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Highlights:

- MyCare Ohio integrates medical care, long-term services and supports, and behavioral health services for Ohioans eligible for both Medicare and Medicaid.

- MyCare Ohio's creation is made possible by the Affordable Care Act, which authorizes states to create "financial alignment" demonstrations for a three-year period.

- MyCare Ohio is being implemented in 29 counties in seven regions. In each region, the state has contracted with two private managed care companies (in the Cleveland region, a third plan is contracted).

- On the Medicaid side, consumers were passively enrolled in one of the plans in their region between May 1 and July 1 of this year. Consumers could also choose to enroll in a Medicare MyCare plan for Medicare services but will not be passively assigned until January 1, 2015. On the Medicare side, consumers may opt out and stay on Medicare fee-for-service or on a Medicare Advantage plan, but the consumers would continue to receive Medicaid services through the MyCare plan. Opting out on the Medicaid side is not an option.

- MyCare enrollees include those in nursing homes, those served in one of Ohio's five Medicaid waiver programs serving elders and younger Ohioans with physical disabilities based on eligibility for nursing home care, including PASSPORT and Ohio Home Care, and the "community well" including consumers with behavioral health needs.

- Operation of MyCare is governed by a Memorandum of Understanding between Ohio and the Centers for Medicare and Medicaid Services. The selected plans entered into a three-party agreement with Ohio and CMS.

- Consumers enrolled in MyCare benefit from protections in Medicare and Medicaid law and have access to a MyCare ombudsman to assist with problem resolution.

- MyCare consumers have a role in plan governance through Consumer Advisory Councils and semi-annual meetings for plan participants.

- Early MyCare implementation issues can be categorized as those dealing with care coordination and assessment for participants, "continuity of care" problems with specific service providers, and payment issues, in particular with independent providers serving consumers under age 60.

What is MyCare?

MyCare Ohio is Ohio's implementation of a new approach to integrating care and services for Ohioans who are eligible for ***both*** Medicare and Medicaid. MyCare constitutes the greatest change to how Medicaid and Medicare services are delivered in Ohio's Medicaid history. The Affordable Care Act authorized the creation of "financial alignment" demonstrations (so-called because of the effort to "align" the incentives in the two largest government-funded health programs). To date, the federal Centers for Medicare and Medicaid Services (CMS) has accepted 13 state proposals creating an integrated approach to Medicare and Medicaid, though each state's approach is quite different in design.[1] Ohio's demonstration is for a three-year period, ending December 31, 2016.

In the summer of 2011, CMS offered states two pathways to integrating care and services—one through a capitated, managed care approach run by private health insurers (called Managed Care Organizations or MCOs) and one through a managed fee-for-service model working with service providers, including medical "health homes." Ohio chose the capitated, managed care approach, electing to pay a fixed monthly rate to an MCO. The MCO is, in turn, at risk to provide all care and services to its enrolled members. If the MCO is able to deliver needed services for less than the capitated payment, the MCO benefits; if not, the MCO is still responsible to pay for the services above and beyond the amount of the payment it received.

The Ohio demonstration is one of the earliest state financial alignment demonstrations to begin operating. It is also broader in scope than many other proposals in that it covers elders, adult Ohioans with physical disabilities, and adult Ohioans with behavioral health needs. In implementing MyCare, Ohio was also required by CMS to obtain a new Medicaid waiver that encompasses all of Ohio's five Medicaid waivers where participation was dependent on the consumer having level of care needs equivalent to that required for Medicaid nursing home coverage. Ohio began rolling out MyCare implementation on May 1 in Northeast Ohio and completed the initial rollout on July 1.

Why MyCare?

Despite very similar sounding names, Medicare and Medicaid are not well-coordinated and may, in fact, have competing objectives.[2] Exacerbating this fact, consumers eligible for both programs have the greatest need for services. According to Ohio Medicaid Director John McCarthy, the 14 percent of Ohio's Medicaid beneficiaries that are also eligible for Medicare constitute 34 percent of Medicaid spending for services.[3] Eighty-eight percent of this Medicaid spending is for long-term services and supports, including nursing home care and home- and community-based services.

Appearing before the newly created Joint Medicaid Oversight Committee of the General Assembly in July, 2014, McCarthy highlighted the goals of MyCare as follows:

- Improve health outcomes,

•Identify new ways to reduce overall cost of care between systems,

•Provide individuals with a single point of contact for the administration of services,

•Establish a delivery system that is easy to navigate for both the individual and provider, and

•Create a seamless transition between care settings and programs as the needs of individuals change.[4]

It is interesting that before passage of the Affordable Care Act, nationally, only 160,000 consumers eligible for both Medicare and Medicaid were enrolled in managed care. In just a few months, Ohio, through MyCare, has added some 103,000 individuals to this number, which may explain, in part, some of the start-up issues experienced with MyCare (discussed below).[5]

Who is Eligible for MyCare Ohio?

Not every dually eligible Medicare and Medicaid consumer is enrolled in the MyCare Ohio demonstration. First, consumers must live in one of 29 Ohio counties participating in the demonstration (see Figure 1). These 29 counties either are urban counties or are contiguous to Ohio's urban population centers. Other eligibility requirements include the following:

- Age 18 and older at the time of enrollment, and
- Eligible for full Medicare Parts, A, B, and D and full Medicaid.[6]

Some examples of those covered include Ohioans who:

- Participate in Ohio Home Care or Transitions Carve-Out Waivers,
- Receive AoD and/or Mental Health Services,
- Participate in PASSPORT or Choices Waiver,
- Participate in Assisted Living Medicaid Waiver receiving Medicare and Medicaid, or
- Receive Medicaid payments for nursing home care.

The following are **not** eligible for enrollment in MyCare:

- Under the age of 18,
- On a delayed Medicaid spend down,[7]
- If other third party creditable health care coverage is available,
- A person with Intellectual Disabilities (ID)or Developmental Disabilities (DD) served through an IDD 1915(c) HCBS waiver or an ICF-IDD (may opt in, but that would end their enrollment in their current Medicaid waiver),
- Enrolled in PACE (Program of All-inclusive Care for the Elderly), or
- Participating in the CMS Independence at Home (IAH) demonstration.[8]

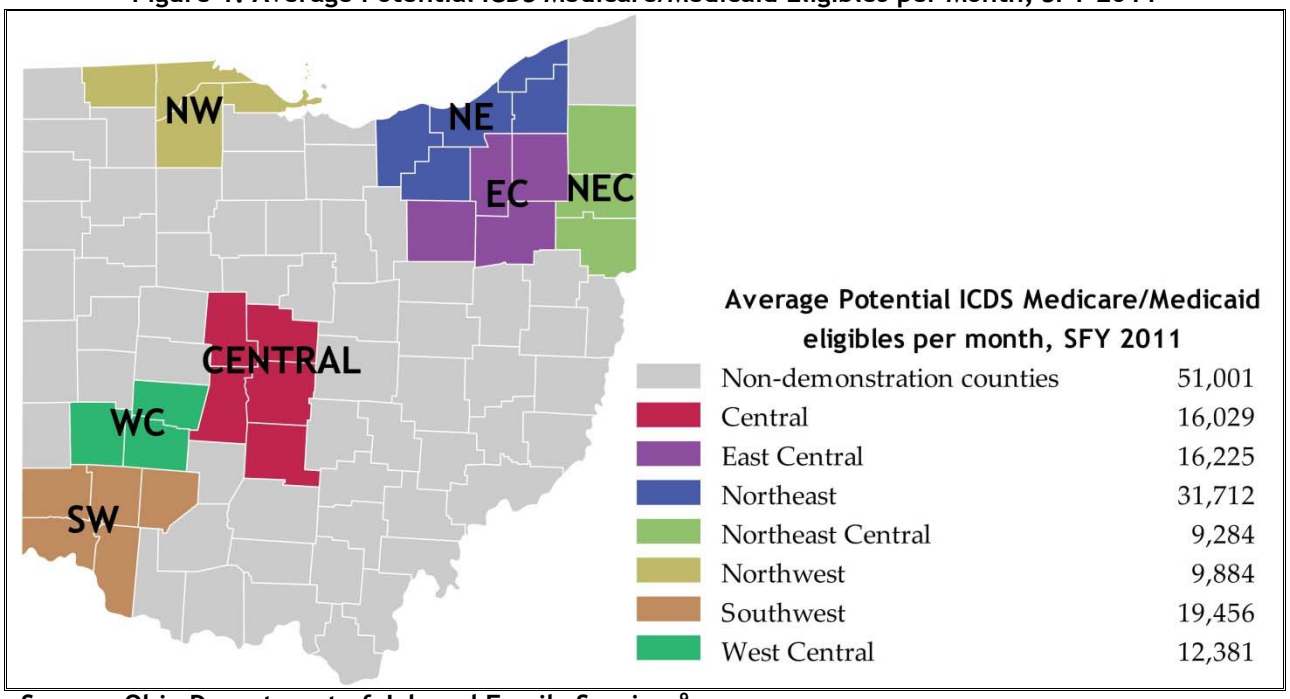
Consumers eligible for MyCare Ohio must select one of the two or three MyCare MCO plans in their region (see Table 1) for receipt of their Medicaid-funded services. Because federal law does not allow the government to require managed-care enrollment in Medicare, the consumer may

opt in or opt out for Medicare-paid benefits. Of course, for the purpose of the demonstration, the state is encouraging consumers to opt in to the MCO's Medicare plan so that benefits are more likely coordinated.

Consumers were given a short period to choose a **Medicaid** MCO plan; those who did not make a selection were "passively assigned" in the spring (see Table 1). Consumers will not be passively enrolled into a Medicare MyCare plan until January 1, 2015. This will give consumers time, during the regular Medicare open enrollment period this fall, to opt out of the MyCare Medicare plans by indicating that they wish to stay on Medicare fee-for-service or by joining a Medicare Advantage plan. Consumers will be passively enrolled into a MyCare **Medicare** plan on January 1, 2015, if they do not make an affirmative election to opt out.

Ohio has divided the 29 participating counties into seven geographic regions, centering on major urban areas within the state:

Figure 1: Average Potential ICDS Medicare/Medicaid Eligibles per Month, SFY 2011



Source: Ohio Department of Job and Family Services[9]

In summer, 2012, Ohio selected the MyCare MCOs through a competitive process. Each of the five plans selected were allowed to choose three of the seven regions in which to participate. In each region, except the northeast region that includes Cleveland, two plans are available. Due to the large number of consumers enrolled in the northeast region, three plans are available.

Table 1: Medicaid Enrollment Timeline

Region	Plans	Passive Enrollment Reminder Notices	Passive Enrollment Effective Date
NE	Buckeye, CareSource, United Health Care	3/25/14	5/1/14
NW	Aetna, Buckeye	4/24/14	6/1/14
NEC	CareSource, United Health Care	4/24/14	6/1/14
SW	Aetna, Molina	4/24/14	6/1/14
EC	CareSource, United Health Care	5/25/14	7/1/14
CEN	Aetna, Molina	5/25/14	7/1/14
WC	Buckeye, Molina	5/25/14	7/1/14

Source: Ohio Department of Medicaid[10]

Passive Medicaid enrollment was rolled out over a 90-day period, beginning in the northeast region.

Service Delivery under MyCare Ohio

A key question as MyCare is implemented is how the demonstration will change service delivery to benefit consumers. Consumers, agreeing to participate in Medicare, as well as Medicaid, will receive all health, long-term services and supports—including nursing home care and home- and community-based services, and behavioral health services through MyCare. Perhaps the most important factor in whether MyCare is successful is the extent to which these very different types of service can be integrated into a holistic, person-centered care plan for each consumer. Other aspects of MyCare can be divined from the Memorandum of Understanding (MOU) between CMS and Ohio in December, 2012[11]:

- Team approach to care management;
- Periodic home visits;
- 24-hour in-person phone coverage;
- Pharmacy management program
- Aggressive management of care transitions (e.g., between a hospital setting and home);
- Comprehensive behavioral health care management;
- Culturally sensitive approach;
- Common centralized health records; and
- Self-directed service option for LTSS (i.e., the consumer self-directs LTSS and becomes employer of record for staff).

Greater detail is contained in the three-party agreement between CMS, Ohio, and each of the five plans signed in February, 2014.[12] This agreement requires coordination with other important state programs such as HOME Choice, the program that creates opportunities for nursing home residents to relocate to community settings.

For consumers who are eligible for one of Ohio's five nursing-facility-based Medicaid waivers (i.e., PASSPORT, Ohio Home Care, assisted living, Choices, or the Transitions Carve-out waiver), Ohio has received a new MyCare waiver[13] that incorporates each of the elements of the five waivers. PASSPORT services now add nursing services and respite services. The new

waiver design also allows consumers enrolled in MyCare to self-direct their service options, principally by allowing them to become the employer of record for their service providers.

A unique feature of the Ohio MyCare demonstration is the role played by Ohio's Area Agencies on Aging (AAAs) in implementing MyCare—a role not assumed by other financial alignment demonstrations in the country.

In addition to the MyCare care manager employed by the health plan, consumers in need of long-term services and supports receive the assistance of a waiver services coordinator. For Ohioans age 60 and over, the AAAs contract with the plans to be the waiver services coordinator unless the consumer elects a different coordinator. For those under the age of 60, the AAA may contract with the plan to be the waiver service coordinator, the plan itself may supply a coordinator, or the plan may contract with another entity such as a Center for Independent Living to provide a coordinator.

Aside from waiver services coordination, the AAAs also provide important systems functions for MyCare but under contract with the state instead of the plans. As was true in the existing PASSPORT system, AAAs are responsible for determining functional eligibility for either LTSS waiver services or nursing home services (called "level of care" determinations). Through the AAA-led Aging and Disability Resource Networks, enrollment counseling is available to MyCare participants.

Rate Setting in MyCare

As noted earlier, Ohio has elected to use a capitated rate managed care strategy in implementing MyCare. Setting the capitated monthly rate is complicated, but some general principles are important. First, each plan receives three different capitated rates for each consumer enrolled in the plan. One rate is for Medicare-funded services; a second rate is for Medicare Part D prescription drugs; and a third rate is for Medicaid-funded services.

In setting the Medicaid capitated rate, each consumer enrolled in MyCare is assigned to a specific risk category: "Community Well" representing consumers who do not meet the nursing home level of care functional criteria (rates differ according to age for this category and by MyCare region); and nursing facility level of care (NFLOC) which comprises consumers who are enrolled in a Medicaid home- and community-based services waiver or have been in a nursing home for more than 100 days.

The Medicare capitated rate is a blended average of the county Medicare fee for services rate and the Medicare Advantage (a Medicare managed care program). This average is then risk-adjusted according to Medicare principles. The Medicare prescription drug capitation rate is the national average rate which is also risk adjusted.[14]

An aggregate savings percentage of 1 percent in the first year of the demonstration, 2 percent in the second year, and 4 percent in the third year is assumed (except for the Medicare Part D

component)—modest, but the administration has always been clear that the primary goal of the MyCare demonstration is to improve care rather than produce large cost savings.

A "quality holdback" of a small percentage of the plan's overall rate (again, except for the Medicare Part D rate) is withheld which plans can earn back, in effect, by meeting established quality objectives.[15] Both CMS and Ohio have established these quality objectives. CMS measures are those national measures related to quality, access, customer service, and consumer participation in plan governance (discussed below). Ohio measures are related to overall balance in the state's LTSS system and diversion from nursing home care. One percent is withheld in the first year, 2 percent in the second year, and 3 percent in the third year of the MyCare demonstration.

Consumer Protections in MyCare

Consumers enrolled in one health plan in their region have a 90-day period to select another MyCare health plan. Reasons to do this might relate to their primary care network not participating in the plan they were enrolled in or might relate to medications covered under one health plan but not another. This 90-day period will have already expired for those in the northeast region.

Consumers enrolled in MyCare who are dissatisfied with decisions made in regard to their care or treatment may file grievances with their health plan. In addition, consumers are entitled to use all of the appeals processes applicable in general to Medicare and Medicaid. Consumers who follow the formal appeals path may be able to continue receiving disputed services during the appeals process, depending on the type of benefit and how quickly the appeal is filed.

All plans are required to have Consumer Advisory Councils (CACs) in **each** region the plan serves. The CAC has input into the policies and protocols adopted by the health plan. Each CAC must have at least 20 percent participation by consumers enrolled in that particular plan. Beyond the CAC, each plan must organize semi-annual meetings for participants of the plan where grievances and concerns may be aired. The establishment of these CACs should occur in the fall, and are one of the "quality withhold" measures discussed previously.

Though not required by the MOU, Ohio has agreed to convene regular implementation team meetings that include the plans, consumers, consumer advocates, and others involved in MyCare.

To enhance consumer participation in MyCare, the Universal Health Care Action Network of Ohio (UHCAN Ohio) has received a grant through Community Catalyst to support consumers. UHCAN has created a new coalition to support MyCare consumers—the Ohio Consumer Voice for Integrated Care (OCVIC). OCVIC consists of a statewide coalition and three regional coalitions comprising both aging and disability advocates in Cleveland, Cincinnati, and Columbus. A major goal of OCVIC is to organize consumers so that they are equipped to participate meaningfully in the required CACs. OCVIC will also be a participant in the state's

implementation team. Community Catalyst has created a toolkit to assist in ensuring meaningful consumer participation in the "financial alignment" demonstrations.[16]

Consumers may also file complaints and grievances through a MyCare ombudsman. Building on Ohio's successful long-term care ombudsman program, the MyCare ombudsmen are specifically tasked with handling complaints and concerns that arise during the MyCare demonstration.

MyCare Early Implementation Issues

Given the major change MyCare brings to how services are delivered in Ohio, it is not surprising that some early issues have surfaced with demonstration implementation. While this is not an exhaustive list, the issues can generally be grouped into three categories: Issues surrounding care coordination and assessment; issues involving continuity of care; and issues involving payment of service providers.

While most of the public attention has focused on lack of payment to independent providers—more on that below—arguably the most critical issue is that consumers report not knowing how to contact their care managers—or even who those care managers are. This is troubling because the premise of the demonstration is that better outcomes for consumers will occur through better care coordination. There are likely multiple reasons for this problem. Consumers appear not to be well-educated about MyCare and the expectations they should have. Given the number of consumers enrolled in MyCare in a short period of time, the MyCare plans may not have sufficient staff on board to ensure that consumers are properly assigned to care managers. Also, all consumers enrolled in MyCare are to receive an assessment and a care or service plan. The timing for these assessments varies depending on which of four "risk stratification" categories the plan assigns to the consumer. This is done to ensure that those most at risk receive the earliest assessment. However, by now, all initial assessments should have been completed in the northeast region, including Cleveland, but several organizations have reported that consumers still lack that initial assessment. In some cases, consumers are told that a needed service can't be provided because the consumer lacks the appropriate assessment or care plan. In some cases, the plans report that consumers have not responded to repeated requests to schedule an assessment. Given the lack of understanding by MyCare enrollees about the new program, this is likely true. Consumers on Medicaid waivers such as PASSPORT or Ohio Home Care may feel that they have been assessed recently and are reluctant to go through what they perceive to be a redundant process. In other situations, consumers have complained that the plan assessors lack common knowledge about the provision of long-term services and supports or the basic tenets of independent living—an obvious training issue.

These problems make it especially critical that the plans comply with the "continuity of care" provisions in the three-way contract they signed. There are several dimensions of this problem as well. Specifically, in regard to the problem with assessments, the plans should be honoring the provisions of the most recent care plan until an assessment occurs and a new plan is developed. Continuity of care also has implications for the provider network serving

consumers. While complicated, in essence, providers are guaranteed participation in the plan's service provider network for a given period that varies by type of provider. But provider continuity is a two-way street. Some providers have indicated their unwillingness to participate in MyCare; under Medicare and Medicaid law, the provider does have the choice of whether to participate. Often, though, the problem is that, just as consumers lack an understanding of MyCare, so also do the service providers. As the demonstration continues, it is hoped that more effort can be put into educating the service provider community more fully about MyCare.

The third category of issues—provider payment—may be a uniquely Ohio issue, primarily affecting consumers under age 60. For many years, LTSS (and the ability to provide assistance with activities of daily living such as dressing, feeding, bathing, toileting, and mobility transfers) for consumers under 60 enrolled on the Ohio Home Care waiver has been delivered by individual providers. Often, the living circumstances of these independent providers are as perilous as it is for the consumers they serve. Managed care plans are used to reimbursing claims filed on a 30-day cycle, which jeopardizes the independent provider. Adding to the issue of timely payment is that, often, independent providers simply do not know how to submit a "clean claim" to the plan. Most independent providers prior to MyCare implementation were accustomed to billing through a third-party agent, but as the demonstration started, this agent announced that it would no longer serve this purpose, leaving the independent provider to learn the plan's claim submission system. How great is this problem? The Ohio Department of Medicaid has estimated that there are 6,000 independent providers in Ohio whose identity was likely unknown to the plan until MyCare started. Plans have been forced to scramble to educate these independent providers on claims submission, but in the meantime, there are reports that some independent providers have walked off the job, leaving the consumers they serve in very great jeopardy.

Conclusion

Implementation of MyCare Ohio is very new, and time will tell if the early startup issues can be successfully resolved. Ohio has tools to address issues both through the aforementioned implementation team that begins meeting shortly and through its own internal Contract Management Team.

Because the "financial alignment" programs are demonstrations, CMS will undertake its own evaluation. CMS has contracted with RTI International—a well-respected evaluator—to undertake the evaluation. But evaluations take time, and the problems encountered with MyCare Ohio to date will have to be addressed long before even preliminary evaluation data are available.

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[1] The Kaiser Family Foundation has written a comparison of all of the approved demonstrations, current as of this summer: http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/

[2] An exhaustive list of conflicting program requirements was published by CMS at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FederalRegisterNoticeforComment052011.pdf

[3] Director John McCarthy, testimony before the Joint Oversight Committee on Medicaid, July 15, 2014.
[4] Ibid.
[5] As expected, enrollment numbers fluctuate daily. This number is taken from the August 7, 2014, update posted on the Website of the Office of Health Transformation as well as the Department of Medicaid's Website.
[6] Some individuals receive special assistance from Medicaid toward the payment of Medicare premiums or co-insurance; they are not considered to be full Medicaid beneficiaries and are not enrolled in MyCare.
[7] "Delayed Medicaid spend down" means that each month, the beneficiary must incur medical expenses sufficient to offset enough of the individual's income to make them income-eligible for Medicaid. Because these individuals may be eligible for Medicaid in one month, but not the next, the individual is not enrolled in MyCare.
[8] Exclusion of this small group (again in Cleveland) raises an interesting question. Historically, CMS has taken the position that an individual can participate in only one CMS demonstration at any given time. The question arises: Can a consumer participate in MyCare and also receive services from an Accountable Care Organization (ACO), another demonstration created through the Affordable Care Act? Thus far, it appears that the ACO would need to work out a payment arrangement acceptable to one of the five MCOs responsible for MyCare Ohio.
[9] Ohio Department of Job and Family Services, State Demonstration to Integrate Care for Medicare-Medicaid Enrollees, Proposal to the Center for Medicare and Medicaid Innovation, Appendix B: Ohio ICDS Regions (April 2, 2012). Available at: http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=JHx1uMEdLjE%3d&tabid=105
[10] Ohio Department of Medicaid, Enrollment update, January 2014, Available at: http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=g_oVQjI3h8A%3d&tabid=105
[11] The entire MOU can be accessed at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OHMOU.pdf
[12] http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/ICDS/3-WayContract.pdf
[13] Ohio's approved waiver application can be accessed through CMS at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html
[14] Op. cit., ICDS 3 way contract, pp. 125 ff.
[15] Op. cit., CMS Ohio MOU, pp. 40 ff.
[16] http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement

Please note that Roland Hornbostel's opinions are not necessarily those of The Center for Community Solutions.

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