Ohio | Department of Medicaid

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MyCare Conversion Charter and Principles

Moving to the Next Generation of Managed Care for Individuals Dually Eligible for Medicare and Medicaid

DRAFT of CMS Submission-Due October 1, 2022

Purpose

This "Conversion Charter" is a preliminary draft for the purpose of beginning stakeholder discussions and initiating discussion with CMS prior to the October 1st deadline for submission.

This initial Conversion Charter is subject to future amendments based on the feedback received from all the relevant stakeholders and CMS as outlined below.

MyCare Overview

Since the initial award in December 2012, the Ohio Department of Medicaid (ODM) has supported the Medicare-Medicaid Financial Alignment Initiative (FAI) demonstration known as MyCare. See attachment 1 for a list of abbreviations. The MyCare program was designed to provide coordinated care for the individual's Medicaid and Medicare services and to pay the MyCare Medicaid-Medicare managed care plans (MMP or MyCare plans) a capitated, blended payment using a three-way contract among MMP, Ohio Medicaid, and CMS. All individuals are mandatorily enrolled in Medicaid managed care and may choose to be "in" or "out" of managed care for their Medicare benefit. This is referred to as "opt in" (to managed care for Medicare) or "opt out" (of managed Medicare). Individuals who are 18 years old and over who are eligible for Medicare and Medicaid are included if they live in the seven regions comprising 29 counties. (See figure 1) See attachment 2 "Ohio Findings at a Glance, the second evaluation report".[i]

In addition to Medicare benefits, Medicaid benefits currently required of the MMPs include acute care, behavioral health, long-term services and supports (LTSS), dental, vision, home health, and durable medical equipment. Providing person-centered planning and coordination of services is key. MyCare utilizes a combination of care coordination strategies. Specifically, regarding care coordination, there are two groups of responsibilities, known as "waiver service coordination" and "care management". The roles of the MMP and the Area Agency on Aging (AAA) in carrying out these

responsibilities differ among MMPs and AAAs. This will be discussed further later in this Conversion Charter. (See figure 2)

Figure 1. MyCare Ohio Regions and Plans

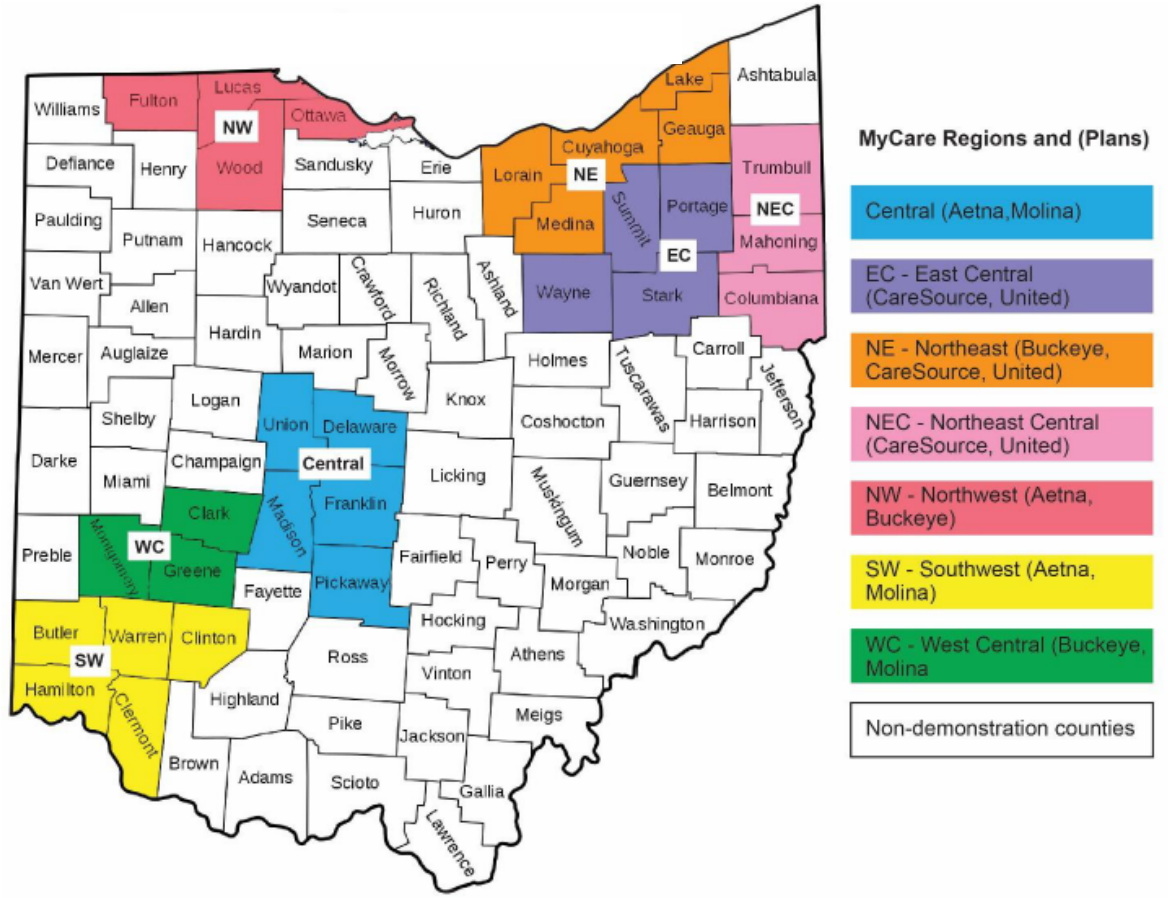


Figure 2. My Care Regions and MMP/AAA Responsibility

MyCare Region	Counties	Area Agency Aging (AAA)	My Care Plans
NW	Fulton, Lucas, Wood, Ottawa	4	Aetna & Buckeye
NE	Lorain, Cuyahoga, Medina, Geauga, Lake	10a	Buckeye, CareSource & United Health Care (UHC)
E Central	Summit, Portage, Stark Wayne	10b	CareSource & UHC
NE Central	Trumbull, Mahoning, Columbiana	11	CareSource & UHC
W Central	Montgomery, Greene, Clark	2	Buckeye & Molina
SW	Butler, Warren, Clinton, Clermont, Hamilton	1	Aetna & Molina
Central	Union, Madison, Franklin, Delaware, Pickaway	6	Aetna & Molina
Non MyCare		3, 5, 7, 8, 9	

The Starting Point for Discussion with Stakeholders

The starting point for discussion with stakeholders is as follows. We propose to transition the current MyCare program to a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) model with fully aligned enrollment in a companion Medicaid managed care plan (MMC) subject to the Next Generation program requirements, in the same geographic territories as they exist in MyCare today, serving individuals 21 years of age and older. The benefit package will remain the same, recognizing that each of the MMPs provides value added benefits. The choice to opt in or opt out of Medicare managed care will remain. Self-direction will be streamlined, making it amenable to greater use by individuals. Care coordination has a variety of issues that will be discussed, and modifications considered. For example, the large number of younger individuals who have significant mental health needs, while benefiting from the integration of their care, may require changes to the care coordination model to meet their needs.

With the expiration of Ohio's demonstration authority, CMS promulgated a new rule that informs what Ohio can do to continue offering integrated care to individuals who are dually eligible and must navigate both Medicare and Medicaid, and gives additional time to Ohio, if needed, to transition the MyCare program in a thoughtful and seamless manner[ii]. The FAI demonstration will end no later than December 31, 2025.

The Importance of Medicare and Medicaid Integration

Definition of an Individual who is Dually Eligible for Medicare & Medicaid

How do Medicare and Medicaid Intersect?

Individuals can qualify for Medicare based on their age as well as various disabilities. Ohioans who are on Medicare can qualify for Medicaid in one of approximately 50 Medicaid "aid categories". The various Medicaid aid categories fall into three groups: Full, QMB and SLMB.

- Full Medicare coverage and full Medicaid coverage. Only this group is eligible for MyCare.
- Qualified Medicare Beneficiaries (QMB)—Medicaid pays Medicare co-insurance and premium support only.
- Specified Low Income Medicare Beneficiaries (SLMB)—Medicaid pays only Medicare premium support.

Individuals who receive services funded by both Medicare and Medicaid have a daunting challenge in a system with multiple payers with different rules and different coverage of needed healthcare services.[iii] According to the Integrated Care Resource Center (ICRC)[iv], dually eligible individuals often have a substantial need with multiple chronic conditions and often have a need for long-term services and supports or behavioral health services. According to the ICRC, dually eligible individuals represent a disproportionate amount of both Medicare and Medicaid spending compared to the number of enrolled individuals in either program. The MyCare program has demonstrated the need to continue the improved coordination that has contributed to the reduction in

hospitalizations for this population. By integrating the coordination of Medicare and Medicaid funded services, there is the opportunity to help dually eligible individuals navigate this system better, ease their stress, improve their outcomes, and more effectively care for this important group of older Ohioans and individuals with disabilities.

Below is a figure regarding individuals enrolled in MyCare. There is a total of 258,149 who are dually eligible, with 201,030 with full dual eligibility and 68% of them enrolled in MyCare.

Figure 3. MyCare Enrollment by Age and Race (July 2022 data)

Breakdown by Age	Opt-In	%	Opt-Out	%
Over 65	35,805	49%	36,781	51%
45-64	22,497	52%	21,165	48%
Under 45	14,176	68%	6,569	32%
	72,478	53%	64,515	47%

Breakdown by Race and Ethnicity	Opt-In	%	Opt-Out	%
NH White	40,713	54%	34,217	46%
All other race/ethnicity groups	31,765	51%	30,298	49%
	72,478	53%	64,515	47%

Breakdown by Type of Member	Opt-In	%	Opt-Out	%
Community-Well	49,882	55%	40,926	45%
LTSS Waiver	14,458	50%	14,177	50%
LTSS NF (≥ 100 days LOS)	8,138	46%	9,412	54%
	72,478	53%	64,515	47%

Timeline for Stakeholder Collaborative Discussion for Finalizing the Conversion Charter to the Next Generation MyCare Program

The stakeholder process will begin in September 2022, with ODM meeting informally with stakeholders to gather ideas for the formal input and advisory process. A workgroup will be created to meet on a more frequent basis and provide input into the design and implementation of the Conversion Charter and final program design. ODM and sister agencies, Ohio Department of Aging (ODA), Ohio Department of Insurance (ODI), Ohio Department of Developmental Disabilities (DODD), and the Ohio

Department of Mental Health and Addiction Services (ODMHAS) will collaborate and meet as needed.

ODM may adjust the Conversion Charter based on this initial and informal stakeholder input prior to the formal submission of the Conversion Charter to CMS by October 1, 2022.

1. ODM will publicly post the Conversion Charter submitted to CMS for external feedback for at least a sixty-day period.

2. In October and November 2022, ODM will hold several formal stakeholder meetings with stakeholder groups including but not limited to consumers, family members, providers, managed care plans, and others:

AARP of Ohio	Arc of Ohio
Breaking Silences	Ohio Family Health Information Center
Ohio Center for Autism and Low Incidence	Ohio Self Determination Association
Ohio Statewide Independent Living Council	National Alliance on Mental Illness Ohio
Ohio Association of Area Agencies on Aging	Academy of Senior Health Sciences
Ohio Council for Home Care & Hospice	Leading Age
Ohio Heath Care Association	Ohio Assisted Living Association
The Ohio Council of Behavioral Health and Family Service Providers	Ohio Adult Day Healthcare Association
Current Ohio D-SNP Plans	Ohio Association of Health Plans
General public, consumers & families	PACE Representatives

3. In January 2023, ODM will hold a second round of meetings with external stakeholders to continue these conversations and receive continued feedback on the transition plan. This meeting may also include any changes to the transition plan made based on either earlier stakeholder feedback or CMS recommendations. ODM's budget will be considered by the Ohio General Assembly beginning in February 2023, with adoption by June 30, 2023. We anticipate that MyCare will be a topic for consideration.

   Starting in the second half of 2023, ODM will hold a series of stakeholder meetings to give updates and get input. These meetings will continue until the transition to the new program. (The process for initial and ongoing input will be similar to the process ODM is utilizing for the development of the Next Generation Managed Care program that began in 2019 and continues today with stages of implementation underway.)

4. Subsequent work will include developing the selection and implementation processes and timelines. Federal amendments, renewals or new authorities; any needed legislative authority and administrative rules, and information technology system changes will be completed. A more precise set of steps and timelines will be developed after receiving stakeholder input. The effective date for the new program will be no later than January 1, 2026.

5. ODM will continue the external stakeholder process through the first quarter following transition, if not longer.

Maximize Integration with a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) model with Next Generation Medicaid Managed Care Enhancements

Since 2019, ODM has been engaged in a process of seeking significant stakeholder input to our Medicaid Managed Care Program, which currently serves more than three million Ohioans. The implementation of this new program, referred to as the "Next Generation" began July 1, 2022, with OhioRISE, and will continue October 1st with implementation of the provider network module (PNM) /centralized credentialing and single pharmacy benefit manager (SPBM). On December 1st, with the full cutover to the new program with seven statewide managed care plans, the remaining two stages of the staggered implementation will be complete. The policy, program, and IT changes with the Ohio Medicaid Enterprise System (OMES) modular design are significant. The Next Generation changes will represent the new platform for the MyCare conversion. Additional specificity regarding the Next Generation program is included below.

Below is a figure based on information from the CMS Rule describing the federal requirements for Medicare-Medicaid Managed Care Plans (MMP) operating in the new model of FIDE SNPs.

Figure 4. New Requirements of FIDE SNPs Based on 2022 CMS Rule

MMP Characteristic	FIDE SNP
Enrollee advisory committee	Required
Health Risk Assessment of members to include social risk factors	Required
Exclusively aligned enrollment	Required starting 2025
Capitation for Long Term Services and Supports (LTSS) & behavioral health	Required starting 2025
Capitation for Medicare cost-sharing	Required starting 2025
Unified appeals & grievances process for Medicare & Medicaid	Required starting 2025 for all FIDE SNPs
Continuation of Medicare benefits pending appeal (This is already required for Medicaid)	Required starting 2025 for all FIDE SNPs

Integrated member materials	Finalized a new pathway for States to require for certain plans
State Medicaid Agency Contract (SMAC or Contract) includes duals living in-state only	Finalized a new pathway for States to require for certain plans
Mechanisms for joint Federal-State oversight	Finalized for States meeting specified criteria at CFR 422.107€
State Health Plan Management System (HPMS) access[v]	Finalized for States meeting specified criteria at CFR 422.107€

What is the difference between MyCare and the proposed FIDE SNP?

When we compare the current MyCare demonstration program to the changes in the federal rules, the following figure illustrates the impact of the transition.

Figure 5. Similarities and Differences between MyCare to the Next Generation FIDE SNP Plan [vi]

Similarities:

- Integrated coordination of care across both Medicare and Medicaid with integrated member materials
- Unified appeals and grievances
- Enrollee advisory committees continue
- Default enrollment is very similar to passive enrollment
- Continuation of Medicare benefits pending appeals
- Existing federal funding for Ombudsman and other informational supports is ending but Ohio is committed to continuing these supports

Differences:

- Transition to the next generation managed care requirements
- Rather than the current three-way contract between CMS, ODM, and each MyCare Plan, there will be a SMAC contract for the FIDE SNP and a Medicaid Managed Care plan contract or one contract combining both.
- The Medicare and Medicaid Medical Loss Ratios (MLR) will not be combined into a single MLR
- Enrollment processing may look a little different
- Additional changes based on stakeholder feedback

Sustain Ombudsman Support for the MMPs/Integrated FIDE-SNPs Without Federal Funding

Through the MyCare demonstration there has been federal funding to support Ombudsman programs assisting MMP members to resolve problems they may encounter. It has also funded counseling programs such as State Health Insurance

Assistance Programs (SHIP) that help individuals make an informed decision in the choice of Medicare options or Aged and Disabled Resource Centers (ADRC) that may help educate potential enrollees on different options and settings that are available for long-term services and supports. Beginning with the start-up of the new Next Generation MyCare program, ODM intends to continue funding the current MyCare Ombudsman program and one-to-one counseling programs, by providing funding to the Ohio Department of Aging when the current federal funding ends. The amount of annual funding would be approximately $960,000, the amount that has previously been federally funded. This state funding would continue after the FAI demonstration transitions.

Description of Necessary Policy and Operational Tasks and the Estimated Timeline

As a component of the Conversion Charter, CMS requires the State to identify those policy and operational issues that are central to the design and implementation of the new Next Generation MyCare program.

The following is an initial list of key issues that will be discussed with stakeholders. We expect that additional issues will be identified. Several of these issues are discussed in further detail below.

- Geography: Stay with the same seven catchment areas (29 counties), expand statewide or somewhere in between. If not statewide, are there other considerations for the non-FIDE areas?
- Application of the Next Generation Managed Care program requirements to the new MyCare program and conditions for the State Medicaid Agency Contract (SMAC)
- Enhancements to the ombudsman role
- Expansion of consumer self-direction, including streamlining the processes to enroll direct care providers and increase consumer budget authority
- Default enrollment to increase the opportunity for improving coordination of care
- The roles of the MMP and the Area Agency on Aging (AAA) in carrying out the responsibilities of “waiver service coordination” and “care management”
- Selection of new plans
- Coordination with the Program for All-Inclusive Care for the Elderly (PACE), especially regarding member transitions
- Current D-SNPs operating in Ohio

A variety of opportunities and “pain points” have been identified with the current MyCare program by providers and individuals served by the program. Additional information will be collected through discussions with stakeholders, so these can be addressed with the new program.

- Improving the availability of information through the enrollment broker to facilitate the individual's decision making; the enrollment broker making contact with the individual and maintaining a list of active providers.
- Timelines for authorization requirements
- Transportation- add the Next Generation requirements to improve transportation access.
- Alignment/resolution of confusion between waiver rules
- Developing value-based arrangements with nursing facilities

Obtaining Necessary State Legislative or Additional Federal Medicaid Approvals

As noted earlier, ODM and sister agencies, ODA, ODI, DODD, and the ODMHAS will be working together and with the Governor's Office. The Human Services Cluster, convened by the Governor's Assistant Policy Director, is one vehicle that currently exists.

Also as noted, ODM's budget will be considered by the Ohio General Assembly beginning in February 2023, with adoption by June 30, 2023. We anticipate that MyCare will be a topic for consideration. In addition, Ohio's General Assembly has a joint legislative committee, the Joint Medicaid Oversight Committee (JMOC), will be consulted.

Regarding federal authorities, ODM would likely submit either an amendment/renewal or submit a new 1915(b)(c) waiver combination to CMS to obtain federal authority for the transition of the FAI demonstration to a FIDE SNP model with fully aligned enrollment with a companion Medicaid managed care plan subject to the Next Generation program requirements.

Transition to Next Generation Managed Care Requirements

With a focus on better transparency and accountability, ODM has been in the process of improving the existing managed care process for the Medicaid managed care (MMC) program. With extensive stakeholder feedback, the various concerns identified with the Medicaid managed care program are also instructive to the MyCare program.

The Next Generation program is focused on the individual, rather than the business of managed care, putting the individual—and person-centered care—at the center of our design. Consumer and provider input was overwhelming, that it doesn't feel like "a" Medicaid program, but like six different programs each with its own unique administrative requirements. So, there is a significant priority on reducing the burden on providers and streamlining the overall consumer and provider experience.

The implementation of the new, modular Ohio Medicaid Enterprise System (OMES) uses various modules, simplifies the processes for providers, including centralized provider enrollment, credentialing, securing authorizations, and billing. The single pharmacy benefit manager (SPBM) provides a single benefit management function for all those served by the seven Next Generation plans. The Fiscal Intermediary will serve

as the central clearinghouse for Ohio Medicaid's claims and prior authorization activity, giving Ohio Medicaid unprecedented accountability and access to timely information about the member and provider experience in the Medicaid managed care program.

Coordination of Care

Improved coordination of care is also a priority for the Next Generation program. In order to offer better coordination of care, which is the central intention for improving the integration of services and supports for dual eligible individuals, there are several areas of needed focus:

- MyCare is uniquely positioned nationally, using a combination of care coordination strategies. (See figure 6) Specifically, regarding care coordination, there are two groups of responsibilities, known as "waiver service coordination" and "care management". The MyCare plans are required to contract with the Area Agency on Aging (AAA) for waiver service coordination for individuals 60 years and older, at a minimum. The roles of the MyCare plans and the AAAs in carrying out these responsibilities differs among MMPs and AAAs.
    - Aetna and CareSource use "Fully-Delegated Waiver Care Management", with the AAA creating and implementing the care plan and coordinating medical, behavioral and HCBS services for those 18 years and older. In this case the individual has one care manager.

    - Buckeye, Molina and United create and implement the care plan, coordinate medical, behavioral health services for all ages, and HCBS waiver services for those 18 to 59 years of age, while the AAA coordinates the HCBS services for those age 60 years and older. In this case, the individual has two care managers.

- In addition to the design described above, feedback will be solicited to refine this set of responsibilities, caseloads, types of activities required, degree of delegation, opportunities to streamline the relationships, etc. Information sharing and access to case management information has been identified as an opportunity for improvement.

- Care coordination for individuals with behavioral health needs is an area of significant concern.

- Self-Direction is currently an option in the MyCare program. However, extensive feedback in this area has already identified the need to streamline and expand the options here for individuals.

Figure 6. Current Individual Categorization & Care Coordination Responsibilities

Categorization of Individuals	Care Management & Waiver Service Coordination
#1 & #2 Individual has a Nursing Facility Level of Care (NF-LOC)	
6. **HCBS:** Receiving Home & Community Based Waiver services	AAA responsible for waiver service coordination for individuals ≥60 and MyCare plan for those 18-59. OR fully delegated to the AAA.
7. **NF:** Individual is receiving Nursing Facility services	MyCare plan is responsible.
#3 Individual does not have a NF-LOC	
8. **Community Well**[vii]**:** Individual not receiving NF or HCBS services	MyCare plan is responsible.

Network Adequacy and Delegation/Sub-Delegation Relationships

Several issues that have been identified in this area have also been raised through the course of our work on the Next Generation program. As we work through discussions with stakeholders on these issues, we think many will be addressed by the Next Gen changes.

Individuals with Significant Behavioral Health Needs

Inclusion of the full array of behavioral health benefits has been identified as a strength of the current MyCare program. It is important to note the age profile of those with behavioral health conditions is more varied than that of individuals with a nursing facility level of care, with more individuals under age 65. See figure 7A and 7B. To help address the needs for these individuals, all the MyCare plans have dedicated behavioral health professionals to work with members. Community behavioral health providers serve as essential partners to the MyCare plans in working with individuals with significant behavioral health needs, many who have other chronic conditions as well. Within the full scope of care coordination, attention is needed to identify best practices to meet the unique needs of these individuals.

Figure 7A. Individuals with any BH Condition Served by MyCare[1] (7/2022)

		Percent with a current BH Condition			
MyCare Group	**Total Population**	**All Years**	**Under 45 yrs.**	**45-64 yrs.**	**65 yrs. & Over**
NF Residents	17,550	90%	90%	91%	90%
MyCare Waiver	28,635	58%	65%	66%	56%
Community Well	90,808	46%	55%	55%	32%
	136,993	**54%**			
		Percent with an Identified BH Condition			
NF Residents	17,550	95%	94%	97%	95%
MyCare Waiver	28,635	77%	81%	85%	75%
Community Well	90,808	64%	74%	74%	50%
	136,993	**71%**			

For comparison, the total of all individuals served by MyCare is reflected below:

Figure 7B. All Individuals Served by MyCare (7/2022)

			Total MyCare Individuals by Age					
MyCare Group	**Total Population**		**Under 45 yrs.**		**45-64 yrs.**		**65 yrs. & Over**	
NF Residents	17,550	100%	268	2%	2,956	17%	14,326	82%
MyCare Waiver	28,635	100%	1,025	4%	6,794	24%	20,816	73%
Community Well	90,808	100%	19,452	21%	33,912	37%	37,444	41%
	136,993		20,745	15%	43,662	32%	72,586	53%

Provider Appeals

Additional enhancements from the Next Generation provider agreement would be included related to provider appeal processes, as follows.

- Peer-to-Peer Consultation – When the MCO denies a service authorization request from a provider, the MCO must notify and offer the provider the option to request a peer-to-peer consultation.
- Provider Internal Appeal Process - Available to providers for adverse prior authorization decisions as required in Ohio Revised Code 5160.34.
- Provider Claim Dispute Process – The MCO must establish and maintain a provider claim dispute resolution process for its network and out-of-network providers to dispute adverse claims payment decisions made by the MCO.

[1] Notes:
1. "Current BH condition" = any BH condition within past 6 months (2/22-7/22)
2. "Identified BH condition" = any BH condition within past 24 mos. (8/20-7/22)
3. Includes primary and secondary BH diagnoses
4. The most common BH diagnoses among MyCare individuals are, in order: anxiety, major depressive disorder, schizophrenia, bipolar disorders, PTSD, dementia, and opioid dependence.
5. Example interpretation: NF Residents; Current BH; Under 45 yrs. = "90% of MyCare recipients under 45 yrs. who had resided in a NF for >= 100 days as of 7/1/22 had a BH claim within the past 6 months"

- External Medical Review – The MCO must offer an external medical review to a provider who is not satisfied with the MCO's decision to deny, limit, reduce, suspend, or terminate a covered service (specified in Appendix B of the Next Generation provider agreement, Coverage and Services) for lack of medical necessity. This will be at no cost to the provider.

Non-Emergency Transportation (NEMT)

To address concerns about NEMT, ODM will include the following requirements in the Next Generation Medicaid MyCare contract to align with the Next Generation requirements.

- The MCO's member services call center must have a selection for transportation for members.
- Member services representatives must be trained to respond to transportation requests in accordance with MCO policies and procedures for arranging and providing transportation services. The MCO must not require more than 48 hours of advance notice for transportation needs and must provide exceptions for advance notice requirements for urgent member needs (e.g., for same or next day urgent appointments) and hospital discharges.

Identifying and Executing System Changes and Process to Implement Exclusive Alignment

As described very briefly above, the Next Generation policy and IT changes in OMES are significant. In addition to this new functionality, ODM will work with vendors to identify system and process changes necessary to implement exclusively aligned enrollment. The review would include who notifies CMS of the enrollment into Medicare. Today, ODM notifies CMS for MyCare enrollment. However, it is the D-SNP who notifies CMS if the individual resides in a region not served by MyCare or the individual opts-out of the Medicare managed care component. It would also identify what systems need to share with one another, as well as reviewing all related enrollment documents a consumer may receive.

Executing Medicaid Selection and State Medicaid Agency Contracts (SMACs)

There are several important considerations that will determine how Ohio proceeds with selection and developing provider agreements and SMACs; including maintaining or expanding geography, the role of the current D-SNPs in the Next Generation MyCare program, care coordination and alignment, and others. The final decisions in these areas will have an impact on the final timeline for the complete conversion to the new program.

The State Medicaid Agency Contract (SMAC) will be updated to include additional requirements to ensure FIDE SNP requirements are met and to ensure integration and a smooth transition from the current MyCare program to the FIDE SNP Next Generation Medicaid Managed Care program.

As described in figure 1, today five MyCare plans operate in three specific regions; with two plans in all the regions, except for the northeast region with three plans. A variety of issues factor into the decision whether to limit the Next Gen MyCare plans to specific regions.

Also, for consideration as noted above, ODM will engage the current D-SNP plans in stakeholder discussion, including the role of the current D-SNPs and whether to contract with any additional D-SNPs in existing MyCare geographic regions or statewide for the new program.

Figure 8 below utilizes ODM data to depict the current full dually eligible enrollment in different D-SNPs that operate in Ohio today, as well as their current Medicaid and Medicare expertise in Ohio. Some of the organizations may have more than one D-SNP. In that case these totals are cumulative.

Figure 8. Current Ohio D-SNPs--Enrollment, MMP and MMC Experience

Current Ohio D-SNPs	D-SNP Enrollment	Ohio Next Gen MMC & MyCare Plan	Ohio Next Gen MMC but not MyCare	No Ohio MMC or MMP
Aetna	7,806			
Anthem	31,720		Yes	
Buckeye	2,869	Yes		
CareSource	1,538	Yes		
Cigna	0			Yes
Devoted	0			Yes
HealthPlan WV	204			Yes
Humana	12,992		Yes	
Molina	1,166	Yes		
United Health Care	36,288	Yes		
			AmeriHealth	

Fiscal Impact & Financial Considerations

Figures 9 and 10 provide some financial information for the most complete fiscal year, SFY 2021, comparing location of service and expenditures.

Note: additional information is being compiled related to this topic.

Figure 9. MyCare Opt In and Opt Out SFY21 PMPM

MyCare Opt In	MyCare Opt Out
$1,538	$2,010

Figure 10. SFY 21 MyCare Individuals and Expenditures PMPM

Category	Expenditures	PMPM	Ave. # Individuals per month
NF	$2,416,464,457	$3,948.42	18,880
MyCare Waiver			32,120
Community Well	$361,701,009	$366.53	82,236
	$2,778,165,466	$1,737.61	$133,237

Conclusion

As noted above, this "Conversion Charter" is a preliminary draft for the purpose of beginning stakeholder discussions and initiating discussion with CMS prior to the October 1st deadline for submission. The October 1st submission, as well as subsequent updated versions will be amended based on feedback received from all the relevant stakeholders and CMS as outlined above. We look forward to these discussions.

Attachment 1

List of Abbreviations

AAA	Area Agency on Aging
CMS	Centers for Medicare & Medicaid Services
D-SNP	Dual Eligible Special Needs Plan
FIA	Medicare – Medicaid Financial Alignment Initiative Demonstration; in Ohio, known as MyCare
FIDE SNP	Fully Integrated Dual Eligible Special Needs Plan
FFS	Fee-For-Service
HCBS	Home and Community-Based Service
JMOC	Joint Medicaid Oversight Committee of the Ohio General Assembly
LOC	Level of Care
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MA	Medicaid Advantage
MCO	Managed Care Organization
MLR	Medical Loss Ratio
MMC	Medicaid Managed Care Plan
MMP	Medicare-Medicaid Plan
NF	Nursing Facility
OMES	Ohio Medicaid Enterprise System
PACE	Program for All-Inclusive Care for the Elderly
PHE	Public Health Emergency
PMPM	Per Member Per Month
SMAC	State Medicaid Agency Contract

End Notes:

[i] Centers for Medicare & Medicaid Services. Financial Alignment Initiative (FAI) MyCare Ohio Demonstration Second Evaluation Report Findings at a Glance (March 8, 2022), Financial Alignment Initiative (FAI) MyCare Ohio Demonstration (cms.gov),[OBJ][OBJ] visited Sep. 9, 2022). (Results are limited to Medicare only).

[ii] United States, Department of Health & Human Services. "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs." 87 Fed. Reg. 27704 (May 9, 20022). Available at Federal Register :: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

[iii] Centers for Medicare & Medicaid Services. People Dually Eligible for Medicare and Medicaid. Fact Sheet March 2020, People Dually Eligible for Medicare and Medicaid Fact Sheet (032020) (cms.gov), (last visited Sep. 9, 2022).

[iv] Integrated Care Resource Center (ICRC), FACT SHEET (April 2022), Dually Eligible Individuals: The Basics (integratedcareresourcecenter.com) (last visited September 2nd, 2022).

[v] Health Plan Management System (HPMS), Health Plan Management System Login Page (cms.gov) (last visited September 2nd, 2022). (HPMS allows Plans, CMS, & others for compliance requirements).

[vi] Centers for Medicare & Medicaid Services (January 2022), *Overview of D-SNP and MMP Provisions in CY 2023 Medicare Advantage and Part D Proposed Rule* [PowerPoint slide 9].

[vii] The term "Community Well" may be misleading. While individuals in this group do not receive NF or HCBS waivers, the individual's behavioral health or other health related needs are significant enough to qualify for SSI disability.

ATTACHMENT 2

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Findings at a Glance

Financial Alignment Initiative (FAI) MyCare Ohio Demonstration

Second Evaluation Report

MODEL OVERVIEW

The Financial Alignment Initiative (FAI) aims to provide individuals dually enrolled in Medicare and Medicaid with a better care experience and better align the financial incentives of the Medicare and Medicaid programs. CMS is working with States to test two integrated care delivery models: a capitated model and a managed fee-for-service model.

Ohio and CMS launched the MyCare Ohio demonstration in 2014. The demonstration has been extended until 2022.

Key Features of the Ohio Demonstration

- Uses the capitated model based on a three-way contract between each Medicare-Medicaid Plan (MMP), CMS and the State to finance all Medicare and Medicaid services.
- MMPs provide care coordination and flexible benefits that vary by MMP.
- MMPs provide integrated benefits to all full-benefit Medicare-Medicaid enrollees age 18 and older.

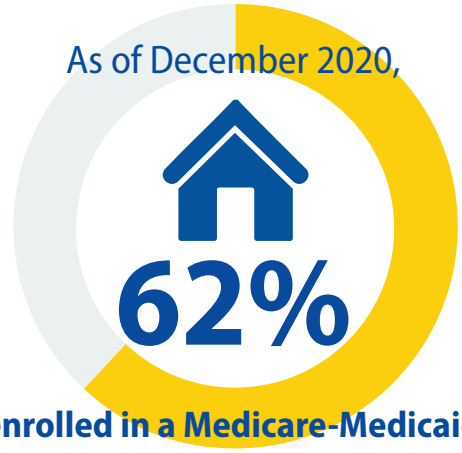
PARTICIPANTS

MEDICARE-MEDICAID PLANS

- The demonstration operates in seven regions, comprising 29 of Ohio's 88 counties.
- Five MMPs contract with medical, behavioral health, and long-term services and supports (LTSS) providers to provide integrated Medicare and Medicaid services.
- Medicare-Medicaid beneficiaries who choose not to receive their Medicare benefits through a MyCare Ohio MMP are not enrolled in the demonstration but are still required to receive their Medicaid benefits through a MyCare Ohio plan.
- MMPs are required to contract with Area Agencies on Aging waiver service coordinators to coordinate waiver services for members who are age 60 or older and have the option to delegate waiver service coordination for enrollees under age 60.

BENEFICIARIES

As of December 2020,



were enrolled in a Medicare-Medicaid Plan.

82,863 of the total 134,194 eligible Medicare-Medicaid beneficiaries were participating in the Ohio demonstration.

FINDINGS

IMPLEMENTATION

- MMPs credited the design of MyCare Ohio with the **relatively high rate of enrollment**.
- The State requires MMPs to adopt a **population health management** model for care management and has **developed an assessment** that captures information about the **social determinants of health**.
- MMPs are working collaboratively to **reduce the administrative burden on nursing facilities** by creating more **consistent processes and tools across MMPs**.
- The percentage of members with **at least one documented discussion of care goals** in their care plan has been **consistently high throughout the demonstration**.
- The percentage of MyCare Ohio enrollees who rated their health plan as a 9 or 10 **increased from 51% to 66% between 2015 and 2018**.

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Findings at a Glance

Financial Alignment Initiative (FAI)
MyCare Ohio Demonstration

Second Evaluation Report

FINDINGS *(continued)*

MEDICARE EXPENDITURES

Regression analyses of the demonstration impact on Medicare Parts A and B costs, relative to a comparison group, found statistically significant increases during the overall demonstration period.

Monthly demonstration effect on Medicare Parts A and B costs, by demonstration year

Demonstration Period	Average Demonstration Effect on Medicare Expenditures, PMPM
DY 1 (May 2014–Dec 2015)	$-24.52
DY 2 (Jan 2016–Dec 2016)	$127.35*
DY 3 (Jan 2017–Dec 2017)	$147.66*
DY 4 (Jan 2018–Dec 2018)	$183.89*
Cumulative (DY 1–4)	$97.55*

DY = demonstration year; PMPM = per member per month

*p<0.05

SERVICE UTILIZATION AND QUALITY OF CARE: Demonstration Years 1 through 4 (2014–2018)

Favorable Results	Unfavorable Results
↑ Increased monthly number of physician visits	↑ Increased monthly probability of any emergency department visit
↑ Increased probability of any 30-day mental health follow up after a mental health discharge	↑ Increased number of preventable emergency department visits
↓ Decreased monthly probability of any inpatient admission	↑ Increased probability of ambulatory care sensitive condition admissions
↓ Decreased annual probability of any long-stay nursing facility use	

- There was no demonstration effect on the probability of skilled nursing facility admissions or the probability of 30-day readmissions.

KEY TAKEAWAYS

There was strong support among Ohio stakeholders for extending the demonstration, despite some challenges in 2018–2020. MyCare Ohio has maintained relatively high enrollment during the demonstration. The proportion of enrollees with documented discussions of care goals has also been consistently high, and care quality and enrollee satisfaction have improved over time. There were statistically significant increases in cumulative Medicare costs. The demonstration had mixed results on service use.