Selected Highlights of Ohio's Memorandum of Understanding with CMS for its Demonstration to develop an Integrated Care Delivery System

Scope:

- Participants include full benefit duals ages 18 and older with some exceptions, including: persons enrolled in PACE programs; individuals served through the IDD Section 1915(c) HCBS waiver program; and those Medicare-Medicaid enrollees participating in Ohio's Independence at Home Demonstration.
- The demonstration will be implemented in 29 counties in 7 regions of the State and runs from September 1, 2013 to December 31, 2016.

Contracting and Rates:

- CMS and the State are using selective contracting to choose Integrated Care Delivery System (ICDS) Plans.
- Medicaid actuarial soundness will apply to payments to health plans.
- CMS will develop baseline spending and payment rates for Medicare A and B services using estimates of what Medicare would have spent on behalf of beneficiaries without the demonstration using a blend of Medicare Advantage projected payment rates and Medicare FFS standardized county rates.
- Rates for each demonstration year will incorporate projected savings as follows: Year 1, 1%; Year 2, 2%; and Year 3, 4%.
- CMS-HCC risk adjustment methodology will be applied to the Medicare A/B portion of the rate and Part D RxHCC will be applied to the Part D portion (that is based on the national average bid).
- The Medicaid portion of the blended rate paid to ICDS Plans will include an adjustment for case mix that takes into account whether a plan has a higher proportion of individuals requiring nursing facility (NF) level of care.
- An adjustment will be made to the Medicare rate baseline to reflect any delay or replacement of the Sustainable Growth Rate (SGR) formula used to adjust Medicare physician rates and such adjustment will be made retroactively if Congress makes retroactive changes.
- CMS will forego applying a Medicare Advantage coding intensity adjustment factor to risk scores in calendar year 2013.
- CMS will impose Minimum Medical Loss Ratio (MMLR) requirements on ICDS Plans and will convene a group of CMS and State officials to review payment parameters if two or more ICDS Plans have MMLRs below 90% or show annual losses exceeding 5%. Plans must remit back to the Medicare and Medicaid programs any amounts by which the 85% threshold exceeds a plan's actual MMLR multiplied by the total applicable revenue of the contract.

Enrollment:

- Enrollees can opt in or out of an ICDS Plan on a monthly basis.
- Upon opting out, a Medicare-Medicaid enrollee can continue to receive Medicaid benefits in accordance with approved State Plan services and any approved 1915(b) and 1915 (c) waivers.
- Beneficiaries will receive notices about passive enrollment 60 and 30 days prior to the effective date and such enrollment will be phased in between October 1, 2013 and Dec. 1 2013 across three different areas of the state.

Consumer Protections:

- Medicare-Medicaid enrollees will be provided independent enrollment assistance and options counseling.
- Communication with Medicare-Medicaid enrollees must include accommodations for those deaf or hard of hearing, those with cognitive impairments, and those who do not speak English (i.e., interpreters).
- Quality withhold measures will include a comparison of enrollees living outside NFs during the year compared to the previous year and the percent of the demonstration population residing in NFs year to year. The percentage withhold will be 1%, 2%, and 3% in each of the three demonstration years, respectively.
- There will be a unified set of requirements for ICDS Plan grievances and internal appeals processes that incorporate relevant Medicare Advantage and Medicaid managed care requirements, and a streamlined external appeals process conforming to both Medicare and Medicaid standards, except Part D appeals and grievances will continue to be managed under existing Part D rules.

Care Model and Assessments:

- All ICDS Plans will be required to implement an evidence-based model of care (MOC) having explicit components consistent with the Special Needs Plan Model of Care.
- Each enrollee will have a person-centered, individualized care plan developed by a Trans-disciplinary Care Management Team. This team will be led by an "accountable" care manager to ensure integration of the member's medical, behavioral health, substance use, LTSS and social needs.
- If an enrollee requires 1915(c) waiver services, the waiver service coordinator identified by the ICDS Plan (i.e., either directly employed by the ICDS Plan or through a contractual arrangement with a qualified individual or community-based entity) will be responsible for coordination of HCBS services. The waiver service coordinator will be a full member of the Trans-disciplinary Care Management Team.
- Initial comprehensive assessments must be completed within 90 days of enrollment and must be in person for the highest risk enrollees (determined by risk and acuity stratification) and all persons receiving 1915(c) HCBS services. Enrollees must also receive annual assessments unless required sooner.

Continuity of Care

- The MOU includes continuity of care requirements for treatments in process and extended use of current providers for certain services (e.g., up to one year for HCBS waiver and BH services and up to three years for assisted living and nursing facilities).
- ICDS plans are required to provide or arrange for all medically necessary services provided by the three-way contract, whether by sub-contract or by single-case agreement in order to meet the needs of an individual beneficiary.

Evaluation

- CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the demonstration on cost, quality, utilization and beneficiary experience of care. The evaluator will use a comparison group for its impact analysis.