THE OHIO DEPARTMENT OF MEDICAID

JOHN R. KASICH, GOVERNOR JOHN B. McCARTHY, DIRECTOR

MyCare Ohio Annual Report SFY 2015

SUBMITTED JUNE 30, 2015

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, 2015

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 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 efforts to implement a truly innovative program aimed at serving residents with complex health care needs.

As we forge ahead with this endeavor, 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

Table of Contents

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[1].

MyCare Ohio is a three-year 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.

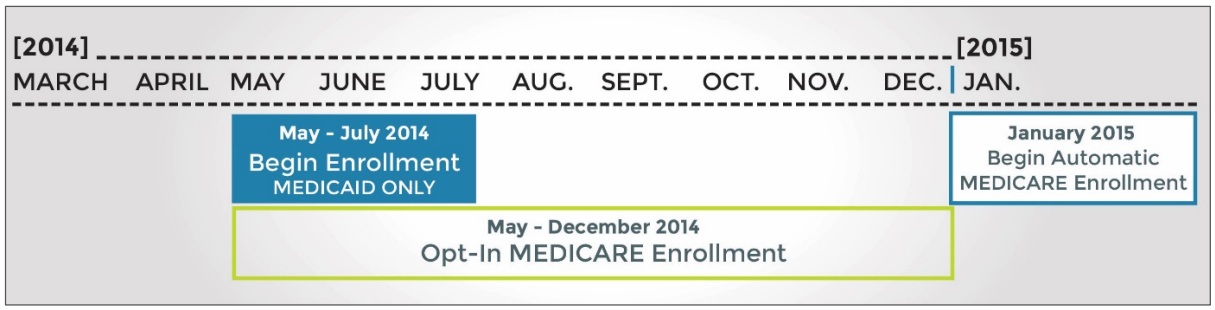
The demonstration integrates and coordinates health care delivery by:

- 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 the Medicare benefits if they choose. The average monthly enrollment for *MyCare Ohio* is approximately 95,000 individuals.

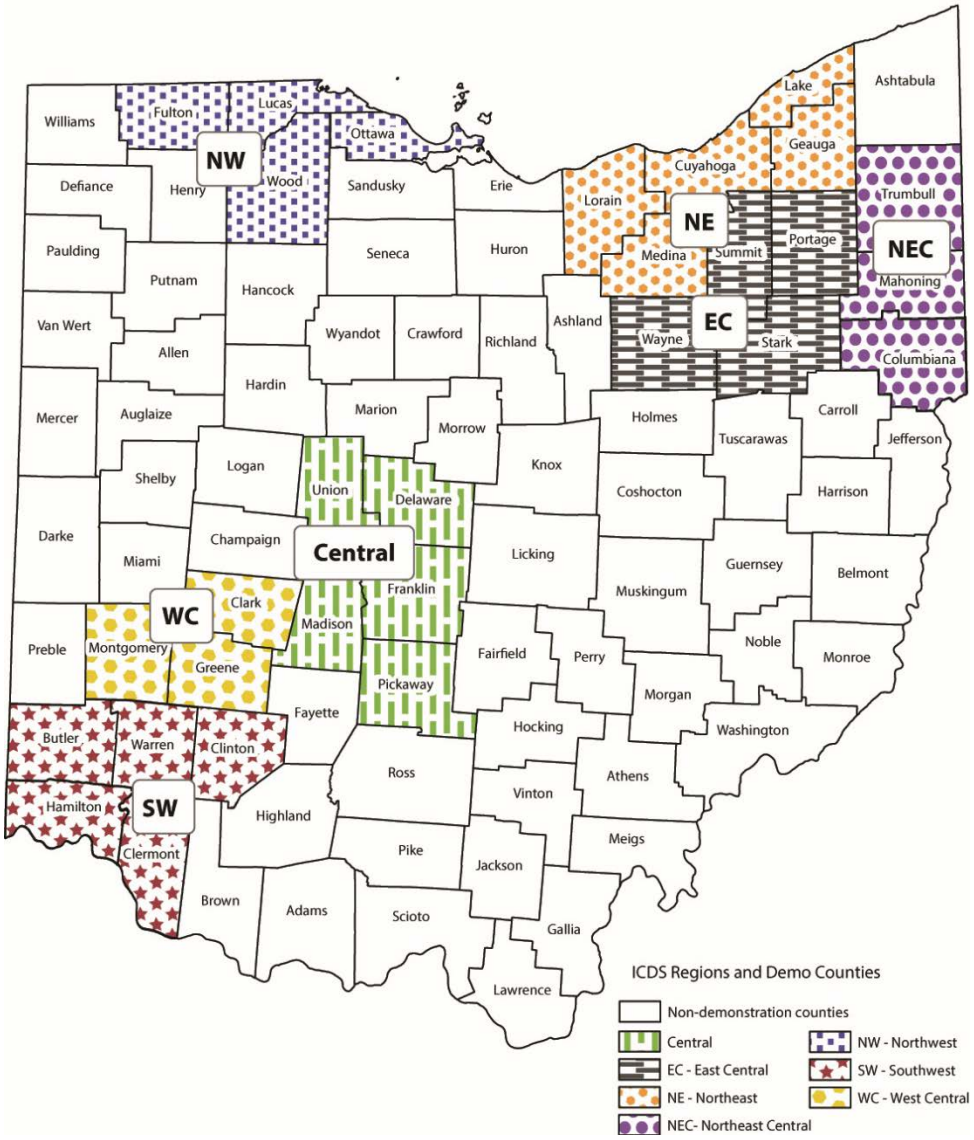
Ohio Medicaid continues to work closely with CMS through weekly update calls and also facilitates monthly meetings involving the managed care plans.

Figure 1: MyCare Ohio Enrollment Timeline



[1] *MyCare Ohio* was initially referred to as the Integrated Care Delivery System (ICDS) during its conceptualization and design stages.

Figure 2: MyCare Ohio Regions and Demonstration Counties with Enrollment Dates



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

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.

Enrollment Data

The tables below contain enrollment data as of March 2015. Table 1 compares enrollment numbers for *MyCare Ohio* dual members to Medicaid-only members, by plan in each region. Figure 4 shows the types of enrollment by plan.

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

MyCare REGION	Managed Care Plans										Total		Overall MyCare	% of Duals to MyCare
	Aetna		Buckeye		Caresource		Molina		United					
	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	2,285	5,224	0	0	0	0	1,573	4,064	0	0	3,858	9,288	13,146	70.7%
East Central	0	0	0	0	1,960	4,205	0	0	2,267	5,009	4,227	9,214	13,441	68.6%
Northeast	0	0	1,034	3,573	4,076	8,836	0	0	2,502	6,202	7,612	18,611	26,223	71.0%
Northeast Central	0	0	0	0	906	2,753	0	0	1,015	2,809	1,921	5,562	7,483	74.3%
Northwest	1,150	3,073	901	3,021	0	0	0	0	0	0	2,051	6,094	8,145	74.8%
Southwest	3,183	5,939	0	0	0	0	2,446	4,632	0	0	5,629	10,571	16,200	65.3%
West Central	0	0	2,941	4,189	0	0	1,202	2,570	0	0	4,143	6,759	10,902	62.0%
Total	6,618	14,236	4,876	10,783	6,942	15,794	5,221	11,266	5,784	14,020	29,441	66,099	95,540	69.2%
Total/Opt-in (%)	**20,854**	**68.3%**	**15,659**	**68.9%**	**22,736**	**69.5%**	**16,487**	**68.3%**	**19,804**	**70.8%**	**95,540**	**69.2%**		

Table 2: Types of Enrollment by *MyCare Ohio* Plan – March 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	8,633	2,657	11,290	54.2%	3,344	1,622	4,966	23.9%	2,120	2,440	4,560	21.9%	20,816
Buckeye	6,533	1,850	8,383	53.8%	2,914	1,750	4,664	29.9%	1,202	1,328	2,530	16.2%	15,577
CareSource	10,453	2,491	12,944	56.9%	3,617	2,306	5,923	26.0%	1,619	2,264	3,883	17.1%	22,750
Molina	7,270	2,224	9,494	58.2%	2,342	1,421	3,763	23.1%	1,425	1,633	3,058	18.7%	16,315
United Healthcare	8,042	2,318	10,360	52.8%	3,227	1,553	4,780	24.4%	2,484	2,005	4,489	22.9%	19,629
TOTAL	**40,931**	**11,540**	**52,471**	**55.2%**	**15,444**	**8,652**	**24,096**	**25.3%**	**8,850**	**9,670**	**18,520**	**19.5%**	**95,087**

Prior Authorization

MyCare Ohio plans must provide timely access to all medically necessary covered services. Additionally, plans may require prior authorization 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 prior authorization (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 for denied requests.

Table 3: Total Number of Prior Authorization Requests Received by *MyCare Ohio* Plans between March 1, 2014 and March 31, 2015

Total Prior Authorization Requests	Total Prior Authorization Requests Per 1000 Member Months	Approval Percentage	Denial Percentage	Total Prior Authorization Requests	Total Prior Authorization Requests Per 1000 Member Months	Approval Percentage	Denial or Limited Approval Percentage
148,431	156.88	93.43%	6.57%	832,900	880.308	92.82%	7.18%

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 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 May 1, 2014 to March 31, 2015

Total Number of Appeals	Number of Appeals per 1,000 Members Months*	Number of Appeals Sustained**	Number of Appeals Overruled***
488	.0524	179	309

* 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, percent rejected, and percent paid within 30 days as of March 2015.

Table 5: Claims Processing within 30 days by the *MyCare Ohio* plans from May 1, 2014 to March 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	4,532	187,835	$52,480,167	17.2%	91.4%
			CareSource	15,782	1,512,597	$245,042,621	12.6%	91.2%
			United	8,551	428,548	$370,410,495	18.2%	91.6%
Northeast Central	Trumbull, Mahoning, Columbiana	June 1, 2014	CareSource	4,592	339,027	$52,502,445	12.3%	92.4%
			United	3,716	137,496	$128,160,541	21.4%	94.7%
Northwest	Fulton, Lucas, Wood, Ottawa	June 1, 2014	Aetna	4,166	175,149	$45,825,194	14.2%	87.5%
			Buckeye	3,883	163,972	$40,262,573	19.5%	90.8%
Southwest	Butler, Warren, Clinton, Hamilton, Clermont	June 1, 2014	Aetna	8,929	321,024	$122,267,593	14.5%	87.3%
			Molina	7,415	261,760	$115,128,762	11.6%	97.1%
East Central	Wayne, Summit, Stark, Portage	July 1, 2014	CareSource	8,819	643,476	$100,280,753	12.2%	93.8%
			United	7,202	250,900	$220,869,548	18.2%	94.3%
Central	Franklin, Union, Delaware, Madison, Pickaway	July 1, 2014	Aetna	7,440	354,204	$96,749,880	10.5%	92.7%
			Molina	5,984	249,213	$82,685,046	13.2%	97.8%
West Central	Montgomery, Clark, Greene	July 1, 2014	Buckeye	7,099	296,217	$83,540,383	18.9%	91.4%
			Molina	4,022	164,411	$48,536,973	13.7%	97.4%
TOTAL				102,132	5,485,829	$1,804,742,973		

*Includes cumulative number of claims and amount of claims paid from the date enrollment began in that region.
**Duplicate claim denials have been removed from rejection rate

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 over 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 year of implementation. 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.