Ohio | Department of Medicaid

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

Director John B. McCarthy
JMOC Testimony
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Good morning Chairwoman Sears, Vice Chairman Burke, Executive Director Ackerman, and members of the committee. I have been asked to come before you this morning to offer an update on *MyCare Ohio*. As you are all aware, *MyCare Ohio* is Ohio Medicaid's three-year demonstration project designed to coordinate health care benefits for individuals served by both Medicare and Medicaid. The demonstration's initial launch took place in May 2014 with full implementation occurring on January 1 of this year.

Prior to the end of fiscal year 2015, our department submitted the second iteration of the *MyCare Ohio* Annual Report. While the report is available online, I have been asked to provide a brief summary of the report. Data available at the time of the report's publication show:

- an average monthly enrollment of approximately 95,000 individuals, among the five managed care plans;
- as of March 2015, nearly 5.5 million claims had been processed and more than $1.8 billion in claims payments had been paid to *MyCare Ohio* providers; and
- also, among all five plans, nearly 93% of claims had been paid within 30 days. This figure is within federal prompt pay standards.

Last month, Executive Director Ackerman provided our agency with follow-up questions regarding information found in the report. We have gone ahead and included answers to those questions as an attachment to today's testimony.

Like all of our Medicaid programs, we continue to seek out new ways to innovate and improve *MyCare Ohio*. With that said, we have recently made a number of changes to the *MyCare Ohio* provider agreements. These changes include:

- a new requirement that managed care plans provide ODM with at least 4 months' notice when changing the availability of any provider or combination of providers serving 100 or more *MyCare Ohio* members;

- updated standards around transportation. Requirements have been added to improve timeliness of pick-up and drop-off for appointments;

- Transportation vendors must attempt to contact beneficiaries should they not be able to show up for pick-up. They are also prohibited from leaving a pick-up location prior to the scheduled pick-up time;

- ODM has clarified requirements for payment of physician Medicaid claims in accordance with ODM secondary payment methodology related to cost-sharing, unless contract incentives are clearly documented;

- we have also strengthened the Coordination of Benefits Agreement (COBA) requirements for managed care plans to exchange files with CMS verifying eligibility and accepting Medicare claims for Medicaid payment; and

- finally, we are requiring *MyCare Ohio* plans to develop a methodology for assigning appropriate caseload sizes for care managers to ensure health, safety and effective care management for beneficiaries.

Reforms such as these are not just refining the responsibilities of our managed care partners and providers, but also enhancing care quality for the individuals we serve. While additional modifications to provider agreements and contracts are likely, I wanted to take the opportunity to share these recent improvements with you.

Once again, thank you for the opportunity to testify before this panel. I am happy to field any questions you may have.