improve health outcomes.

Consumer and Provider Engagement

Substantial engagement with beneficiaries and providers has been consistent from the start of the planning process. On November 20, 2013, the Council on Aging in Southwestern Ohio held an information event which attracted more than 300 people, mostly providers. This was the first area agency to hold this type of information session. The goal was to help professionals understand the new MyCare Ohio demonstration. Similar events were held across the state during the first half of 2014.

In December 2013, Ohio Medicaid sent a general information letter to all potential MyCare Ohio beneficiaries. The letter directed individuals to the Ohio Medicaid Consumer Hotline, and its associated website, for general program information. For beneficiaries who use specific services such as a nursing home, assisted living, home and community based waivers, or behavioral health care, additional information specific to those settings and services was provided.

On February 26, 2014, Ohio Medicaid began distributing the first enrollment letters to prospective MyCare Ohio beneficiaries in the Northeast Ohio region. The letter described the three MyCare Ohio plan options from which Northeast beneficiaries could choose and outlined the enrollment selection process. Beneficiaries could choose to receive their Medicare benefits from the selected MyCare Ohio plan.

From January to June 2014, Ohio Medicaid collaborated with the Ohio Department of Aging to convene nine regional educational forums for both providers and beneficiaries. A typical forum would look like the one held on January 29 in Cleveland: the morning session was dedicated to "A Consumer's Perspective on MyCare Ohio," while the afternoon session focused on, "What Providers Need to Know About Contracting to Serve Northeast Ohio MyCare Ohio Consumers." Ohio Medicaid representatives were present, as well as representatives from each of the MyCare Ohio plans offered in the specific region. Figure 1 shows attendance numbers for the different regions.

Region	**Consumers**	**Providers**	**Plans Offered**
Southwest	129	458	Aetna, Molina
West Central	18	246	Buckeye, Molina
Northwest	104	121	Aetna, Buckeye
Central (estimated)	50	175	Aetna, Molina
Northeast	134		Buckeye, CareSource, United
East Central	72	194	CareSource, United
Northeast Central	30	200	CareSource, United

Figure 1: Attendance at Regional Forums

In addition, MyCare Ohio plans held their own provider educational forums to educate providers on MyCare Ohio, how claims are paid, transition requirements for certain services, obtaining authorization for services, and how clinical care is structured.

Because Medicare and Medicaid beneficiaries are often new to managed care and use substantial health care services, seven regional enrollee counseling forums were developed in January 2014. These forums offer enrollment assistance to potential enrollees, either by phone or in person. Local coalitions of consumer advocates joined together to provide enrollment assistance to individuals eligible of MyCare Ohio. Figure 2 shows the number of individuals seeking this type of support in February, March, and April.

Totals (February, March, April)	
MyCare Region	**# consumers interactions**
Southwest	48
West Central	13
Northwest	97
Central	22
Northeast	696
East Central	5
Northeast Central	110
Totals	**991**

Figure 2: Regional enrollment counseling usage

Northeast Ohio has the largest number of consumer interactions since it was the first region implemented and represents a full enrollment period. This process initiated in February and will end on June 30, when all regional enrollments are complete.[3]

Program Description

If Ohio is going to address the rapid growth of its aging population over the coming decades, it must continue to develop new, efficient program models for meeting both the health and long-term support needs of this population. MyCare Ohio is an important step toward developing a higher quality, lower cost program for dual-eligible individuals.

Ohio chose a capitated managed care model in developing an integrated care system that will comprehensively manage the full continuum of benefits for Medicare-Medicaid Enrollees, including Long Term Services and Supports (LTSS) as well as individuals with severe and persistent mental illness (SPMI). Close collaboration among state agencies, CMS, numerous advocacy groups and the five MyCare Ohio plans facilitated these efforts MyCare Ohio has been implemented in seven regions comprised of 29 counties across the state. As of July 1, 2014, enrollment exceeds 104,000 beneficiaries with all regions having gone “live.”

Management Information Systems Integration

Enrollment processing for the MyCare Ohio demonstration requires close interaction between the Medicaid Information and Technology System (MITS) and the Medicare enrollment system. Ohio Medicaid and Hewlett Packard Enterprise Services (HP) collaborated to design and develop a system able to meet new and complex requirements. One of the biggest challenges

[3] Complete monthly data for all regions is available in Appendix 2

was building a cohesive system that accounts for the fact that some beneficiaries receive Medicare and Medicaid coverage through MyCare Ohio (Dual Benefits members) while others receive only their Medicaid benefits through MyCare Ohio (Medicaid Only members). Ohio Medicaid and HP also amended the public facing provider portal in order to assist the provider community with the MyCare Ohio demonstration to assure that providers' standard verifications of eligibility include information about MyCare Ohio enrollment.

In addition to claims and enrollment data, prior authorization and plan of care data needed to be exchanged with the plans. To accomplish this two other systems had to be accessed. For individuals on the PASSPORT waiver, a file exchange was developed between the Department of Aging and the plans, and for people on the Home Choice waiver a file exchange was developed between CareStar[4] and the plans.

Program Design and Waiver Incorporation

MyCare Ohio beneficiaries previously enrolled in other Medicaid waivers continue to receive waiver services in the new program. In fact, under MyCare Ohio services were expanded to better meet the needs of individual and allow them to live independently at home. These services include homemaker and home care attendant services. To ensure that all medically necessary benefits under the waiver are provided, plans must designate waiver service coordinators. The waiver service coordinators are responsible for monitoring waiver service plans, assuring health and welfare, and addressing all issues related to specific waiver services.

Capitation Rate Structure

One of the challenges associated with MyCare Ohio was to build two unique capitation rate structures: one for Dual Benefits members and one for Medicaid-only members. There are also different capitation rates for people on waivers or for those in a nursing facility. This resulted in the need to create four different rates (Figure 3).

[4] Ohio Medicaid's FFS Waiver Case Management Agency

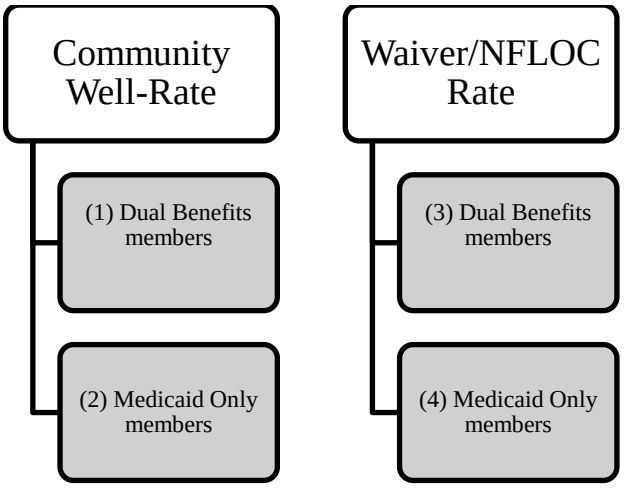


Figure 3: Four Distinct Rates

Enrollment

Between a region's "go-live" date and January 1, 2015, individuals must pick a plan for their Medicaid benefits including the long-term services and supports (LTSS) portion of their services. If a person does not pick a plan they are auto-assigned to a plan for their Medicaid services. During this period, an individual could also choose to have the same plan provide Medicare services, but that is not mandatory. Individuals will have until January 1, 2015, to select a plan for their Medicare services in order to complete MyCare Ohio enrollment. Those individuals who do not select a plan for their Medicare services will be automatically enrolled adding Medicare to their current MyCare plan, but will have the option to decline that enrollment and remain in either traditional Medicare fee-for-service or Medicare Advantage.

The Medicaid Consumer Hotline and website serve as the primary educational and enrollment mechanism. The hotline has provided significant beneficiary support since the initial batch of MyCare Ohio letters were sent in December 2013.[5]

The hotline saw an increase to call volume in conjunction with the distribution of enrollment notices. Some common questions from callers concerned enrollment, co-pay amounts, and potential changes in services.

Federal-State Integration: Challenges and Opportunities

The diverse natures of the state-administered Medicaid program and the federally-administered Medicare program result in a number of challenges when trying to achieve integration.

[5] Appendix4 contains Hotline data from the month of April.

CMS operates a managed care oversight and approval system called Health Plan Management System (HPMS) and has required both the MyCare Ohio plans and the State of Ohio to use this system. The system is traditionally used to support information pertaining to Medicare coverage, as plans store all their Medicare benefits coverage data in the system. Whereas Medicare benefits are static among all states, Medicaid benefits vary across the nation. Therefore, incorporating Ohio's Medicaid coverage information in the HPMS system required CMS processes to be amended. Ohio Medicaid and its MyCare Ohio plans had to standardize their benefits submission process in order to fit within HPMS.

Marketing

The MyCare Ohio demonstration is subject to rules governing marketing and beneficiary communications as specified under Section 1851(h) of the Social Security Act. Additionally, all managed care plans in Ohio must abide by OAC 5160-26-08. OAC 5160-26-08 defines marketing very broadly:

> (A) Marketing means any communication from an MCP to an eligible individual who is not a member of that MCP that can reasonably be interpreted as intended to influence the individual to select membership in that MCP, or to not select membership in or to terminate membership from another MCP.

This means that plans are very restricted as to what and how they can market. CMS and Ohio Medicaid both monitor the marketing practices of the MyCare Ohio plans in order to ensure proper compliance. Current Bureau of State Hearing processes are maintained.

Managed care plans' marketing is closely regulated and varies by the line of business. A Medicare Advantage plan is permitted to go to a beneficiary's home and sign them up for their plan (known as 'one-on-one' marketing). However, this is not permitted in MyCare Ohio. While plans can market in public forums, they cannot go to beneficiary's home for enrollment purposes. Ohio Medicaid-CMS Contract Management Team (CMT) and the consulting firm of Booz Allen Hamilton will conduct supplemental oversight of the MyCare Ohio plans' marketing practices.

Appeals Process

Appeal processes vary at the state and federal levels. As a result, significant negotiation occurred between Ohio Medicaid and CMS to reach agreement on an appeals process that aligns with state and federal requirements and satisfies 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. 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 State Hearing Processes are maintained.

Adding New Benefits and Providers to Managed Care

MyCare Ohio added new benefits and new provider types to managed care, specifically behavioral health, waiver providers and nursing facilities. Behavioral health is part of MyCare Ohio even though it traditionally has not been fully incorporated into managed care. MyCare Ohio aims to create a comprehensive managed care program that integrates behavioral health services and long term care services and supports. Medicare-Medicaid enrollees with a primary diagnosis of serious mental illness will also have access to the State's Health Home model targeted to this population.

Prior to MyCare Ohio, Medicaid managed care plans had some experience working with nursing facilities which has provided a foundation for the future interactions resulting from MyCare Ohio. Medicaid managed care plans have not had the same level of interaction with waiver providers, which will necessitate more detailed engagement with these providers.

Implementation Planning and Oversight

Ohio Medicaid hosts a weekly meeting with the five MyCare Ohio plans. All areas of program development have been – and will continue to be – strategized, communicated, clarified and addressed through this forum.

Demonstration Measurement and Evaluation Design

Evaluation is an essential part of the MyCare Ohio demonstration. In addition to the requirements specified in the Ohio Revised Code, CMS contracted with an independent evaluator, RTI, to assess the impact of the MyCare Ohio demonstration. RTI's evaluation of MyCare Ohio 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
- Appeals and grievances

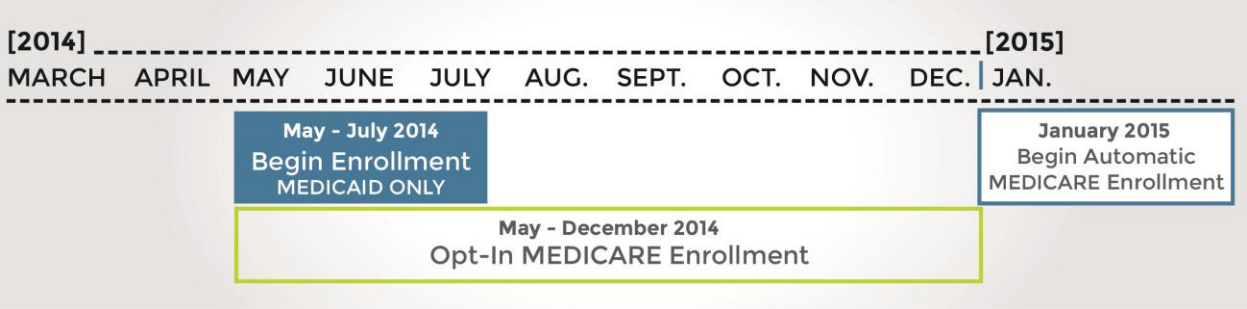
In order for RTI to accurately and comprehensively assess the MyCare Ohio program, full cooperation from the State, CMS and health plans is essential. In the three-way contract, the State and the MyCare Ohio plans agreed to submit all necessary data to RTI for its report. There are over a hundred different performance measures, both quantitative and qualitative, that will be used. Qualitative measures will be compiled through site visits, focus groups, interviews/surveys and analysis of program data. Quantitative measures will include changes in utilization, costs/savings, and readmission rates among others. The data will be pulled together for an Ohio-specific annual report, which will eventually lead to a final evaluation report at the end of the MyCare Ohio demonstration.

Ohio Medicaid has the responsibility to conduct a performance assessment as part of the 1915 (b)(c) waiver obtained from CMS. This waiver is the federal operating authority for the MyCare Ohio demonstration. Ohio Medicaid has devised a systematic rubric for measuring the success of the 1915 (c) waiver program which can be found in Appendix 3. There are six main areas that will be evaluated: (1) administrative authority; (2) level of care; (3) qualified providers; (4) service planning; (5) health and welfare; and (6) financial accountability. Each measure contains a list of specific metrics. Appendix 3 contains a complete list of the various waiver performance measures.

Early Feedback and Enrollment Data

Appendix 5 contains early enrollment data including how many people have enrolled, what plan they selected, whether they chose to opt-in and receive both benefit packages from the MyCare Ohio plan or if they opted-out and receive just their Medicaid benefits from the MyCare Ohio plan.

Appendix 1



Ohio Department of Medicaid

MyCareOhio
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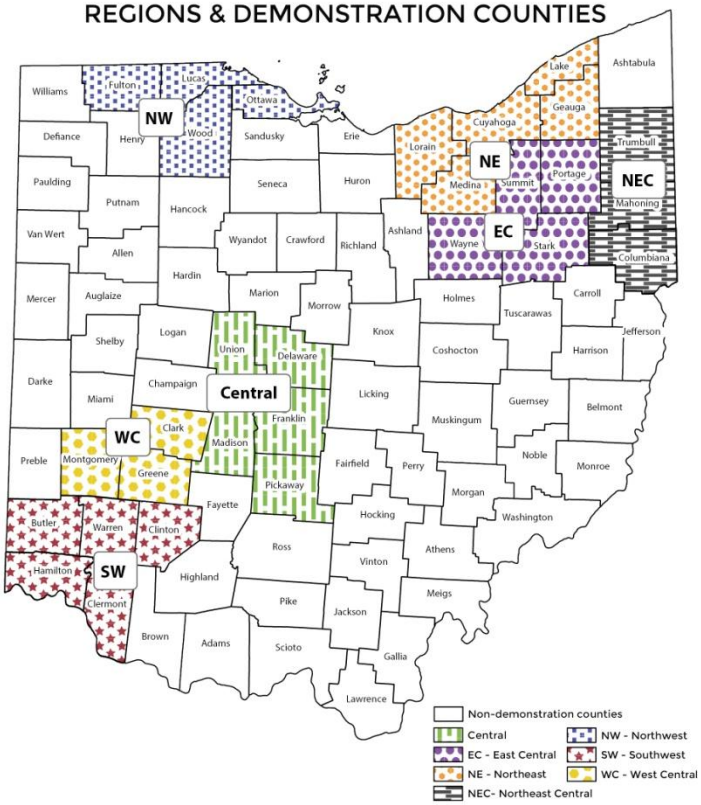
REGION	EFFECTIVE ENROLLMENT DATE
Northeast	5/1/2014
Northwest Northeast Central Southwest	6/1/2014
East Central Central West Central	7/1/2014

REGIONS & DEMONSTRATION COUNTIES



Appendix 2

MyCare Ohio enrollment counseling numbers that are a combination of either phone counseling or in-person counseling

February	
MyCare Region	**# consumers interactions**
SW	
WC	1
NW	
Central	5
NE	
EC	
NEC	
Totals	**6**

March	
MyCare Region	**# consumers interactions**
SW	
WC	
NW	
Central	1
NE	488
EC	
NEC	
Totals	**489**

April	
MyCare Region	**# consumers interactions**
SW	48
WC	12
NW	97
Central	16
NE	208
EC	5
NEC	110
Totals	**496**

Totals for Sites	
MyCare Region	**# consumers interactions**
SW	48
WC	13
NW	97
Central	22
NE	696
EC	5
NEC	110
Totals	**991**

Appendix 3

My Care Ohio1915(c) Waiver Performance Measures

1) Administrative Authority
    a. Percent of sampled MyCare Ohio waiver participants reviewed each year who are verified to meet level of care eligibility requirements.
    b. Number and percent of MyCare Ohio waiver participants reviewed who had their level of care determined or re-determined within the past 12 months.
    c. The number and percent of provider structural reviews due that were completed within required timeframes.
    d. The number and percent of reported MyCare Ohio waiver participant incidents investigated by the provider monitoring vendor that were found to have been resolved.
    e. Number and percent of required reports submitted by the MyCare Ohio plans in a complete and a timely manner.
    f. Number and percent of findings of MyCare Ohio plans' non-compliance that were remediated through an approved corrective action plan or other method as required by Ohio Medicaid/MyCare Ohio provider agreement.
    g. Number and percent of performance reports submitted by the level of care vendor in the correct format and in a timely manner.

2) Level of Care
    a. Number and percent of new MyCare Ohio Waiver participants who had a level of care indicating a need for institutional level of care prior to receipt of waiver services.
    b. Number and percent of level of care redeterminations for MyCare Ohio Waiver participants that were completed within 365 days of the previous level of care determination.
    c. The number and percent of sampled MyCare Ohio waiver participants whose initial level of care determinations were completed with Ohio Medicaid approved processes and instruments.
    d. The number and percent of sampled MyCare Ohio waiver participants whose reassessment of level of care were completed with Ohio Medicaid approved processes and instruments.

3) Qualified Providers
    a. The number and percent of new independent/individual MyCare Ohio waiver providers who meet provider enrollment requirements prior to providing waiver services.
    b. The number and percent of new MyCare Ohio waiver agency providers that meet provider enrollment requirements prior to providing waiver services.
    c. The number and percent of independent RNs and LPNs who continue to meet licensure requirements at the time of their structural review.

d. The number and percent of providers that have an active Medicaid provider agreement with Ohio Medicaid prior to the MyCare Ohio Plans authorizing the provider to provide waiver services.
e. The number and percent of existing independent/individual providers that continue to meet certification requirements at the time of Structural Compliance Review.
f. The number and percent of existing agency providers that continue to meet certification requirements at the time of Structural Compliance Review (SCR).
g. The number and percent of existing independent MyCare OhioWaiver personal care aides who have been verified to meet required and continuing education training requirements.
h. The number and percent of MyCare Ohio Waiver agency providers that have been verified to have met training requirements.

4) Service Planning
    a. The number and percent of MyCare Ohio waiver participants reviewed whose waiver service plans adequately address their assessed needs.
    b. Number and percent of MyCare Ohio waiver participants reviewed whose waiver service plan have strategies to address and mitigate their health and welfare risks factors.
    c. The number and percent of waiver service plans reviewed that address individuals' personal goals.
    d. The number and percent of MyCare Ohio Waiver participants reviewed whose waiver service plans were developed according to the processes described in the approved waiver.
    e. The number and percent of MyCare Ohio waiver participants reviewed whose waiver service plans were updated at least once in the past twelve months.
    f. The number and percent of sampled MyCare Ohio waiver participants whose service plans were revised, as needed, to address changing needs.
    g. The number and percent of MyCare Ohio waiver participants reviewed who received services in the type, scope, amount and frequency specified in the service plan.
    h. Number and percent of the MyCare Ohio waiver participants reviewed whose records contained a document signed by the participant to indicate their choice to receive waiver services instead of institutional care.

5) Health and Welfare
    a. The number and percent of incident reviews/investigations for MyCare Ohio Waiver participants that were initiated as specified in the waiver.
    b. The number and percent of incident reviews/investigations for MyCare Ohio Waiver participants that were completed as specified in the waiver.
    c. The number and percent of participants reviewed with an incident who had a plan of prevention/documentation of a plan developed as a result of the incident.

d. The number and percent of reported incidents of unauthorized restraint, seclusion or other restrictive interventions that were reported and investigated as specified in the MyCare Ohio waiver.
e. The number and percent of sampled MyCare Ohio waiver participants reviewed for whom there was a back-up plan in place in the event providers do not show up.
f. Number and percent of MyCare Ohio Waiver participants (and/or family members or legal guardians) reviewed who received information/education about how to report abuse, neglect, exploitation and other incidents as specified in the waiver.
g. The number and percent of reported MyCare Ohio Waiver participant incidents investigated by the MyCare Ohio plans that were found to have been fully investigated and resolved.

6) Financial Accountability
    a. The number and percent of individuals whose claims verified through a review of provider documentation to have paid in accordance with individuals' waiver service plans.
    b. The number and percent of providers sampled in performance measure #1 that submitted undocumented claims for waiver services that had payment recouped.

Appendix 4

Medicaid Consumer Hotline Activity Summary for April 2014

- 473,986 total calls for the Ohio Medicaid Consumer Hotline
  The breakdown of this total is:
- 434,275 Total Calls (inbound and outbound)
- 9,503 Automated Outbound Calls
- 22,629 MyCare Outreach Calls
- 7,320 Provider Calls
- 259 Insure Kids Now/Governor's Hotline
- 5% abandonment rate
- 6:48 minutes average talk time
- 1:53 minute average speed to answer
- 61 average CSR inbound calls per day

Appendix 5

Enrollment Data for MyCare Ohio

Table 1. **Number of MyCare Ohio Enrollments by the Effective Date of Enrollment and How They Enrolled**

	May 2014		June 2014	
How They Enrolled	Number	Percent	Number	Percent
Voluntary Enrollment	10,950	40.8%	7,231	20.4%
Passive Enrollment	15,910	59.2%	28,196	79.6%
Total	**26,860**	**100%**	**35,427**	**100%**

Table 2. **Number of MyCare Ohio Members by Managed Care Plan and Month**

	May 2014		June 2014	
Managed Care Plan	Number	Percent	Number	Percent
Aetna	0	0%	13,090	22.3%
Buckeye	4,996	19.2%	8,959	15.3%
CareSource	11,755	45.2%	15,888	27.1%
Molina	0	0%	7,370	12.6%
UnitedHealthCare	9,238	35.5%	13,384	22.8%
Total	**25,989**	**100%**	**58,691**	**100%**

The number of members enrolled, as reflected in this table, may be less than the number of enrollments, as reflected in the preceding table, because some members lose Medicaid eligibility or they may no longer be eligible for the MyCare program because of a change in circumstances.

Table 3. **Number of MyCare Ohio Members by Their Degree of Care Coordination***

	May 2014		June 2014	
Degree of Care Coordination	Number	Percent	Number	Percent
Medicaid Only	20,631	79.4%	49,531	84.4%
Dual Benefits	5,358	20.6%	9,160	15.6%
Total	**25,989**	**100%**	**58,691**	**100%**

* "Medicaid Only" means that the member has one managed care plan for their Medicaid benefits and a different managed care plan or Medicare fee-for-service for their Medicare benefits. "Dual Benefits" means that the same managed care plan manages the member's Medicaid and Medicare benefits.

Table 4. **Number of Unduplicated MyCare Ohio Members by Age Group (May-June 2014)**

Age Group	Number	Percent
18-44	9,956	16.8%
45-64	17,347	29.3%
65 and older	31,824	53.8%
Total	**59,127**	**100.0%**

Table 5. **Number of MyCare Ohio Members by Region, County, and Month**

	May 2014		June 2014	
East Central				
	Number	Percent of Total	Number	Percent of Total
Portage	0	0%	1	0%
Stark	0	0%	1	0%
Summit	2	0%	1	0%
Subtotal	2	0%	3	0%
Northeast				
Cuyahoga	20,569	79.1%	20,985	35.8%
Geauga	484	1.9%	494	0.8%
Lake	1,382	5.3%	1,435	2.4%
Lorain	2,733	10.5%	2,792	4.8%
Medina	819	3.2%	841	1.4%
Subtotal	25,987	100%	26,547	45.2%
Northeast Central				
Columbiana	0	0%	1,433	2.4%
Mahoning	0	0%	3,617	6.2%
Trumbull	0	0%	2,510	4.3%
Subtotal	0	0%	7,560	12.9%
Northwest				
Fulton	0	0%	310	0.5%
Lucas	0	0%	6,770	11.5%

Ottawa	0	0%	329	0.6%
Wood	0	0%	893	1.5%
Subtotal	0	0%	8,302	14.1%
Southwest				
Butler	0	0%	3,152	5.4%
Clermont	0	0%	1,669	2.8%
Clinton	0	0%	491	0.8%
Hamilton	0	0%	9,795	16.7%
Warren	0	0%	1,172	2.0%
Subtotal	0	0%	16,279	27.7%
Total	**25,989**	0%	**58,691**	**100%**

Appendix 6

Data Provided by Buckeye Community Health Plan

(A)(2) How changes to the administration of the MyCare Ohio affect all of the following:
(a) Claims processing;
Average time between receipt of claim and payment of claims, MyCare Ohio provider agreement vs. Medicaid Provider agreement

Buckeye will continue to have weekly checkwrites/EFT to providers under MyCare Ohio, which will allow turnaround time (TAT) to claim payment for MyCare to be consistent with the TAT under the regular Medicaid Provider Agreement. TAT is contingent upon providers being loaded into the claim system, so Buckeye is working to mitigate as much of that risk as possible by loading providers as soon as their information can be verified, and we are able to validate that they will be treating Buckeye's MyCare members. Priority is also given to providers who submit claims to Buckeye, but had not yet been identified as an entity that will be serving our members.

(b) The Appeals Process;
Average number of appeals per 1,000 members by month for the last twelve months under Medicaid provider agreement vs. what happened in May for MyCare Ohio

Appeal volume is dependent upon the volume of prior authorization requests which end up being denied. Under MyCare Ohio, typical prior authorization requests aren't required for any services already being received prior to the member's enrollment into MyCare as evidenced by the transition requirements. As such, the appeal volume for MyCare is 0.00 per 1,000 members compared to 0.36 per 1,000 members under the Medicaid Provider Agreement.

(c) The number of reassessments requested;
Please provide the number of assessments

For May 2014, Buckeye did not receive any requests for reassessments, but conducted 490 assessments.

(d) Prior authorization requests for services;
Same as (b) above

Like appeals as discussed above, prior authorizations are not required for any services being transitioned and as such, resulted in very low volume for May 2014. Under the Medicaid Provider Agreement, Buckeye received 61.7 PA requests per 1,000 members. Under MyCare, Buckeye received 13.2 PA requests per 1,000 members.

(A)(3) The provider panel selection process used by Medicaid managed care organizations participating in the MyCare Ohio;
A formal write-up as to how this was done.

Buckeye's preference is to have the member select their PCP, and when the information comes across on the daily file, that PCP is used for the member's ID card. If the member doesn't communicate their PCP of choice, our system is designed to automatically search for the closest available PCP to assign members. PCP selection however, always remains member choice and will be changed upon member request, or upon completion of the members' assessment when Buckeye more fully determines the members' needs and choices.

(B)(2)(b) Identify all of the following:
(i) Changes in the amount of time it takes to process claims and the number of claims denied and the reasons for the changes

1,410 claims were received in May, with approximately 1,000 of the claims being received in the final 2 weeks of the month. 236 were paid in May, 557 were denied with explanations as to why the claim wasn't payable and 617 hadn't yet paid by 5/31.

(ii) The impact that changes to the administration of the MyCare Ohio had on the appeals process and number of reassessments requested

No final impact has yet been determined since there were no appeals or reassessments in May, however impact will primary be volume driven, and staffing levels have been budgeted accordingly.

(iii) The number of prior authorization denials that were overturned and the reasons for the overturned denials.

No prior authorization denials were overturned in May 2014.

Appendix 7

Data Provided by CareSource

(A)(2) How changes to the administration of the MYCARE OHIO affect all of the following:

(a) Claims processing;

Average time between receipt of claim and payment of claims, ICDS provider agreement vs. Medicaid Provider agreement

Response: ***Answers below are for medical claims received from May 1, 2014 through May 31, 2014 with status of claims on June 2, 2014.***

- ***The average time to process Medicaid clean claims is (17.93) days***
- ***The average time to process Medicaid unclean claims is (10.06) days***
- ***The average time to process MyCare Ohio clean claims is (7.23) days***
- ***The average time to process MyCare Ohio unclean claims is (13.45) days***

(b) The Appeals Process;

Average number of appeals per 1,000 members by month for the last twelve months under Medicaid provider agreement vs. what happened in May for MyCare Ohio

Response:

Month	***Appeals per 1000 Medicaid members***	***Appeals per 1000 MyCare Members***
May-13	***7.3***	***-***
Jun-13	***6.89***	***-***
Jul-13	***5.38***	***-***
Aug-13	***6.38***	***-***
Sep-13	***6.14***	***-***
Oct-13	***4.86***	***-***

Nov-13	***0.49***	***-***
Dec-13	***0.48***	***-***
Jan-14	***0.37***	***-***
Feb-14	***0.43***	***-***
Mar-14	***0.47***	***-***
Apr-14	***0.49***	***-***
May-14	***-***	***-***

No Appeals have been filed by MyCare members as of 5/31/2014. For June 2014: 1 appeal and 2 State Hearing requests have been received.

(c) The number of reassessments requested;

Please provide the number of assessments

Response: ***The number of assessments completed as of June 8, 2014 is 1,914.***

(d) Prior authorization requests for services;

Same as (b) above

Response:

YYYYMM	***PA's***	***Enrollment***	***per 1,000 Mbrs***
201405	***690***	***11,660***	***59.17***

(A)(3) The provider panel selection process used by Medicaid managed care organizations participating in MyCare Ohio;

A formal write-up as to how this was done.

Response: ***The contracting team at CareSource focused on increasing our network within MyCare by first utilizing our existing network. We issued a Material Amendment to providers contracted to add MyCare to their agreement and to our ancillary contracts. We expanded contracting where needed. For example, we opened up our contracts for all of our SNF in market providers. Our CareSource Provider Relations team did an outreach to deemed***

providers to review and orient these existing providers. Additionally, we reached out to all facilities in our three regions to solicit into the program. Through the outreach program we identified affiliated providers and are aggressively pursuing those providers as well to become MyCare providers. Lastly through our AAA relationship (in the 3 regions) we contracted the non-traditional provider population to form an existing partnership with CareSource.

(B)(2)(b) Identify all of the following:

(i) Changes in the amount of time it takes to process claims and the number of claims denied and the reasons for the changes

<u>Response:</u> Currently there have been no changes in the amount of time to process our Medicaid claims because MyCare Ohio was just effective on 5/1/2014. During implementation of the MyCare Ohio product, CareSource has expedited payment for our providers to ensure a smooth transition.

Number of denied claims
Answers below are for medical claims received from May 1, 2014 through May 31, 2014 with status of claims on June 2, 2014.

- ***The denied amount of claims for Medicaid clean claims is 68,523***
- ***The denied amount of claims for Medicaid unclean claims is 37,148***
- ***The denied amount of claims for MyCare Ohio clean claims is 207***
- ***The denied amount of claims for MyCare Ohio unclean claims is 66***

Overall denial percent for Medicaid claims is (14%)
Overall denial percent for MyCare Ohio claims is (11%)

(ii) The impact that changes to the administration of the MyCare Ohio had on the appeals process and number of reassessments requested

<u>Response:</u> The impact to the appeals process for the administration of the MyCare Ohio demonstration is expected to be significant, with the appeal process needing to encompass potentially reviews under both Medicare and Medicaid regulations. CareSource has not received any appeal requests as of 5/31/2014.

(iii) The number of prior authorization denials that were overturned and the reasons for the overturned denials.

<u>Response:</u> As of May 31, 2014, there have been no prior authorization denials that have been overturned. No appeal requests have been filed during the timeframes within the reporting period that was requested by ODM. *** During the first week of June, we have had two (2) State Hearing requests and one (1) appeal request for lower partials.

Appendix 8

Data Provided by UnitedHealthcare Community Plan

I. Claims processing

Average time between receipt of claim and payment of claims, MyCare Ohio provider agreement vs. Medicaid Provider Agreement

For Medicaid, the average time between receipt of the claim and payment of claims was 8.59 days. For MyCare Ohio, the same metric was 12.57 days. The reason for the difference is that we chose not to release any claims until the 15th of May to complete a thorough quality check, and secondary review on MyCare Ohio claims.

II. The Appeals Process

Average number of appeals per 1,000 members by month for the last twelve months under Medicaid provider agreement vs. what happened in May for MyCare Ohio

The data below provides the Medicaid appeal per thousand by month for the last twelve months under the Medicaid provider agreement for OH:

Month	Membership	Appeals per 1000
May-13	114,766	0.44
Jun-13	114,595	0.40
Jul-13	162,530	0.31
Aug-13	162,164	0.47
Sep-13	165,769	0.46
Oct-13	166,902	0.54
Nov-13	167,788	0.42
Dec-13	167,699	0.41
Jan-14	174,779	0.54
Feb-14	171,276	0.51
Mar-14	176,887	0.52
Apr-14	187,357	0.55

MyCare Ohio: Only one appeal received in May 2014.

III. The Number of Reassessments Requested

Please provide the number of assessments

No reassessments have been requested since 5/1/14 implementation.

IV. Prior Authorization Requests for Services

Average number of prior auth requests per 1000 members by month for the last 12 months under Medicaid vs. what happened in May for MyCare Ohio

The data below provides the Medicaid prior authorization requests per thousand by month for the last twelve months under the Medicaid for OH:

Month	Prior authorization requests
Jun-13	39.64
Jul-13	46.61
Aug-13	59.3
Sep-13	59.21
Oct-13	71.6
Nov-13	56.21
Dec-13	54.65
Jan-14	58.54
Feb-14	59.05
Mar-14	69.69
Apr-14	76.55
May-14	67.23

MyCare Ohio: There were 195.66 prior authorization requests per thousand in May 2014.

V. The Provider Panel Selection Process Used By Medicaid Managed Care Organizations Participating in the MyCare Ohio

A formal write-up as to how this was done.

The UnitedHealthcare network development strategy was developed and implemented in early 2013, to ensure an adequate network to support the MyCare Ohio program by establishing a network of providers that met the appropriate state and CMS access and adequacy requirements. UnitedHealthcare initiated several mailings in 2013 to the providers identified by the Memorandum of Understanding (MOU), to introduce the MyCare Ohio program and provide the related contracting documents (Amendment and required Addenda). Targeted contracting efforts continued throughout the readiness phases, monitoring progress and identifying gaps, and UnitedHealthcare implemented additional outreach to meet readiness requirements.

UnitedHealthcare targeted both the current Medicare and Retirement ("M&R") and Community and State ("C&S") provider networks within the required geographic area. Physicians who practice within the CMS defined time and distance requirements for any of the 12 counties were identified and were recruited to be in the MyCare Ohio program. All state-required hospitals were identified and were offered a UnitedHealthcare MyCare Ohio contract.

For the Home and Community Based Services ("HCBS") provider network, UnitedHealthcare developed and implemented recruitment strategies in early 2013, to meet state access and adequacy requirements. Targeted mailings and outreach continued into early 2014. UnitedHealthcare reviewed the Medicaid Provider Master File by HCBS provider type in the 12 counties and sent out recruitment letters and contracting documents to home and community based provider types identified in the MOU. UnitedHealthcare coordinated informational meetings with home health agencies, and community agencies, and attended regional provider meetings organized by ODM. UnitedHealthcare presented at regional conferences and responded to all interested providers, offering an enrollment application and one-on-one education to assist providers with the application and contracting process.

For Dental, Vision and Transportation, United renegotiated our existing vendor agreements and added the MyCare Ohio product to the vendor contract. UnitedHealthcare reviewed the Medicaid provider files and identified additional providers and met all state and CMS access and adequacy requirements.

For Pharmacy, Behavioral Health and Long Term Care, UnitedHealthcare utilized the existing networks in the geographic region, and recruited and contracted additional providers to meet state and CMS access and adequacy requirements.

VI. Identify all of the following:

Changes in the amount of time it takes to process claims and the number of claims denied and the reasons for the changes

As noted above, the reason for the difference was UnitedHealthcare's choice to hold claims to complete a thorough quality check and secondary review.

UnitedHealthcare denied 903 MME claims in May. The vast majority of them were denied as we were requiring a Medicare EOB prior to Medicaid payment. 84.6% of UnitedHealthcare's May 2014 MyCare Ohio membership is Medicaid-only membership.

The impact that changes to the administration of the MyCare Ohio had on the appeals process and number of reassessments requested

There have been no reassessments requested to date. In order for the plan to effectively implement requirements for MyCare Ohio, the following were addressed:

- Staffing capacity adjusted for new population
- System modifications were required to support the State reporting needs
- New Policy and Procedures drafted and submitted to the state

- New Standard Operating Procedures (SOP) were developed to illustrate processes for MyCare Ohio specific requirements

- How to determine Full MMP vs. MMP Medicaid Only plan and benefits

- New Grievance SOP and How to determine Access Grievance

- New Appeals processes based on Medicaid-only or dual benefit ICSD member and benefit type

- New Letter templates were drafted, submitted for approval, and trained to the staff

The number of prior authorization denials that were overturned and the reasons for the overturned denials.

Only one prior authorization denial was overturned in May 2014. The denial was in regards to an authorization for dental. The prior authorization denial was overturned as the services were authorized by Medicaid prior to the member's May 1, 2014 effective date with UnitedHealthcare.