#### STATE OF OHIO

### OHIO DEPARTMENT OF JOB AND FAMILY SERVICES OFFICE OF OHIO HEALTH PLANS

## STATE DEMONSTRATION TO INTEGRATE CARE FOR MEDICARE-MEDICAID ENROLLEES

## PROPOSAL TO THE CENTER FOR MEDICARE AND MEDICAID INNOVATION



**FEBRUARY 27, 2012** 

#### A. Executive Summary

Over 250,000 Ohioans are enrolled in both Medicare and Medicaid, but the two programs are designed and managed with almost no connection to one another. Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, but they account for almost 40 percent of total Medicaid spending. This proposal presents a new approach to meeting the needs of individuals who are eligible for both Medicaid and Medicare benefits. Ohio has chosen the capitated managed care model offered by CMS in a July 8, 2011 Medicaid Director's letter. Through the Centers for Medicare and Medicaid Services' (CMS) Medicare-Medicaid Demonstration Program, Ohio will develop a fully integrated care system that comprehensively manages the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees, including Long Term Services and Supports (LTSS). Ohio's Integrated Care Delivery Systems (ICDS) Program will be implemented in selected regions across the state, with enrollment beginning in January 2013.

Under Ohio's Demonstration Proposal, competitively selected ICDS health plans will manage a comprehensive benefit package for their dually eligible members, utilizing a variety of care management tools to ensure that services are coordinated. The ICDS plans will arrange for care and services by specialists, hospitals, and providers of LTSS and other non-Medicaid community based services and supports; allocate increased resources to primary and preventive services in order to reduce utilization of more costly Medicare and Medicaid benefits, including institutional services; cover all administrative processes, including consumer engagement, which includes outreach and education functions, grievances, and appeals; and utilize a payment structure that blends Medicare and Medicaid funding and mitigates the conflicting incentives that exist between Medicare and Medicaid.

Ohio will demonstrate that its model of integrated care and financing will improve the delivery of quality care and reduce health disparities across all populations, improve health and functional outcomes, and reduce costs for beneficiaries by reducing or avoiding preventable hospital stays, nursing facilities admissions, emergency room utilization, and improving transitions across care settings

Ohio will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. Ohio intends to conduct an ongoing process of monitoring beneficiary and provider experiences through a variety of means, including surveys, focus groups, and data analysis. In addition, Ohio will require that ICDS plans develop meaningful consumer input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to eligible beneficiaries.

#### **Overview of the Ohio Integrated Care Delivery System Demonstration**

Target population	Beneficiaries fully eligible to receive Medicare and Medicaid benefits
Total Number of Full benefit Medicare-Medicaid Enrollees Statewide (Average dual eligibles per month, SFY 2011)	196,369
Total Number of Beneficiaries eligible for the Demonstration (Average dual eligibles per month, SFY 2011)	122,409
Geographic Service Area	Seven regions of 3-5 counties each
Summary of Covered Benefits	Medicaid State plan, Medicaid Waiver, Medicare Parts A,B,D, Behavioral health, Community based services
Financing Model	The capitated financial alignment model offered in the 7/8/11 State Medicaid Director Letter
Summary of Stakeholder Engagement/Input	Vision for ICDS released Feb 2011; ICDS proposal submitted to CMS, Feb 2011; Request for Information, Sept.2011; Five statewide consumer-caregiver forums. Jan 24, Jan 31, Feb 3, Feb 7, Feb 14. A statewide consumer conference call, Feb 17, 2012; An on-line consumer survey, Feb 2012; Two additional stakeholder forums for providers and others stakeholder, March 2012.
Proposed Implementation Date	January 2013

#### B. Background

#### i. Overall Vision and Barriers to Integration

Ohio's vision for the ICDS program is to create a fully integrated system of care that provides comprehensive services to Medicare-Medicaid Enrollees across the full continuum of Medicare and Medicaid benefits, including Long Term Services and Supports (LTSS). Prior demonstrations of fully integrated health care systems for Medicare-Medicaid Enrollees in other states have demonstrated improved outcomes for consumers as well as more efficient utilization of Medicare and Medicaid benefits. The objective of the ICDS program is to provide higher quality and more person-centered care to Ohio's most vulnerable citizens, while also addressing the inefficiencies and incorrect incentives of the existing Medicare and Medicaid fee-for-service systems. Through the ICDS program, Ohio

anticipates that more Medicare-Medicaid Enrollees will be able to receive the medical and supportive services they need in their own homes and other community-based settings, rather than in more costly institutional settings.

Ohio's ICDS program is one critical component of a broader effort underway in Ohio to improve overall health system performance. On January 13, 2011, just three days after taking office, Ohio Governor John Kasich established the Office of Health Transformation (OHT) to modernize Medicaid programs and streamline the state's health and human services. OHT quickly identified Medicare-Medicaid Enrollees as a high-cost population in the Medicaid program, as well as one that was poorly served by a fragmented health care system. OHT applied for but did not receive one of the 15 demonstration grants offered by the Medicare-Medicaid Coordination Office to support planning activities for a demonstration program. Nonetheless, Ohio proceeded with its own planning activities and submitted a Letter of Intent in October 2011 to CMS, conveying Ohio's intention to participate in the CMS' Medicare-Medicaid Demonstration Initiative.

Earlier this year, Governor Kasich and the Office of Health Transformation made Ohio's Integrated Care Delivery System (ICDS) program proposal for Medicare-Medicaid Enrollees the number one health care priority to be undertaken by the state in 2012. This decision reflects a readiness to take Ohio's experience with Medicaid managed care to the next level, and to use the ICDS program model to overcome barriers to delivery system integration that have resulted in Ohio lagging behind other states in its ability to provide meaningful alternatives to institutional placements and coordinate long-term services and supports across a continuum of services.

Ohio created its Medicaid managed care program in 1978, first as an optional program for children and parents in a limited number of counties, but then expanding the program to mandatory enrollment statewide in 2006. Since 2006, the program also has been mandatory for physical health care services for the aged, blind and disabled (ABD) Medicaid population.<sup>3</sup> However, because of barriers in the current delivery system, certain subsets of the ABD population were exempted from this law, including:

- Individuals who are institutionalized,
- Individuals who become eligible through spending down their income,
- Individuals who are receiving services in a Medicaid 1915(c) Home- and Community-Based Services waiver, and
- Individuals who are dually enrolled in both the Medicare and Medicaid programs.<sup>4</sup>

Thus, the delivery of services to the ABD population through a managed care model is not new in the Ohio Medicaid program, but the exemption has caused the approximately 196,000 Medicare-Medicaid Enrollees in Ohio to be provided Medicare and Medicaid benefits primarily through the existing fee-for-service system.

<sup>&</sup>lt;sup>1</sup> Ohio Office of Health Transformation, **Medicaid Program Background** at <u>www.healthtransformation.ohio.gov</u>.

<sup>&</sup>lt;sup>2</sup> Ohio Office of Health Transformation, **Ohio's Demonstration Model to Integrate Care for Dual Eligibles,** February 1, 2011, found at: <a href="https://www.healthtransformation.ohio.gov">www.healthtransformation.ohio.gov</a>.

<sup>&</sup>lt;sup>3</sup> Ohio 5111.16 Care Management System

<sup>&</sup>lt;sup>4</sup> Individuals under 21 years of age also were excluded from Medicaid managed care, but the exemption was recently removed and, beginning in January 2013, these individuals will be served in a managed care delivery system.

Managed care for the Medicare-only population also is not a new concept in Ohio. According to The Kaiser Family Foundation's StateHealthFact.org website, Ohio has the sixth highest Medicare enrollment in the United States (1,909,462 Medicare enrollees in 2011) but ranks fifth in Medicare Advantage (MA) enrollment (640,245 MA enrollees). Based on those enrollment numbers, the percent of Medicare enrollees in a MA plan in 2011 was 34%, significantly higher than the national average of 26%. While the percentage of Medicare-only enrollees in Ohio in Medicare Advantage plans is higher than the national average, managed care enrollment among Medicare-Medicaid Enrollees is very low. Only between 2-3% of Medicare-Medicaid enrollees are enrolled in Special Needs Plans.

Figure 1
Total Medicare Advantage Plan
Enrollment in Ohio, 2006 through
2011

Year	Total MA Enrollment	Percent Change
2006	273,775	
2007	315,607	15%
2008	453,920	44%
2009	487,578	7%
2010	620,138	27%
2011	640,245	3%

Source: StateHealthFacts.org

Over the last ten years, with significant investments in the PASSPORT program and other Medicaid home- and community-based waiver programs, Ohio has made considerable progress towards rebalancing its LTSS system.<sup>5</sup> The PASSPORT waiver for disabled individuals 60 to 64 and individuals age 65 and older, provides services to over 30,000 individuals daily across the state, and is the third largest HCBS waiver program in the nation. This expansion in HCBS services has had a clear impact on reducing nursing home use in the state. Despite significant growth in the aged population over the last decade, the average daily census of persons receiving Medicaid-financed nursing home care has declined by about 5%.

However, more progress needs to be made. Ohio's Long-Term Services and Supports System remains out of balance, tilted heavily towards institutional service settings. Ohio lags behind most other states in its rebalancing efforts. Medicaid spending per capita for nursing home care in Ohio still ranks in the top quintile of all states, and the relative proportion of Medicaid spending for institutional care versus community-based care is well above the national average. If Ohio is going to address the rapid growth of its aged population over the coming decades, it will have to develop new program models for meeting both the health and long-term support needs of this population more efficiently. The ICDS

<sup>&</sup>lt;sup>5</sup>Mehdizadeh et al, Coming of Age: Tracking the Progress and Challenges of Delivery Long-Term Services and Supports in Ohio. Scripps Gerontology Center, June 2011.

program is an important step toward developing a higher quality, lower cost program model for individuals who qualify for both Medicare and Medicaid benefits.

#### ii. Detailed Description of Target Population

The population that will be eligible to participate in the ICDS program is limited to "Full Benefit" Medicare-Medicaid Enrollees only. Individuals who are only eligible for Medicare Savings Program benefits (QMB-only, SLMB-only, and QI-1) will not be eligible. Additionally, the following specified populations will also be excluded from participating in the ICDS program:

- Individuals with Intellectual Disabilities (ID) and other Developmental Disabilities (DD) who are served through an IDD 1915(c) HCBS waiver or an ICF-IDD
- Individuals enrolled in PACE
- Individuals under the age of 18.

Medicare-Medicaid Enrollees with Intellectual Disabilities (ID) and other Developmental Disabilities (DD) who are not served through an IDD 1915(c) HCBS waiver or an ICF-IDD may opt into the ICDS program.

Additionally, Medicare-Medicaid Enrollees with severe or persistent mental illness (SPMI) will be included in the ICDS program. The Ohio Medicaid program is currently working with CMS on a Medicaid state plan amendment to create Medicaid Behavioral Health Homes for all individuals in the Medicaid program with SPMI. The assumption in this proposal is that the state plan amendment will be approved and the Health Home program will be implemented in October 2011. Ohio is proposing that ICDS health plans will be required to contract with the Medicaid Behavioral Health Homes, and individuals with SPMI will not be required to change to a new provider for behavioral health services.

The target population is further reduced because Ohio is proposing to implement the ICDS program in seven regions of 3-5 counties each. A map of the proposed geographic areas is shown in Section C – Care Model Overview. Based on the eligibility criteria stated above and the regions that are being proposed, Ohio estimates that approximately 122,409 Medicare-Medicaid Enrollees will be eligible to participate in the ICDS Program. Figure 2 provides detailed estimates of the number of Medicare-Medicaid Enrollees eligible to participate in the ICDS Program, by region.

Ohio has conducted preliminary analyses of Medicaid spending for the ICDS target population. It is estimated that in FY 2011, Ohio Medicaid spent approximately \$3.7 billion providing services to Medicare-Medicaid Enrollees in the ICDS target population. Of this total, \$2.3 billion (62%) was for Medicaid-covered nursing home stays, while approximately \$900 million (another 24%) was spent for PASSPORT and other home and community-based services. The remaining \$500 million (14%) was spent on Medicare cost-sharing services and other Medicaid benefits not available through the Medicare program. Thus, in all, 86% of Medicaid spending for the target population is for Long-Term Services and Supports, either in institutional or community-based settings. More detailed analysis of current Medicaid spending for the target population will be developed through the rate development process.

Figure 2 - Proposed ICDS Target Populations by Region

													NEC			
	NW Region	egion	WCR	WC Region	SW Region	egion	<b>Central Region</b>	Region	NE Region	gion	EC Region	gion	Region		Total	
	In Demo	Not In Demo	In Demo	Not In Demo	In Demo	Not In Demo	In Demo	Not In Demo	In Demo	Not In Demo	In Demo	Not In Demo	In Demo	In Demo	Not In Demo	Total
Total Full Benefit Medicare-Medicaid																
Enrollees	11,844	9,225	15,112	3,322	23,062	3,740	19,655	32,531	36,193	5,840	17,653	7,567	10,625	134,144	62,225	196,369
Enrollees 65+	5,525	4,722	7,761	1,823	11,169	1,980	9,376	17,027	19,770	2,864	9,464	4,066	5,551	68,616	32,482	101,098
Enrollees 18-64	608'9	4,500	7,347	1,497	11,878	1,758	10,246	15,484	16,372	2,976	8,179	3,499	5,070	65,401	29,714	95,115
Enrollees with SMI over 18	1,319	674	1,552	181	2,378	323	1,886	2,297	3,817	753	1,475	537	299	13,094	4,765	17,859
Excluded Enrollees																
Enrollees with ID (DD waiver, ICF-MR)	1,230	924	1,108	376	1,999	183	2,103	1,927	2,698	452	1,781	902	069	11,609	4,568	16,177
Enrollees < 18	10	4	3	2	15	_	33	20	51	0	10	3	4	126	30	156
Total MMEs Eligible for ICDS Program	10,604	8,297	14,001	2,944	21,048	3,556	17,519	30,584	33,444	5,388	15,862	6,858	9,931	122,409	57,627	180,036
Source: ODJFS/DDS Average Enrollment February 24, 2012	ge Enrollment	February 24,	2012													

6 February 27, 2012

#### C. Care Model Overview

#### i. Description of Proposed Delivery System

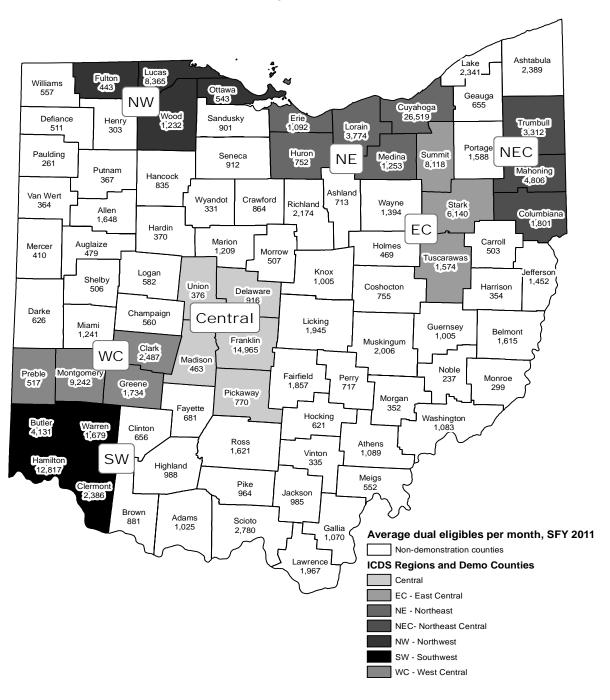
Ohio will implement a comprehensive, fully-capitated, competitive model for the ICDS program. Through a competitive procurement, the state will select two competing health plans to serve Medicare-Medicaid Enrollees in each of the designated regions. Medicare-Medicaid Enrollees will be able to choose to enroll in either of the two ICDS plans selected for each region.

#### (a) Geographic Service Areas

The ICDS program will be implemented in seven geographic regions of 3-5 counties each (see Figure 3). Each of the seven regions includes a metropolitan area. Additionally, six of the regions have at least four Medicare Advantage (MA) plans currently serving Medicare enrollees in all the counties in the region, and the Northwest Region has at least three MA plans currently serving Medicare enrollees in all of the counties in that region. The presence of established MA plans was influential in the choice of regions shown in Figure 3. All eligible Medicare-Medicaid Enrollees in the designated counties will be enrolled in the ICDS program in 2013, starting January 1, 2013.

**Figure 3. Proposed ICDS Regions** 

Figure 3.



#### (b) Enrollment Method

Enrollment in the ICDS Program will be mandatory for Medicaid-covered benefits. For Medicare-covered benefits, Ohio proposes to implement an "opt out" enrollment process. During the Medicare open enrollment period (October 1, 2012 through December 31, 2012) Medicare-Medicaid Enrollees in the targeted geographic regions will be notified of their enrollment into the ICDS program, and requested to select one of the two plans available to them in their region. The letter of notification will inform individuals that they will be enrolled in their plan of choice for both their Medicaid-covered benefits and their Medicare-covered benefits, unless they notify the state of their decision to opt out of the ICDS Program for their Medicare-covered benefits. Participants will be given multiple options for informing the state of their decision to opt out on the Medicare side.

If eligible participants elect to opt out of the ICDS program for their Medicare-covered benefits, they will remain enrolled in the ICDS program for their Medicaid-covered services. There will no longer be a feefor-service Medicaid option in the ICDS program target regions for ICDS participants. If individuals fail to notify the state of their plan selection choice, they will be automatically enrolled in one of the two plans available in their region.

Once enrolled in one of the two ICDS plans, individuals will be offered the option of switching plans twice a year—on July 1 and January 1. There is no "lock in" provision on the Medicare side, so that individuals can disenroll from ICDS plans for their Medicare-covered benefits at any time. However, if they choose to disenroll for Medicare, they will not be permitted to re-enroll in the ICDS program for their Medicare-covered services until the next July 1 or January 1 enrollment period.

#### (c) Available Medical and Supportive Service Providers

Because the geographic regions chosen include large urban areas in Ohio, access to both medical and supportive service providers is enhanced. More importantly, these areas are home to some of the nations' most comprehensive and integrated health care systems for both inpatient and outpatient care. Additionally, the ICDS regions are consistent with Ohio's Area Agencies on Aging networks, and the model envisions that those services also can be accessed for non-medical supports for this population.

#### ii. Description of Proposed Benefit Design

Ohio will implement a fully-integrated model delivering all Medicaid-covered services and Medicare-services. No Medicaid benefit carve-outs are proposed. The baseline design requirement is that ICDS plans administer Medicare and Medicaid benefits jointly such that participants experience their coverage as a single, integrated care program. The program will cover:

- All Medicare benefits,
- All Medicaid state plan benefits,
- All current Medicaid home- and community-based services, and
- Additional home- and community-based services that are currently provided in one of the five nursing facility level of care HCBS waivers.

Figure 4 provides a high level summary of the services that will be provided.

#### Figure 4 **Summary of Proposed Services in the ICDS Program**

#### **Medicare Services**

#### Part A Hospital Insurance:

helps cover inpatient care in hospitals, including critical success hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice and some home health care.

#### Part B Medical Insurance:

helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists and some home health care.

#### **Part D Prescription Drug**

Coverage: helps cover prescription drugs. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium.

#### **Medicaid Services**

Current Inpatient/Outpatient hospital services **Chiropractor Services** Allergy Testing and Treatment **Emergency Room Services Audiology Services Dental services** Optometrist and **Ophthalmologist Services Nursing facility Services Independent Psychologist** Services **Prescription Drugs** Prosthetics/Orthotic Services PT, OT, and Speech/language Pathology Services **Urgent Care Transportation Services Podiatrist Services** Diabetic Supplies and Insulin **Durable Medical Equipment** Preventive Exams and Screening **Immunizations** Lab & X Rays

### Services/Supplies **Proposed**

**Medication Therapy** Management Dietician

Home Health Services **Private Duty Nursing HCBS Services** Hospice

**Physician Services** 

Family Planning

**Pregnancy Related Services** 

#### Additional **Behavioral Health** Services

Community mental health services will provide clinically appropriate alternatives to inpatient services or support individuals returning to the community or provide intensive support to maintain functioning in the community These services may include:

**Crisis Intervention Community Support** Programs Partial Hospitalization Behavioral Health Counseling Mental Health Assessment Pharmacologic Management Psychiatric Diagnostic

interview

Services

Case Management

#### Additional Community **Support Services**

Community support services will promote independent living and help avert unnecessary medical interventions, e.g., avoidable or preventable emergency department visits. May include these and/or other services subject to further analysis:

Personal care assistance Home modifications Assistive technologies Assisted living Home delivered meals Telehealth **Social Work Counseling Community Transition** Services **Chronic Disease Self** management Nursing Home Care Attendant Respite Adult Day Service **Nutritional Counseling Independent Living Skills** Training

The vision of the ICDS program is to significantly enhance the individual's experience with the entire health care system, across all providers and services. By a "seamless" health care system is meant a system in which individuals no longer experience the frustration of accessing services from a host of disparate providers, who may not communicate effectively with one another about the individual's condition or treatment plan. Rather, in the ICDS program, the individual's experience with both the

10 February 27, 2012

medical system and the Long Term Services and Supports system would be greatly simplified through his or her affiliation with a single ICDS plan and care coordinator that is responsible for the complete continuum of care for that individual including links to non-Medicaid covered social services.

The concept of a seamless health care system also applies to the providers in the ICDS plan's provider network. There will be no coinsurance amounts or deductibles applied to any claim—participating ICDS plans will be invoiced for the entire cost of any Medicare or Medicaid service provided.

In the specifications included in the state's Request for Applications, the state will request that prospective ICDS health plans adopt a care management model that <u>fundamentally transforms the manner in which health care is provided to persons who are dually eligible for Medicare and Medicaid, particularly those with high functional needs.</u> Prior demonstrations of integrated care models for Medicare-Medicaid enrollees have shown that increased investments in primary and preventive services can produce high returns on investment in terms of reduced utilization of tertiary care, including inpatient hospital services and extended nursing home stays. This transformation in care management includes extensive use of home visits, high use of physician substitutes such as physician assistants and nurse practitioners, and the employment of advanced pharmacy management programs to increase adherence and eliminate contra-indicated drug use. The state will be looking to enter into contracts with health plans that are willing to make the kinds of investments in primary and preventive services for Medicare-Medicaid enrollees that are needed to reduce inappropriate use of higher-cost services.

The state will also be looking to purchase care management models that are culturally sensitive to the Medicare-Medicaid enrollees they serve. Medicare-Medicaid Enrollees are, by definition, low income. Many have significant disabilities or frailties related to advanced age, but they share a common desire to be treated with dignity and respect by the health care system. Culturally sensitive care management models, which make sincere efforts to build provider networks that reflect the cultural characteristics of their members, will be rated more highly in the plan selection process. The state will also be looking for models that recruit providers capable of communicating with members in their own primary language.

iii. Description of Supplemental Benefits and Ancillary Services.

Other features of the preferred care management model that will be built into the state's procurement specifications include:

- A team approach to care management, in which the core team is the beneficiary, the primary care
  practitioner, and the care manager, supplemented by LTSS specialists, behavioral specialists, and
  other health care practitioners as indicated by individual needs, to achieve a trans-disciplinary
  approach to effective management of the beneficiary's health care needs.
- A requirement to conduct periodic home visits with members so that individuals can be observed
  and assessed in their own home environment. Individuals with more significant health and
  functional needs will be required to be visited more frequently than individuals in relatively good
  health and with no functional impairments.

- Twenty-four hour in-person coverage for all beneficiaries, such that if a person calls at any time of day, a trained health care professional with access to the beneficiary's records will be available to assess their situation and take an appropriate course of action.
- A pharmacy management program that includes the pharmacists in the pharmacy where the
  individual obtains their prescriptions. This program must continually monitor the proper adherence
  of individuals to fill prescriptions and take medications in accordance with the prescriber's
  instructions.
- Aggressive management of care transitions, including admissions and discharges from hospitals, nursing facilities, and other facilities, to ensure communication among providers, primary care follow-up, medication reconciliation, timely provision of formal and informal in-home supports, etc.
- A comprehensive and aggressive process to review all hospital admissions and nursing home
  placements to identify admissions/placements that were inappropriate and avoidable and to
  develop systemic approaches to reducing inappropriate use of high-cost tertiary services.
- A comprehensive behavioral health management program that integrates physical and behavioral
  health services and that has the requisite staff and resources to develop appropriate care
  interventions for beneficiaries with cognitive impairments and behavioral issues, including the
  ability to rapidly respond to acute psychotic episodes for beneficiaries with severe mental illnesses.
  Pending successful implementation, this will be based on a health home model of delivery for
  persons with serious mental illness.
- A culturally sensitive approach to care management, such that beneficiaries have an opportunity to
  communicate with their health care practitioners in their primary language, either directly or
  through interpreters, and to receive care that is sensitive to their cultural background and
  preferences.
- A common or centralized record, provided by the ICDS, for each beneficiary, whose care is
  coordinated by the ICDS, that is accessible to all health care practitioners involved in managing the
  beneficiary's care, so that all encounters with the beneficiary by any practitioner can be shared
  across the ICDS.

While Ohio intends to provide specifications for the "architectural framework" of the care management model for ICDS members in its Request for Applications, the state also recognizes that the organizations bidding for ICDS health plan contracts will also bring to the table their own care management models for effectively managing care for Medicare-Medicaid Enrollees. Thus, the care management model provided to individuals in the ICDS program will reflect a balance of state requirements and contractor competencies. Further, the state wishes to establish a truly competitive market environment in which ICDS health plans compete for members based upon the quality of the services they provide. The state also fully expects that care management models for ICDS program participants will evolve over time, as fully integrated models for Medicare-Medicaid Enrollees are a relatively new product that will no doubt benefit from the experience gained from real world experience.

#### iv. Discussion of employment of evidence based practices

Ohio's quality strategy is predicated upon nationally recognized evidenced based practices and is implemented across delivery systems in all of Ohio's Medicaid programs. The strategy includes:

- Improving the overall quality of care by making health care more patient-centered, reliable, accessible, and safe, by eliminating preventable health-care acquired conditions and errors.
- Improving the health of the Ohio Medicaid population by creating a system that is less
  fragmented, where communication is clear, and patients and providers have access to
  information in order to optimize care and by supporting proven interventions to address
  behavioral, social, and, environmental determinants of health.
- Practicing best evidence medicine by facilitating the implementation of best practices to Medicaid providers through collaboration and improvement science approaches.
- Preventing and reducing the harm caused by high cost, prevalent conditions by focusing on certain clinical areas including: behavioral health, cardiovascular disease, diabetes, asthma, and upper respiratory infections.
- Supporting person and family centered care by integrating patient/family feedback on preferences, desired outcomes, and experiences into all care settings and delivery.
- Ensuring effective and efficient administration by sustaining a quality focused, continuous learning organization.

A finer delineation of these principles can be found in Appendix A.

- v. How the proposed care model fits with:
- (a) Current Medicaid waivers and state plan services

In May 2008, Ohio formed a "Front Door Stakeholder Group" to address balancing activities occurring through its Money Follows the Person Demonstration Grant in support of recommendations from the Unified Long-term Care Budget workgroup. The Front Door Stakeholder Group is modifying policies and procedures regarding entry into long-term services and supports by focusing attention on the functional criteria and operational processes that support individual access.

Ohio Medicaid, in conjunction with other stakeholders, is working toward a system of long-term care that maximizes choice and promotes community integration. For the past two years, Ohio Medicaid has been revising and reforming the state's current Medicaid level of care (LOC) determination process. Current work has centered on making short-term LOC process changes and clarifying policy and procedures. The next phase of LOC work is long-term reform of the current, fragmented, paper-based LOC determination process. Another component of this work is the development of a new assessment tool (Level 2 assessment) that will be used to determine eligibility for an array of Medicaid programs that serve individuals with a nursing facility LOC.

#### (b) Existing managed long-term care programs.

As stated previously, Ohio has mandatory Medicaid managed care for physical health services for the ABD population except not for individuals who reside in a facility, receive services from a 1915(c) HCBS waiver, or are dually enrolled in both the Medicare and Medicaid programs. Ohio does not currently use a managed care delivery model for long-term care programs or services.

#### (c) Existing Specialty Behavioral Health Plans

Ohio does not have specialty behavioral health plans.

#### (d) Integrated Program via Medicare Advantage Special Needs Plans (SNPs) or PACE programs

Individuals will be required to choose one of the two ICDS plans in a region. Thus, if the SNP is not one of the ICDS plans, the individual will be disenrolled from the SNP and given the choice of one of the ICDS plans.

The PACE program and the individuals in the program will be excluded from the ICDS program.

#### (e) Other state payment delivery efforts

The top priority of Ohio Medicaid, improving health outcomes, is monitored and encouraged through a variety of methods, including Ohio's managed care plan accountability and pay-for-performance (P4P) system. In addition to the strategies identified below, Ohio Medicaid continues to pursue promising strategies that increase the value of health care by using payment reform as a means to reward the delivery of high quality person centered health care. For example, Ohio Medicaid was the first state Medicaid program to join Catalyst for Payment Reform (CPR), a private-sector payment reform initiative to coordinate efforts among the participants to improve value in health care purchasing. CPR's guiding principles can be found at <a href="http://www.catalyzepaymentreform.org/Principles.html">http://www.catalyzepaymentreform.org/Principles.html</a>.

Some organizations have more experience in providing acute care services to this target population, including hospital care, post-acute care, specialty services, physician services, behavioral health services, and so on. Other organizations have more experience in providing long term services and supports to the target population, including personal care, in-home services, nursing home care, assisted living services, and other home-and community-based services. The ICDS program will involve strategic partnerships among organizations with these two different skill sets, and through contract requirements set clear expectations that these organizations will form a collaborative structure that can efficiently manage the full continuum of Medicare and Medicaid benefits that will be covered under the ICDS contract with the state and CMS.

#### (f) Other CMS payment/delivery initiatives or demonstrations.

Ohio's 2012-2013 budget included a Medicaid Health Home initiative to enhance the traditional patient-centered medical home model to better coordinate medical and behavioral health care consistent with the needs of individuals with severe and/or multiple chronic illnesses. Health Homes are an intense

form of care management that includes a comprehensive set of services and meaningful use of health information technology. For each chronically ill person in the Medicaid program, a Health Home will be required to:

- Provide quality-driven, cost-effective, culturally appropriate, person centered services;
- Coordinate or provide access to high-quality and evidence-based preventive/health promotion services, mental health and substance use/dependence services, comprehensive care management across settings, individual and family supports, and long-term care services;
- Build linkages to other community and social supports to aid the patient in complying with their care treatment plan;
- Form a team of healthcare professionals and develop a person-centered care plan that integrates clinical and non-clinical health care needs and/or services;
- Establish a continuous quality improvement program; and
- Use electronic health records, link services with health information technology, and communicate across teams and with individual and family caregivers.

The Health Home initiative will build on the medical home initiatives already underway throughout Ohio. It will add to these efforts by taking advantage of the federal Affordable Care Act provision that allows states to claim a 90% federal match for eight quarters (two years) for a defined set of care coordination services for individuals who are severely chronically ill or have multiple chronic conditions.

Ohio's Medicaid Health Homes initiative will initially focus on Medicaid beneficiaries who meet the State's definition of serious and persistent mental illness (which includes adults with SPMI and children with serious emotional disturbance), initially using a regional approach. Ohio's Community Behavioral Health Centers (CBHCs) will be eligible to apply to become Medicaid health homes for Medicaid beneficiaries with SPMI.

#### D. Stakeholder Engagement and Beneficiary Protections

i. Description of stakeholder engagement in planning.

Ohio has formally sought internal and external stakeholder input into the design of an ICDS program beginning in January 2011. Over the past year, the State has conducted numerous activities to solicit this input and has given serious consideration to stakeholders' concerns and expectations in making key decisions about the program design. These activities include:

- A Request for Information and summary of responses;
- Testimony of the Ohio Medicaid Director before the Ohio Legislature;
- Establishment of an advisory group made up of internal and external stakeholders;
- Presentation of a concept paper to the State's Unified Long Term Care Systems Advisory Workgroup;
- Development of a Question & Answer document and fact sheet associated with the concept paper;
- Development of a beneficiary questionnaire and summary of responses; and
- A series of public meetings and statewide conference call.

In addition, the Governor's Office of Health Transformation launched a website with a description of the initiative and links to key information about the stakeholder engagement activities listed above and

documents such as the concept paper and associated Q&A and fact sheet. The Office of Health Transformation will be posting a compendium of Stakeholder Engagement activities related to the ICDS Initiative entitled: "The Ohio Integrated Care Delivery System Demonstration Proposal to Better Serve Medicare-Medicaid Enrollees: Stakeholder Engagement Process and Summary of Findings" as a companion document to this Demonstration proposal.

Figure 5 shows the sequence of activities described above that the State has conducted to obtain stakeholder input. As shown, the ICDS concept was first made public in early 2011 with the release of a vision statement and proposal submitted to the Centers for Medicare & Medicaid Services to compete for a contract to design an integrated program. The first formal step in stakeholder engagement was the release of a Request for Information (RFI) in September of 2011. ODJFS released the RFI to solicit input from "those most affected by and interested in the provision of care to" Medicare-Medicaid Enrollees. Stakeholders were given one month to submit responses, and were encouraged to address a standard set of questions designed to elicit proposals and descriptions of best practices. ODJFS received responses from 24 stakeholder groups, including: health plans and health care delivery systems; care management and care coordination companies; provider associations; the Ohio Association of Area Agencies on Aging; social service and advocacy organizations; and others.

In late 2011 and again in February 2012, Medicaid Director John McCarthy testified before the Ohio Joint Legislative Committee for Unified Long-Term Care Services and Supports on the integration of care and services for Medicare-Medicaid Enrollees and other state Health Transformation initiatives. In addition, the State contracted with researchers to conduct key informant interviews with several members of Ohio's Unified Long-Term Care Systems Advisory Workgroup to obtain their input on an ICDS program. This Workgroup, first established in 2007, is charged with developing strategies to unify the State Long-Term Care Services System and better address the needs of a growing population of older adults and individuals with disabilities.

In late December, State staff met with advocates for consumers and family caregivers to formulate a strategy to obtain input directly from individuals and other interested stakeholders in their communities. Based on recommendations from that meeting, during January and February 2012 state staff participated in five regional meetings in Athens, Cleveland, Columbus, Dayton, and Toledo. Over 180 individuals attended these meetings. A statewide teleconference was held February 17, with over 70 individuals participating. Three more public meetings will be held in March 2012, beginning with a presentation of the demonstration proposal to the Unified Long-Term Care System Advisory Workgroup on March 8, 2012.

To complement the public meetings, the State developed a questionnaire for Medicare-Medicaid Enrollees and Medicaid Waiver Participants to obtain input on their current health and LTSS service delivery, service use, experience with care coordination and care during transitions from inpatient settings, and gaps in services. The questionnaire also solicited comments on how services could be improved. The Ohio Olmstead Task Force conducted outreach through its member organizations to these two (overlapping) target groups about the questionnaire and the public meetings. The questionnaire was posted online on the Governor's Office of Health Transformation website in early

February 27, 2012 16

<sup>&</sup>lt;sup>6</sup>Ohio Office of Health Transformation, **Ohio's Demonstration Model to Integrate Care for Dual Eligibles,** February 21, 2011.

February. Individuals can either complete the questionnaire online or download it and mail it in. All responses received by February 20th were reviewed and considered in developing the demonstration proposal. Over 500 questionnaires were submitted online by this date, with Medicare-Medicaid Enrollees comprising roughly a quarter of the respondents. Questionnaires received after this date will be considered as the program design progresses.

Figure 5
Timeline of Stakeholder Activities

o 1 1 11 5						20	11					2012					
Stakeholder Engagement Activity	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Vision for Integrated Healthcare Delivery System for Medicare-																	
Medicaid Enrollees released by Governor Kasich's Office of		•															
Health Transformation		Ť															
Proposal submitted to CMS to develop an integrated care																	
delivery system (ICDS) for Medicare-Medicaid enrollees (not																	
selected)		•															
Governor Kasich's Jobs Budget authorizes the State to seek						٠											
federal approval to implement an ICDS						•											
Letter of Intent submitted to CMS to design a Medicare-																	
Medicaid enrollee fiscal alignment model									•								
Request For Information (RFI) released to Stakeholders regarding																	
an ICDS for Medicare-Medicaid Enrollees									•								
24 stakeholder groups submit responses to RFI																	
Medicaid Director, John McCarthy, testified before Ohio																	
Legislature									•			•		•			
Independent researchers interview several members of State's											٥						
Unified Long-Term Care System Advisory Workgroup											_						
Stakeholder Advisory Group for ICDS formed											•						
Meeting with consumers and consumer advocates to plan for a																	
strategy to solicit public input on ICDS												•					
ICDS concept paper presented to Unified Long-Term Care System																	
Advisory Workgroup, ICDS FAQs and fact sheet													•				
Public input meeting - Toledo													•				
Public input meeting - Columbus													<b>*</b>				
Public input meeting - Dayton														•			
Public input meeting - Cleveland														•			
Beneficiary Questionnaire														$\Rightarrow$			
Public input meeting - Athens (rural area)														•			
Statewide public input conference call														•			
State posts ICDS proposal on Ohio Office of Health																	
Transformation website for public comment																	
ICDS Proposal presented to Unified Long-Term Care System															<b>A</b>		
Advisory Workgroup															•		
2 additional public input meetings (locations TBD)															<b>*</b>		
CMS publishes ICDS proposal in federal register for public																	
comment																	

#### Themes from Stakeholder Engagement Activities

Stakeholder feedback fell mainly into five major categories: delivery system structure; care management and other beneficiary points of contact; role of local infrastructure and providers; benefits and groups covered; and the process of developing and implementing the program. A report summarizing the stakeholder input received to-date will be posted to the Office of Health Transformation website Comments on these general themes are summarized briefly below:

**Type of Delivery System.** Stakeholders expressed a wide range of views on the best type of delivery system to achieve the goals identified in the RFI. The most common delivery systems proposed were: full-risk managed care; and various hybrid, "managed" fee-for-service (FFS) approaches. Among supporters of the former approach, stakeholders differed on whether the model should be based on Medicare Advantage Dual Eligible Special Needs Plans or Medicaid managed care plans. To achieve scale, most managed care entities supported automatic enrollment of Medicare-Medicaid Enrollees with the ability to opt out for Medicare services. Many proponents of the managed FFS approach favored building on care coordination currently provided by community-based organizations in conjunction with a primary care physician or interdisciplinary team within a medical health home.

Care Management and Beneficiary Point of Contact. Stakeholders were overwhelmingly supportive of a single point-of-entry system and enhanced care coordination that would be more tailored to individuals' needs and preferences. Numerous groups provided very specific proposals for meeting these goals based on their current product lines or model programs in other states. At the public forums, Medicare-Medicaid Enrollees and their caregivers raised myriad obstacles to receiving high-quality, person-centered care; many of which could be addressed through effective care coordination and linkages, a central point of contact, and greater flexibility in service coverage.

Role of Local Providers and Infrastructure. Many of the concerns stakeholders had related to a full-risk managed care approach was the potential for managed care organizations to cut out or reduce the role of the existing community-based infrastructure. A number of the managed care organizations identified strategic alliances with these organizations to be essential to their success in serving the Medicare-Medicaid Enrollees. Stakeholders disagreed regarding the type of organizations best suited to work with patient-centered health homes to coordinate care. In general, supporters of an integrated managed care approach preferred health plans be responsible for care coordination. Supporters of a managed fee-for-service approach preferred that current fee-for-service providers, namely Area Agencies on Aging, have this responsibility.

**Benefits and Groups Covered.** Broad support was expressed for health management and prevention programs to encourage beneficiaries to be involved in their health and functioning. In addition, several stakeholders expressed support for benefits not currently covered by Medicare or Medicaid that could be provided on a cost effective basis by preventing re-hospitalizations and long-term nursing facility placement. Many beneficiaries expressed frustration that services and equipment that are critically important to them tend to be unreliable and of poor quality. In some cases, these concerns extended to personal care and home health workers. At the same time, many waiver participants are satisfied with their services and are fearful they will be disrupted by a new program.

**Process.** While some stakeholders understand the proposed ICDS timeline within the context of the CMS initiatives, others are concerned that important milestones, such as the release of a Request for Application, might occur without sufficient stakeholder input. Stakeholders agreed on a need for continued interaction between the state, beneficiaries, service providers, health plans, and other groups as program design continues. Several stakeholders proposed a phased-in approach and specified regions they thought should be included in the initial phase of implementation.

How Stakeholder Input Was Incorporated into the ICDS Program Design

A theme that came through loud and clear from many stakeholders was the desire to leverage the expertise and experience within the existing aging, disability, and LTSS infrastructure. Accordingly, the program design emphasizes strategic partnerships among integrated care entities and local aging and disability resources and LTSS providers.

Another strong message was the importance of including behavioral health services and providers with this expertise in the program because mental health and substance abuse issues are often co-occurring with physical and cognitive conditions. The current ICDS program design includes the full range of Medicare and Medicaid services, including behavioral health for individuals with needs for these services. Medicare-Medicaid Enrollees with a primary diagnosis of serious mental illness will be included in the ICDS when the State's Health Home model targeted to this population is operational.

#### ii. Beneficiary Protections

Capitated purchasing models require strong quality management infrastructures to offset any incentives in capitated models to reduce or limit access to services. This section discusses Ohio's approach to establishing a quality management infrastructure for the ICDS Program that ensure that Medicare-Medicaid Enrollees enrolled in the program have access to the medical and support services they need, and that the services they are provided are of the highest quality possible. The beneficiary protections provided in the ICDS program will be no less than the protections provided members of Medicare Advantage plans, Medicaid-only plans, and recipients of section 1915(c) home-and community-based waiver services or in any other affected setting. Further, Ohio intends to work collaboratively with CMS to develop quality and performance measures that are specifically tailored to the needs and characteristics of Medicare-Medicaid Enrollees. Beneficiary protections that are built into the ICDS program model include the following:

**Competitive Program Model.** Beneficiaries will be guaranteed a choice between competing ICDS plans in their geographic region. It is expected that plans which provide higher quality services to their members will gain reputations for doing so, and will be selected by a higher proportion of Medicare-Medicaid Enrollees in the region.

The process for selecting ICDS plans to participate in the program is also competitive. Among the multiple bidders which may submit proposals to participate in the ICDS Program, Ohio (and CMS) will select those plans which have the best track record for providing high quality services to their members, and which demonstrate the competence and ability to meet the diverse service needs of a population with high medical and support needs.

**Beneficiary Choice.** Medicare-Medicaid beneficiaries will be allowed to choose the ICDS plan which provides the higher quality service and which best meets their individualized needs. For Medicare, beneficiaries will be allowed to receive their Medicaid-covered benefits through their ICDS plan, or to opt out of the program and continue to receive services through the traditional fee-for-service system. Further, if beneficiaries are not satisfied with the quality of the services they are receiving in their current plan, they will be allowed to switch plans, up to twice annually.

**Provider Choice**. Although Medicare-Medicaid Enrollees will be required to receive services within the designated networks of each ICDS plan, beneficiaries will be allowed to have freedom of choice of providers within the networks, including choice of LTSS providers such as personal care attendants. Beneficiary choice extends to the selection of each member's designated care manager—if a member is dissatisfied with his or her assigned care manager, he or she will be allowed to request an alternate care manager.

Participant-Directed Services. During the stakeholder engagement process, consumers identified "Participant-Directed" services as a valued LTSS benefit. ICDS plans will be required to provide Participant-Directed services as a service option within their LTSS benefit package. This service allows ICDS members to select their own LTSS providers within an established individualized budget, including the option to pay family members as personal care attendants. ODJFS is considering the option of contracting with a single fiscal agent to manage this benefit for all participating ICDS plans, to reduce the administrative costs related to this service option.

Consumer Participation in ICDS Governance. All ICDS plans will be required to have local governance bodies in each geographic region. These local bodies will have input into policies and protocols utilized by the local ICDS plans (as also governed by contractual requirements and the plans' corporate policies). At least 20% of the members of the local governance bodies will be consumer representatives, who could either be ICDS plan members, family members of ICDS beneficiaries, or representatives of local advocacy organizations which represent the interests of Medicare-Medicaid Enrollees.

Quarterly Meetings with ICDS Plan Members. Every ICDS health plan will be required to convene semiannual meetings with their beneficiaries, to fully document all grievances raised by beneficiaries at the meetings, to keep comprehensive minutes of all beneficiary meetings that are made available to all beneficiaries and to provide written responses to all articulated grievances prior to the convening of the next beneficiary meeting. The ICDS will notify all members at least 15 days prior to each quarterly meeting regarding the date and location of the meeting, and offer to assist with transportation to the meeting if the member cannot travel independently.

**Grievances and Appeals.** Each ICDS will administer a unified Grievances and Appeals process, by which beneficiaries can appeal any decision made by the ICDS to reduce or deny access to covered benefits. An appeal filed within 30 days of a decision by the ICDS will require the continuation of benefits during the appeals process.

**Contact Information for Oversight Agencies.** The ICDS health plan will provide each beneficiary with contact information for regulatory agencies. In the case of beneficiaries receiving long-term care services and supports, the ICDS will provide contact information for the Office of the State Long-Term Care Ombudsman.

#### iii. Ongoing Stakeholder Engagement

Ohio will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. This will be accomplished through an ongoing process of public meetings, monitoring beneficiary and provider experiences through a variety of means, including surveys, focus groups, website updates, and data analysis. In addition, Ohio will require that ICDS plans develop meaningful consumer input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to eligible beneficiaries.

Ohio will also develop consumer notices and related materials about the ICDS program that are easily understood by persons with limited English proficiency, and will translate materials into prevalent languages as determined by the State.

#### E. Financing and Payment

#### i. State-Level Payment Reforms

The Ohio ICDS program will join a family of reforms in the State's Medicaid program designed to leverage Medicaid's purchasing power to pursue best practices in health system delivery. Under the guidance of the Office of Health Care Transformation and the Ohio Health Care Payment Reform Task Force, Ohio will partner with the private sector to design and implement a care system that is based on value and performance rather than the volume of services provided.

Ongoing initiatives include:

Patient-centered health homes. Ohio Medicaid is in the process of designing a person-centered system of care, called a health home, to improve care coordination for high-risk beneficiaries. Ohio Medicaid has teamed up with the Ohio Department of Mental Health, and the Ohio Department of Alcohol and Drug Addition Services to focus first on creating health homes for Medicaid beneficiaries with SPMI; other populations will be phased in. Care managers will be embedded in Patient-Centered Medical Home (PCMH) practice sites to provide intensive care coordination and develop an individualized care plan for each consumer to address both medical and non-medical needs. Ohio Medicaid is seeking federal approval to establish SPMI-focused health homes beginning in July 2012.

**New pay for performance initiative for managed care.** A recently revamped quality program for the managed care program has put Ohio Medicaid in the forefront of programs emphasizing quality as a key component of plan reimbursement. Plans can earn bonus funds for meeting quality targets that have been carefully designed to emphasize patient-centered, evidence-based care. This new reimbursement structure emphasizes the State's intention that "reimbursement rewards value."

**Reformed nursing facility reimbursement.** Ohio Medicaid has recently transitioned from a cost-based Medicaid payment system for nursing homes to a price based system, a change that was initiated by the legislature in 2005 (HB 66) to reward efficiency. More of the Medicaid payment is now linked to direct care for residents and quality. The new system increases Medicaid quality incentive payments for nursing homes from 1.7 percent of the average Medicaid nursing home rate in 2011 to 9.7 percent in

2013, and increases the actual amount spent on average for resident services from \$93.04 to \$102.96 per person per day. The Ohio General Assembly established a Unified Long-Term Care Systems Advisory Workgroup to assist in the implementation of these reforms.

The State's reimbursement goals of emphasizing quality, transparency, patient-centeredness, and value will be carried through the ICDS program reimbursement structure as well. The capitation-based reimbursement model will be designed to produce ICDS plan incentives to provide high quality, coordinated care that will reduce overall system costs. The blended capitation payment structure is expected to provide plans the flexibility to utilize the most appropriate cost effective service for the enrollee, eliminating incentives to shift costs between Medicare and Medicaid. Furthermore, ICDS plans must develop innovative performance-based reimbursement with their network providers.

#### ii. Payments to ICDS Health Plans

Managed care contracts can contain a variety of elements designed to best match payments to population risks. Sustainable, stable programs depend on appropriate payment structures that contain the right incentives for vendors to provide services and manage care effectively. Ohio will work with CMS and the Medicare-Medicaid Coordination Office to develop a sound reimbursement structure to cover the populations and services to be provided under the contract.

The ICDS program envisions making prospective blended capitation payments to ICDS plans, which are responsible for providing all Medicare and Medicaid services and coordinating care. Capitation payments will include expected expenses associated with the medical, behavioral health, and long term services and supports provided to enrollees, as well as the non-medical expenses required to provide and coordinate those services. Both Medicare and Medicaid will contribute to the blended payments in a manner that aggregate expected savings are shared proportionately between the two programs. The reimbursement structure will include carefully-designed rate cells and may include other components such as risk adjustment, risk sharing, and pay-for-performance.

Rate cell structure. Appropriate payment structures start with a foundation of well-designed rate cells. Rate cells stratify the target population into homogenous risk groups, so that payments to MCPs can be aligned with the mix of risk they enroll. Ohio and its actuaries are in the process of evaluating potential rate cell structures for use in the ICDS program. Selected rate cells will be based on objective, measureable characteristics of the target population that correlate well to their expected risk. Careful consideration will be given to ensure that the selected structure appropriately compensates MCPs while encouraging the provision of sufficient, coordinated, cost effective services needed by their enrollees.

**Risk adjustment.** Risk adjustment techniques acknowledge the potential for different ICDS plans to attract different mixes of risk among their enrollees, which may happen even within carefully constructed rate cells. When this happens, an appropriate average rate for a given rate cell can overpay some health plans while underpaying others. Significant misalignment in this manner is not conducive to a stable, cost effective program. As a result, Ohio and its actuaries will work with stakeholders, potential vendors, and CMS to evaluate the need for additional risk adjustment techniques in the ICDS program. Effective risk adjustment models for managed long term care populations are in their infancy.

**Risk sharing.** Often, States elect to use additional risk sharing techniques to attract vendors to a new program and/or to attract smaller vendors. Well known mechanisms such as risk corridors and stop loss programs have been used to increase vendor confidence and ease transition for serving new populations through risk contracts. Through working with potential vendors, stakeholders, and CMS, Ohio will evaluate the need for additional temporary or permanent risk sharing mechanisms for the ICDS program. Ohio will give careful consideration to targeted risk sharing that is designed not to distort plan incentives.

Pay for performance. Ohio's philosophy that reimbursement should reward value suggests that it may be appropriate to include a financial incentive program within the ICDS reimbursement structure. ICDS plans that produce overall system savings while providing high quality care should have the opportunity to share in those savings. As noted above, Ohio has recently updated the pay for performance incentive structure within its existing acute care managed care program. Under the CMS proposed financial model, participating plans will be subject to an increasing quality withhold (1, 2, 3 percent in years 1, 2, and 3 of the demonstration). In partnership with each state, quality thresholds will be established for each year. Plans will be able to earn back the withheld capitation revenue if they meet quality thresholds. Ohio will work with CMS to construct a withhold-based quality incentive program that incorporates quality indicators that have been tailored specifically for the dual eligible population and are based on Ohio Medicaid's Quality Strategy. Furthermore, because providers are the key to improved health outcomes, there will be a requirement that at least 50% of the quality withhold is passed on to providers whose care lead to increases in the quality indicators.

Ohio is also expecting new innovative models of pay-for-performance among the ICDS plans and providers in their networks. Simply paying on a Medicare or Medicaid fee-for-service basis will not provide the right incentives. Plans that propose innovative reimbursement methodologies will be awarded higher scores in the procurement process.

#### F. Expected Outcomes

Ohio expects the ICDS program to result in an entirely different consumer experience for ICDS program members, as well as significantly different service utilization patterns. The outcomes observed in previous demonstrations to fully integrate Medicare and Medicaid benefits have shown that integrated plans have used the flexibility of pooled capitation to make increased investments in primary and preventive care services. Thus, in the ICDS program, we would expect to see increased use of encounters with primary care practitioners, increased use of home visits, increased monitoring of medication adherence, increased focus on post-hospital follow-up care, increased family/caregiver support, and increased use of behavioral health services. Ohio also expects to see decreased nursing home admissions, reduced lengths of stay for nursing home episodes, reduced hospital readmissions rates, reduced emergency room visits, a reduction in duplicative unnecessary tests, and more appropriate use of specialty services. Realistically, Ohio does not expect to observe these kinds of outcomes immediately because it will take time for ICDS health plans to put the care management models into place that are capable of achieving these kinds of results.

Ohio also expects to see significant improvement in individuals' experience with the health care system in the ICDS program. This would include improvements in the quality of LTSS service providers, increased cultural sensitivity to members' social and ethnic backgrounds, increased consumer

participation in his or her own plan of care, improved communication with providers about treatment and medications, and a greater sense of control over how and where LTSS services are provided. These consumer-based outcomes will be objectively measured as part of the state's overall Quality Strategy.

In 2011, Ohio Medicaid completely revamped its Quality Strategy to expand efforts aimed at providing care (see section C), to improve the health of the Ohio Medicaid population, and to promote the practice of evidence-based medicine. The Ohio Medicaid Quality Strategy focuses on five priorities:

- 1. Make Care Safer,
- 2. Improve Care Coordination,
- 3. Promote Evidence-Based Prevention and Treatment Practices,
- 4. Support Person and Family-Centered Care, and
- 5. Ensure Effective and Efficient Administration.

As part of the revamped Quality Management strategy, Ohio developed a new set of performance measures and standards to hold Medicaid managed care plans more accountable, including the adoption of national performance measures specifically tailored to the Aged, Blind, and Disabled (ABD) Medicaid adult population. Ohio will build on its existing Medicaid Quality Management framework to design and implement a comprehensive quality management strategy for the ICDS program, but adapt the ICDS version to reflect the needs of Medicare-Medicaid Enrollees, particularly those receiving Long-Term Services and Supports.

Ohio also recognizes that the Quality Management strategy adopted for the ICDS program must include quality oversight of Medicare-covered benefits as well as Medicaid-covered benefits. The ICDS plans participating in the Demonstration will be required to meet both Medicaid and Medicare standards and requirements. However, it is also recognized that one of the objectives of the Medicare-Medicaid Demonstration as a whole is to unify and simplify the requirements that fully integrated health systems must meet in serving Medicare-Medicaid Enrollees. For example, in its recent guidance to organizations considering participation as fully capitated plans in the Demonstration, CMS states that "CMS and States shall determine applicable standards, and jointly conduct a single comprehensive quality management process and consolidated reporting process." Ohio is committed and looks forward to working with CMS in developing a comprehensive quality management process for the ICDS program that programmatically combines as well as streamlines Medicare and Medicaid reporting requirements.

#### G. Infrastructure and Implementation

i. State capacity to implement and oversee the proposed demonstration

Figure 6 presents the management structure for the Governor's Office of Health Transformation. Overall responsibility for development of the ICDS program model and implementation plan rests with John McCarthy, the State Medicaid Director, and Chair of the ICDS Management Team. The Office of Health Transformation is providing high-level policy input into the ICDS Program and serves as the primary communication channel to Governor Kasich, who named the ICDS program his Administration's

February 27, 2012 25

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<sup>&</sup>lt;sup>7</sup>Centers for Medicare and Medicaid Services, **Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans,** January 25, 2012.

number one health policy priority in 2012. Mr. McCarthy also will serve as the main point of contact with the Medicare-Medicaid Coordination Office at CMS regarding CMS-Ohio collaboration on the ICDS program.

The ICDS Management Team includes staff from the the program areas needed to design and implement the ICDS program:

- John McCarthy, Ohio Medicaid Director, chairs the ICDS Management Team;
- Patrick Beatty, Assistant Deputy Director for Medicaid Policy, has overarching responsibility for all of Ohio's Medicaid Managed Care Programs;
- Harry Saxe, ICDS Project Manager, is the lead staff person on the initiative and devoted full time to the ICDS program;
- Mitali Ghatak, Chief of Fiscal Planning and Management, has lead development for actuarial analysis and rate development, supervising the work of Ohio's actuarial contractor, currently Mercer Government Services;
- Jon Barley, Chief of Health Services Research, oversees Quality Management in Ohio's Medicaid programs; and
- Dale Lehman, Chief of Managed Care Contract Administration, has lead responsibility for monitoring of Medicaid contracts.
- Kim Donica, Matt Hobbs, and Susan Fredman provide technical support to the Management Team in regard to Long-Term Services and Supports issues in the ICDS program, and Rafiat Eshett and David Dorsky provide additional technical support to the Management Team.

The members of the ICDS Management Team will chair additional workgroups devoted to specific components of the program, such as the ICDS plan selection process, beneficiary enrollment and protections, IT systems modifications, rate development, quality management, and CMS collaborations (e.g. development of the Memorandum of Understanding).

Ohio has also secured outside consulting support for development of the ICDS program. The State has two separate engagements with Mercer Government Services—one to provide actuarial support in the rate development process, and one to provide general consulting support. Ohio has also engaged Thomson Reuters to provide consulting support in the development of the design model and implementation plan.

Ohio Medicaid has been working with CMS to facilitate the receipt of Medicare data for the dual eligible population, and preparing and positioning resources both internally and externally to house and analyze the data. Ohio Medicaid will house the data internally and use both internal and external resources to perform analysis to support ICDS operations and the delivery of services to ICDS beneficiaries.

#### ii. Implementation strategy and anticipated timeline

Figure 7 presents a detailed implementation timeline for the ICDS program, including with the completion and posting of this Draft Demonstration Proposal. Many of the details of the implementation timeline have been discussed in previous sections of this proposal. While the timeline is ambitious and there is much work to be done, Ohio is on track to begin enrollment of Medicare-Medicaid Enrollees beginning on January 1, 2013.

#### Initial Enrollment of Medicare-Medicaid Enrollees into the ICDS Program

The initial enrollment of Medicare-Medicaid Enrollees into the ICDS Program will be a significant undertaking, and must be conducted in a manner that results in minimal disruption of existing services and supports to ICDS members. While many of the details of the initial enrollment process are yet to be worked out, a preliminary approach is discussed below.

First, Ohio will establish an ICDS Enrollment Workgroup, whose mission will be to establish a detailed implementation plan for the initial launch of the ICDS program. The Enrollment Workgroup will be tasked with the following responsibilities:

- Establish explicit criteria for determining who will be enrolled in the ICDS program and who will not (e.g. exclusion criteria for persons served by the Ohio Department of Developmental Disabilities);
- Work with Ohio's enrollment broker to develop accurate mailing lists of prospective Medicare-Medicaid Enrollees in each targeted region;
- Develop a comprehensive communications plan for communicating with Medicare-Medicaid Enrollees regarding the implementation of the ICDS program, and informing Medicare-Medicaid Enrollees of their enrollment options;
- Coordinate with the selected ICDS health plans in each of the geographic regions to implement as seamless an enrollment process as possible;
- Coordinate with the selected ICDS health plans regarding marketing materials that will be made available to prospective ICDS enrollees to facilitate their choice of an ICDS plan in their region;
- Develop the specific language for the initial enrollment letter that will go out to all eligible enrollees on October 1, 2012;
- Develop specific policies for allowing consumers to opt out of the Medicare side of the ICDS program; and
- Work with ICDS health plans on the development of initial enrollment packets for ICDS consumers regarding their rights and benefits under the ICDS program.

The Enrollment Workgroup will be established in mid-March 2012 and will report directly to the Medicaid Director, John McCarthy, who has day-to-day operational responsibility for the implementation of the ICDS program. The Enrollment Workgroup will include consumer representatives, to ensure that the consumer perspective is reflected in ICDS enrollment policies. The Enrollment Workgroup will continue its work throughout all of 2012 until the ICDS program is launched on January 1, 2013.

As previously discussed, there are many details to the initial enrollment process that are yet to be worked out, but a basic structure of the initial enrollment process is outlined below:

- All Medicare-Medicaid Enrollees will be sent an initial "information" letter in the summer of 2012
  letting them know about the launch of the ICDS program in their region, and informing them of their
  need to choose an ICDS health plan during the upcoming enrollment period in the fall of 2012.
- Selected ICDS health plans will be requested to develop and submit marketing materials for the ICDS program to the Enrollment Workgroup during the summer of 2012 for review and approval.
- Letters will be mailed to all Medicare-Medicaid Enrollees on October 1, 2012 informing them of their
  enrollment into the ICDS program, asking them to choose one of the two ICDS health plans in their
  region, and communicating information about their right to opt out of the Medicare side of ICDS.
- Medicare-Medicaid Enrollees who have not made a choice of ICDS health plans by November 1, 2012 will be mailed a reminder letter giving them two more weeks to make a choice of plans.
- ICDS enrollees who have not made a plan selection by November 15, 2012 will be automatically assigned to one of the two ICDS health plans in their region.
- All assignments/choices to ICDS plans will be completed by December 1, 2012.
- While assignments will be completed by December 1, 2012, Medicare-Medicaid Enrollees will not be transitioned into their health plans until the month of their birthday in 2013.
- Medicare-Medicaid Enrollees will be mailed information packets from the ICDS plan of their choice in the month prior to their enrollment in the plan.
- Ohio Medicaid will be providing Health Home Services to consumers with SPMI through Community Behavioral Health Centers.

#### Selecting ICDS Health Plans

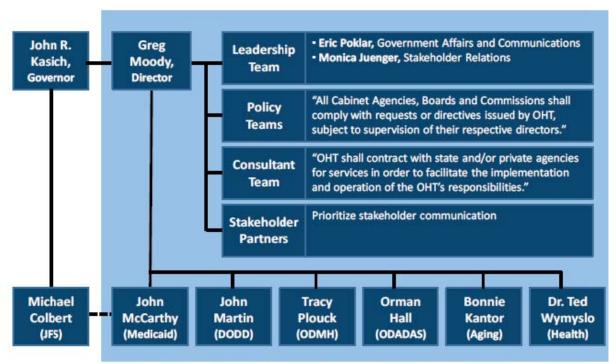
Ohio Medicaid intends to select ICDS health plans through a competitive procurement process. Contracts will be awarded to those organizations that can best meet the criteria established by Ohio Medicaid for a truly integrated care delivery system for beneficiaries. It is anticipated that Ohio Medicaid will issue a Request for Assistance (RFA) in April 2012. A bidders' conference will be held shortly after release of the RFA, at which potential bidders will be given the opportunity to ask clarifying questions about the specifications provided in the RFP. Ohio Medicaid will also respond in writing to all technical and business questions submitted by potential bidders. Bidders will be given approximately six weeks to prepare a response to the RFA.

It is anticipated that the bid review process will be conducted in two-phase process. Proposals that adequately meet all of the criteria specified in the RFA will be considered finalists. Ohio Medicaid may then direct additional technical and business questions to finalists in each target region or county in order to support final selections. Finalists may also be requested to make oral presentations to the ICDS selection committee, which will include representation from CMS.

If no quality bids are submitted in a target region or county, Ohio Medicaid reserves the right to rebid or combine regions to facilitate implementation. If multiple ICDS contractors are selected, it is highly unlikely that more than two contractors will be awarded contracts in any target region or county.

Figure 6.





Source: Ohio Governor John R. Kasich, Executive Order 2011-02K (January 13, 2011)

# Figure 7. Ohio Integrated Care Delivery System (ICDS) Design and Implementation Timeframe

Target Date	Phase I: Getting Organized	On Website
02/01/2011	OHT applies for a CMMI Medicare-Medicaid integration demonstration grant	Yes
06/30/2011	The Jobs Budget (HB 153) creates authority (ORC 5111.944) for Ohio to implement ICDS	Yes
07/08/2011	CMMI releases financial models to support Medicare-Medicaid integration	Yes
08/11/2011	Public meeting: Unified Long-Term Care System (ULTCS) Advisory Group	Yes
09/08/2011	Public meeting: ULTCS Advisory Group	Yes
09/16/2011	Ohio submits a Letter of Intent to CMMI to participate in an ICDS program	Yes
09/20/2011	Ohio Medicaid releases a request for information (RFI) for input on ICDS design options	Yes
09/28/2011	Public meeting: Joint Legislative Committee on ULTCS	Yes
10/14/2011	RFI responses due and considered for incorporation into an ICDS Concept Paper	Yes
11/28/2011	Public meeting: ULTCS Advisory Group	Yes
12/20/2011	Public meeting: Joint Legislative Committee for ULTCS	Yes
	Phase II: ICDS Concept Paper and Public Comment	
01/10/2012	ICDS Concept Paper posted for public review (50 day public comment period begins)	Yes
01/12/2012	Public meeting: ULTCS Advisory Group	Yes
01/24/2012-	Regional meetings to facilitate consumer and family caregiver public comment held in	Yes
02/14/2012	Toledo (1/24), Columbus (1/31), Dayton (2/3), Cleveland (2/7), and Athens (2/14)	
02/06/2012	Additional stakeholder meetings with LTC facilities and health plans	
02/08/2012	Consumer questionnaire posted to facilitate public comment	Yes
02/17/2012	Statewide conference call to facilitate public comment	Yes
02/20/2012	Public comments due and considered for incorporation into an ICDS Draft Proposal	
	Phase III: ICDS Proposal and Public Comment	_
02/27/2012	ICDS Draft Proposal posted for public review (30 day public comment period begins)	Yes
03/08/2012	Public meeting: ULTCS Advisory Group	
TBD	First public hearing: TBD	
TBD	Second public hearing: TBD	
03/27/2012	Public comments due and considered for incorporation into a final ICDS Proposal	
03/30/2012	Ohio submits ICDS Proposal to CMMI	
04/02/2012	CMS posts Ohio Proposal for public review (30 day public comment period begins)	
05/01/2012	Public comments due and CMS/Ohio begin review of public comments	
05/15/2012	CMS/Ohio complete review public comment and make final revisions to the Proposal	

## Figure 7 (continued). Ohio Integrated Care Delivery System (ICDS) Design and Implementation Timeframe

Target Date	Phase IV: ICDS Implementation	On Website
04/02/2012	Ohio releases a request for applications (RFA)	
04/07/2012	RFA bidders conference	
05/01/2012	CMS and Ohio negotiate a Memorandum of Understanding (MOU)	
05/11/2012	RFAs due	
06/04/2012	ICDS applicants submit proposed benefit packages	
06/30/2012	CMS and Ohio sign a Memorandum of Understanding (MOU)	
07/02/2012	CMS and Ohio finalize the content of a 3-way contract (CMS/Ohio/ICDS)	
07/30/2012	CMS/Ohio ICDS plan selection complete	
08/01/2012	Readiness review	
09/20/2012	CMS, Ohio, and ICDS plans sign 3-way contracts	
	Phase V: ICDS Enrollment	
08/23/2012	Initial information letter sent to Medicare-Medicaid beneficiaries in target regions	
10/01/2012	Notification letters sent to ICDS beneficiaries (aligns with Medicare open enrollment)	
10/01/2012	Medicare opt out option ongoing	
11/01/2012	Second notification letter sent to ICDS beneficiaries	
11/15/2012	Auto-assignment for beneficiaries who have not enrolled in an ICDS plan	
12/01/2012	ICDS plans send enrollment packets to ICDS beneficiaries	
01/01/2013	Initial enrollment into ICDS plans	

#### H. Feasibility and Sustainability

#### i. Potential Barriers and Challenges

Ohio does not underestimate the amount of work that needs to be accomplished between now and January 1, 2013, in order to bring the ICDS program up and running. Governor Kasich has designated the launch of the ICDS program as his number one health priority in 2012, and all available resources will be dedicated to the effort. The implementation effort will be managed by the ICDS Management Team (see Section G) under the day-to-day direction of the state Medicaid Director, John McCarthy. The health care leadership in the state, including the Governor's office to the Office of Health Transformation and Ohio Medicaid, is fully focused on implementation of the ICDS program.

Neither does Ohio underestimate the political challenges it faces during the ICDS implementation process. The shift in the state's purchasing strategy from a fee-for-service model to a fully capitated model for Medicare-Medicaid Enrollees will result in an entirely new flow of Medicare and Medicaid dollars to the provider community. The shift is not trivial—the magnitude of the shift is measured in the billions of dollars. These kinds of shifts naturally create significant anxieties among the organizations that provide services to Medicare-Medicaid enrollees.

From the consumer perspective, similar anxieties arise. There are underlying concerns that the shift from a fee-for-service model to a capitated approach will result in service disruptions for some or many consumers. The state is committed to engaging in an ongoing dialogue with consumers to listen to their ongoing concerns regarding the ICDS program, and to candidly discuss both the potential advantages and disadvantages of integrated health care systems for Medicare-Medicaid enrollees. Further, as described earlier in this proposal, the state is committed to implementing the ICDS program in manner that ensures that existing service arrangements for Medicare-Medicaid Enrollees are not disrupted.

#### ii. Remaining Statutory or Regulatory Challenges

There are no Ohio statutory or regulatory barriers to the full implementation of the ICDS program. Ohio Medicaid has full authority to move forward on the implementation of the ICDS program. The state recognizes the need for CMS approval for the Medicare-Medicaid Demonstration Proposal, including the authority to mandate the enrollment of Medicare-Medicaid Enrollees into managed care. The state is fully committed to working with the Medicare-Medicaid Coordination Office to utilize the most appropriate authorities needed for ICDS program implementation.

#### iii. Funding Commitments or Contracting Processes Needed

Over the next 10 months, Ohio will be undertaking a number of contracting processes to support the launch of the ICDS program. These contracting processes include:

- A competitive procurement to select at least two ICDS health plans in each of the seven targeted
  geographic regions for the ICDS program. The scheduled release of the Request for Applications is
  April 2, with a proposal due date from bidders on May 11, 2012. The proposal review process will
  be conducted jointly with CMS and will result in the negotiation of three-way contracts, ready for
  final signature on September 20, 2012.
- Ohio Medicaid has existing contracts in place for consulting and actuarial support from Mercer
  Government Services and Thomson Reuters. Mercer will be providing actuarial support in the rate
  development process as well as general consulting support for the ICDS implementation process.
  Thomson Reuters is also providing consulting support on program design issues and implementation
  processes.
- Ohio Medicaid will be working with the state's Managed Care Enrollment Broker, Automated Health Systems, Inc., to design and implement the initial enrollment of Medicare-Medicaid Enrollees into the ICDS health plans.
- Ohio Medicaid and the Department on Aging are considering new contracts with the Aging and Disability Resource Networks to serve as initial one-stop enrollment agencies for the ICDS program.

#### iv. Scalability and Replicability

The ICDS Program Demonstration already includes approximately 80% of the eligible Medicare-Medicaid Enrolled population in the state. Expansion to the more rural areas of the state in non-Demonstration counties beyond the three-year Demonstration period will depend upon the success of the

Demonstration in meeting its objectives, and the feasibility of replicating the ICDS care management model is in less populated regions. The Ohio ICDS program model should be highly replicable in other states. As a Demonstration state, Ohio is willing and interested in sharing the experience gained in the implementation and management of the Ohio ICDS program with other states also wishing to provide better care for Medicare-Medicaid Enrollees.

#### I. Additional Documentation

Not Applicable.

#### J. Interaction with Other HHS/CMS Initiatives

Ohio will work with HHS and CMS to coordinate on their initiatives aimed at improving health and health care including but not limited to the Partnership for Patients, Million Hearts Campaign, and HHS Action Plan to Reduce Racial and Ethnic Health Disparities.

Reducing racial and ethnic health disparities is one of Ohio's goals to improve health outcomes. In order to achieve improvement in this area Ohio Medicaid join the Ohio Department of Health in applying for a grant for technical assistance from the Nation Academy of State Health Policy (NASHP). NASHP chose Ohio for the project, and Ohio signed the agreement for the project October 2011. Attached in Appendix B is the application Ohio submitted along with the work plan that was developed after the award. The objectives of this project include:

- Implementing Health Homes and Patient Centered Medical Homes in such a way which also addresses social determinants through integrated care services.
- Designing Health Homes which directly address key findings of the 2010 Healthcare Disparities Report (Agency for Healthcare Research and Quality).
- Develop and implement learning opportunities for healthcare providers which include cultural and linguistic competency. This will empower health care providers to better serve diverse communities. Additionally, this will also help healthcare providers understand their role in eliminating healthcare disparities.
- Use data to identify the best locations to establish new Health Homes and/or Patient Centered Medical Homes, especially in areas that are considered "medical hotspots".
- Address healthcare workforce diversity to improve provide patient/provider relationships.

Coordination of the ICDS program with other Ohio LTSS Initiatives

Concurrent with the ICDS initiative, Ohio is implementing several other initiatives to streamline the administration and delivery of LTSS in the state and to improve consumer outcomes. Three specific initiatives which will be coordinated with the ICDS program are: the consolidated HCBS waiver initiative; and Expanded Housing Opportunities under the Money Follows the Person Demonstration. This section discusses how these three initiatives will be coordinated with ICDS.

#### Consolidated HCBS Waiver Initiative

A second LTSS initiative that will be coordinated with the ICDS initiative is the Consolidated HCBS Waiver Initiative. Under the Consolidated HCBS Waiver, Ohio's five NF-based HCBS waivers will be consolidated into one waiver. These five HCBS waivers include: (1) the PASSPORT waiver, (2) the Assisted Living Waiver, (3) Choices waiver, (4) the Ohio Home Care Waiver, and (5) the Transitions II Aging Carve-Out Waiver. The new Consolidated Waiver will serve all persons with physical disabilities age 18 through 64 and all persons age 65 and over who are eligible for HCBS services. Children under the age of 18, and persons who receive services from waivers administered by the Ohio Department of Developmental Disabilities will not be served in the Consolidated Waiver.

The majority of individuals who received LTSS services through Ohio's NF-based HCBS waiver programs are Medicare-Medicaid Enrollees. As the ICDS program is rolled out throughout the entire state of Ohio, it is expected that the ICDS program will be the primary program model for providing all Long-Term Services and Supports in Ohio—both institutional services and HCBS services. Persons who otherwise qualify for LTSS, but who are not Medicare-Medicaid Enrollees, will receive their LTSS services under the Consolidated HCBS Waiver Program.

Ohio is also contemplating how other LTSS structural reforms can be built into the Consolidated HCBS Waiver, namely a Single Entry Point system, a uniform assessment tool, conflict free case management, and Person-Centered Service Plan.

Ohio Medicaid and the Department on Aging are currently working on a detailed transition plan for converting Ohio's five NF-based HCBS waivers into a single waiver and coordinating the Consolidated Waiver with the implementation of the ICDS Program.

#### Expanded Housing Opportunities through Money Follows the Person

Housing is an integral component of serving individuals in Ohio holistically. Because Medicaid cannot pay for housing directly, the agency (through its Money Follows the Person demonstration program, HOME Choice) develops strategic partnerships with many of the agencies responsible for the development of housing and the issuance of rent subsidies. These partnering agencies include the Ohio Housing Finance Agency, Ohio Department of Development, and many of the nearly 80 Public Housing Authorities throughout the state. As a result, Ohio Medicaid has secured over 200 vouchers specifically for Medicaid recipients with disabilities and advocated for new waiting lists with Public Housing Authorities that prioritize individuals with disabilities. The agency is also creating set-aside units at the development stage for HOME Choice participants, including those who may be dually-eligible for Medicare and Medicaid. In the next year, Ohio Medicaid and HOME Choice will explore the development of a system of referral and coordination that will allow for a permanent set-aside of 5-10 percent of all new affordable housing units for individuals with low-incomes and disabilities, including Medicare-Medicaid Enrollees. These housing units will be made available to ICDS health plans as alternative residential placements for persons who need housing assistance, but not the level of care required in a nursing home setting.

<sup>&</sup>lt;sup>8</sup> ODJFS. Concept Paper for the Centers for Medicare and Medicaid Services (CMS) Regarding Ohio's Unified Long-Term Services and Supports Medicaid Waiver, January 20, 2012.



### Office of Ohio Health Plans

# Ohio Medicaid Quality Strategy

### **Medicaid Aims**

- 1. Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- 2. Healthy People/Healthy Communities: Improve the health of the Ohio Medicaid population by supporting proven interventions to address behavioral, social and, environmental determinants of health.
- 3. Practice Best Evidence Medicine: Facilitate the implementation of best clinical practices to Medicaid providers through collaboration and improvement science approaches.

### Medicaid Priorities, Goals, & Initiatives

Make Care Safer	Improve Care Coordination	Promote Evidence-Based Prevention and Treatment Practices	Support Person and Family Centered Care	Ensure Effective and Efficient Administration
		Goals:		
Eliminate preventable health-care acquired conditions and errors.	Create a delivery system that is less fragmented, where communication is clear, and patients and providers have access to information in order to optimize care.	Prevent and reduce the harm caused by high cost, prevalent conditions. These Clinical Focus Areas* include: 1. High Risk Pregnancy / Premature Births 2. Behavioral Health 3. Cardiovascular Disease 4. Diabetes 5. Asthma 6. Upper Respiratory Infections		Sustain a quality focused, continuous learning organization.
	Current	Initiatives Supporting	Goals*:	
<ul> <li>Change hospital payment policy for never events &amp; hospital-acquired infections (P)</li> <li>Eliminate blood stream catheter infections in Neonatal Intensive Care Units (QIS)</li> <li>Human milk feeding to premature infants (QIS)</li> <li>Solutions for Patient Safety (SPS)         <ul> <li>Adverse Drug Events</li> <li>Surgical Site Infections</li> <li>Serious Safety Events (QIS)</li> </ul> </li> <li>Retrospective Drug Utilization Review (AF)</li> <li>Meaningful Use:         <ul> <li>Electronic Prescribing</li> <li>Drug Interaction</li> <li>Drug Allergies</li> <li>Computerized Provider Order Entry (I)</li> </ul> </li> </ul>	<ul> <li>Managed Care Plan Delivery System         <ul> <li>Access to services in a timely manner</li> <li>Availability of a robust provider network</li> <li>Care management</li> <li>24/7 Nurse Advice Line (AF)</li> <li>IMPROVE Collaborative (QIS)</li> <li>Behavioral Health Collaborative (COL)</li> </ul> </li> <li>Health Homes – Intense care management of chronically ill consumers using Patient-Centered Medical Homes as the foundation (COL)</li> <li>Integration of dual eligibles (UD)</li> <li>Accountable Care Organizations (UD)</li> <li>MC enrollment efficiency (P)</li> <li>Presumptive eligibility for pregnant women and newborns (P)</li> <li>Meaningful Use:         <ul> <li>Facilitating appropriate medical information communication (DSS)</li> </ul> </li> </ul>	<ul> <li>MCP Quality Accountability         System:         <ul> <li>Process &amp; outcome measures             for each of the six Clinical Focus</li></ul></li></ul>	<ul> <li>NCQA CAHPS Consumer Satisfaction Survey (CS)</li> <li>Review MCP Grievance/ Appeals/ Complaints / State Hearings (AF)</li> <li>MCP Consumer Quality of Life Surveys (CS)</li> <li>MCP Consumer Care Management Survey (CS)</li> <li>Ohio Family Health Survey (CS)</li> <li>Engage Patient in QI Process (CS)</li> <li>OPQC</li> <li>SPS</li> <li>IMPROVE</li> <li>Meaningful use: Patient empowerment/ access to medical information (DSS)</li> </ul>	<ul> <li>Quality Assessment and Performance Improvement (QAPI) Program:         <ul> <li>Performance Improvement Projects (QIS)</li> <li>Performance Measure reporting (NRM)</li> <li>Over/under utilization Assessment (AF)</li> <li>Special health care needs quality and appropriateness of care assessment (AF)</li> </ul> </li> <li>MCP Compliance Monitoring (AF)</li> <li>Member Services (AF)</li> <li>Provider Services (AF)</li> <li>Program Integrity (AF)</li> <li>MITS (AF)</li> <li>Meaningful Use:         <ul> <li>Consumer Decision Support</li> <li>Provider Decision Support</li> </ul> </li> </ul>

\* The Clinical Focus Areas and Current Initiatives were developed for the CFC & ABD consumers who are not on a waiver, in an institution, or dually eligible. A separate evaluation will be completed to determine the Clinical Focus Areas and Current Initiatives for these populations.

9/9/2011

DSS = Decision Support System

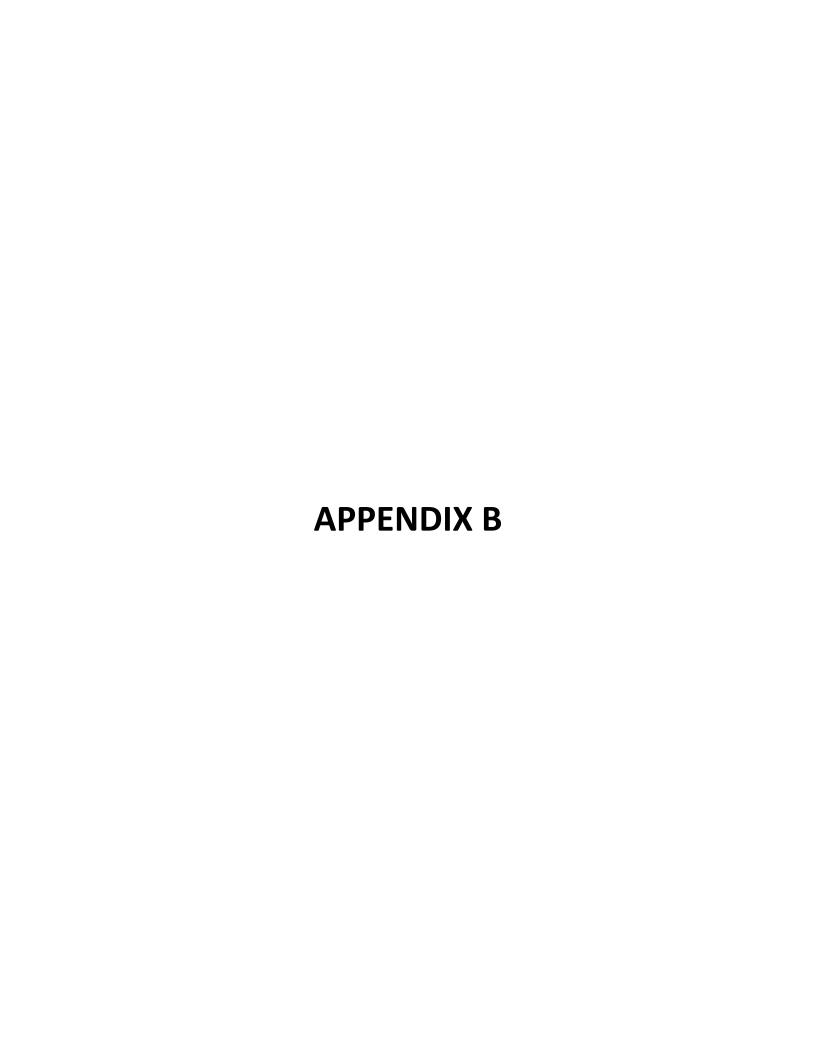
CS = Consumer Survey

AF = Administrative Function

UD = Under Development

QIS = Quality Improvement Science

COL = Collaborative



#### State of Ohio

### Advance Health Equity through State Implementation of Health Reform

### Application for Technical Assistance

#### **Ohio Core team**

#### Team Member (Medicaid)

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#### Team member (Public Health)

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#### Team member (Minority Health)

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#### 1. Role of Core Team Members in Ohio Health Reform Efforts

The depth and complexity of the ACA requires government, private sector and community-based organizations to collaborate in new and innovative ways to take full advantage of provisions outlined in the ACA. One important step in this process is to outline what state cabinet-level agencies are doing to provide leadership, coordination and support of this effort. Below are brief descriptions of what core team agencies/members are doing to implement ACA in Ohio.

#### Ohio Medicaid

Ohio Medicaid is actively taking steps to implement Section 2703 of the ACA which includes the state option to provide Health Homes. This particular initiative is based on the Patient-Centered Medical Home model and is connected to new funding/match opportunities from the Center for Medicaid Services. Key elements of this initiative include:

- Focusing on patients with multiple chronic and complex conditions. This includes Medicaid consumers with two or more of the following conditions: mental health, substance abuse, asthma, diabetes, heart disease and obesity (BMI>25).
- Coordination across medical, behavioral and long-term care.
- Building linkages to community, support and recovery services which also address social determinants of health.

Ohio Medicaid claims/encounter data reveal that there are over 325,000 Medicaid consumers who qualify for this initiative. Moreover, a disproportionate number of these individuals are from racial and ethnic minority groups and Ohio's Appalachia region.

#### Ohio Department of Health (ODH)

The Ohio Department of Health is the state's lead public health agency whose mission is to protect and improve the health of all Ohioans. ODH's core philosophy centers on promoting and demonstrating equity and social justice in our actions, as we engage communities in achieving optimal health for all Ohioans. ODH has a dedicated Office of Health Equity which is responsible for coordinating health equity policy initiatives throughout the agency and among state cabinet-level agencies. To this end, ODH has also applied for membership on the forthcoming Region V HHS Health Equity Council.

ODH has actively worked to address various provisions of the ACA which include Sections 10334 (Minority Health), 3101 (Data Collection, Analysis and Quality), Section 1946 (Addressing Health Care Disparities) and Section 4201 (Community Transformation Grants). Examples of state initiatives include:

- Establishment of a health equity office in 2008 to coordinate health equity efforts throughout the agency and cabinet-level organizations (ACA, Section 10034).
- Infusion of health disparity elimination strategies in <u>all</u> grants from ODH with a focus on social determinants.
- Inclusion of OBM race and ethnicity standards in all new data systems and health information exchanges.
- Statewide implementation of Ohio House Bill 198. This bill authorizes the implementation of a statewide Patient Centered Medical Home Education Pilot Project throughout Ohio which also addresses healthcare disparities (ACA, Sections 2703 and 1946).

#### Ohio Commission on Minority Health (OCMH)

Created in 1987, the OCMH is an autonomous state agency designed to address the disparity that exists between the health status of minority and non-minority populations. The OCMH is dedicated to eliminating racial and ethnic health disparities through innovative strategies, financial opportunities (grants), public health promotion, legislative action, public policy and systems change. The OCMH is responsible for addressing the following ACA Sections:

• Increasing the supply of a highly qualified healthcare workforce to improve access and health care delivery through certified community health workers (ACA, Section 1946- Addressing Health Care Disparities).

- Implementation of the Research and Evaluation Enhancement Program (REEP) to assess quality, grant
  integrity and efficacy of minority demonstration projects throughout Ohio (ACA Section 5307, Cultural
  Competency, Public Health, & Individuals with Disabilities Training).
- Funding to over 100 community-based organizations and health departments for innovative and culturally specific projects designed to address health inequities (Grants to Promote Positive Health Behaviors and Outcomes).

#### 2. State Agency & Stakeholder Involvement in Health Reform/Equity Initiatives

Ohio is very fortunate to have a strong coalition of stakeholders who actively participate in the planning and implementation of health reform activities. Examples of stakeholder involvement are described below:

- The Ohio Medicaid Health Homes Program is led by Ohio Medicaid at the Department of Job & Family Services. Since June 20, 2011 at least eight (8) stakeholder meetings were conducted to obtain input on the design of the program. Stakeholders include community-based organizations, Managed-Care Plans (MCP), health policy research firms, primary health care organizations and large hospital systems.
- In support of the Ohio Medicaid Health Homes, the Ohio Department of Health has implemented the Patient Centered Medical Home Initiative based on recent legislation (Ohio House Bill 198). This is different than the Ohio Medicaid Health Homes Program in that is more comprehensive, because HB 198 is not limited to the Medicaid population and engages multiple payer sources. In addition to enlisting the consultation of national experts, various stakeholders have been engaged including consumer groups, the Ohio Hospital Association, Commission on Minority Health, insurance companies and community-based organizations.
- The Ohio Commission on Minority Health (OCMH) participated in the National Partnership for Action (NPA) Local Conversation Initiative of the U.S. Department of Health and Human Services, Office of Minority Health. The OCMH conducted nineteen (19) local conversations which included stakeholders and partners from public and private sectors. As a result, regional plans/strategies were developed to shape policies designed to eliminate health disparities. These plans will be published and disseminated throughout the Ohio in December 2011.
- The OCMH received funding from the U.S. Department of Health & Human Services (HHS) to increase statewide awareness and implementation of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities. This initiative includes working with a variety of statewide organizations to determine their capacity and level of readiness to implement various aspects of the plan.
- The OCMH, in partnership with the Ohio Department of Health, submitted a joint application to the Centers for Disease Control and Prevention for the Community Transformation Grant. The focus of this proposal mobilizes and assists communities and coalitions to implement policy, environmental, programmatic and infrastructure changes to 83 primarily rural counties. The overall goal is to reduce risk factors for leading causes of death and disability and to prevent and control chronic diseases. Moreover, this application has a significant focus on social determinants of health and identifying segments of Ohio's population who experience chronic disease health disparities (ACA, Section 4201).

#### 3. Prioritize the Top Three Priority Areas for Technical Assistance

The three priorities for technical assistance include *Emphasize Coordination of Care, Promote Quality & Efficiency from the Health Care System,* and *Use Your Data* categories. Objectives and rationale for these choices include the following:

#### **Emphasize Coordination of Care**

Ohio's efforts to establish Health Homes have been outlined in Question #2. Process and impact health equity objectives associated with this priority include:

- Implementing Health Homes and Patient Centered Medical Homes in such a way which also addresses social determinants through integrated care services.
- Designing Health Homes which directly address key findings of the *2010 Healthcare Disparities Report* (Agency for Healthcare Research and Quality).
- Develop and implement learning opportunities for healthcare providers which include cultural and linguistic competency. This will empower health care providers to better serve diverse communities. Additionally, this will also help healthcare providers understand their role in eliminating healthcare disparities.
- Use data to identify the best locations to establish new Health Homes and/or Patient Centered Medical Homes, especially in areas that are considered "medical hotspots".
- Address healthcare workforce diversity to improve provide patient/provider relationships.

#### <u>Promote Quality & Efficiency from the Health Care System</u>

- Develop payment reform demonstrations to improve care for populations that are disproportionately impacted by chronic conditions.
- Investigate the feasibility of using Managed Care Plans or other entities as administrators for greater efficiency.
- Develop payment reform strategies which demonstrate significant cost savings based on the findings within the *Economic Burden of Health Inequalities in the United States* (The Joint Center for Political & Economic Studies).

#### Use Your Data

- Maximize meaningful use of Health Information Technology (HIT) to incorporate metrics identified in the 2010 Healthcare Disparities Report into routine patient care protocols of Health Homes. This will function to directly respond to eliminate healthcare disparities.
- Develop methodologies to maximize HIT to include, for instance, combining public health data, aggregated data from Electronic Medical Records and geospatial market research data. This will help formulate a multi-dimensional snapshot of healthcare issues in Ohio to develop health disparity elimination solutions that are proactive in nature.
- Review Electronic Medical Record systems and identify data elements that should be collected to measure the impact of Health Homes on healthcare disparities.
- Develop evaluation measures based on aggregated data from Electronic Medical Records to determine progress in eliminating healthcare disparities. This data would then be converted to dashboard indicators to share with various stakeholders.

#### 4. Describe the Type of Technical Assistance Most Helpful to You.

Health equity is a difficult concept to grasp and even more difficult to put into practice. The core team represents three governmental agencies with different orientations to address health issues. With this in mind, technical assistance is needed to strengthen our adoption of a syndemic orientation for the selected priority areas. Syndemic orientation is defined by the Centers for Disease Control and Prevention as a way to focus on connections among health-related problems, considering those connections when developing health policies, and aligning with other avenues of social change to ensure the conditions in which all people can be healthy. This is extremely important since the determinants of health which result in health disparities largely occur outside of the healthcare setting.

Development of a syndemic orientation must be coupled with technical assistance to implement and sustain structural solutions within the priority areas identified. This includes, for instance, designing Health Homes which address key quality care measures outlined in the 2011 Healthcare Disparities Report as routine practice (as opposed to an afterthought). The inability to develop structural solutions on how healthcare is rendered and/or evaluated will result in persistent health disparities for years to come.

Technical assistance is also needed to introduce new models of payment reform and demonstrate how these models improve health outcomes and reduce health disparities. It would be particularly useful to show how payment reform could help address and overcome findings outlined in the *Economic Burden of Health Inequalities in the United States* (Joint Center for Political & Economic Studies). It is obvious that what gets funded gets done. Successful models of payment reform will make it much easier to convince decision-makers on the proper allocation of resources for programs which function to eliminate health disparities.

Lastly, we want to fully operationalize the concept of "meaningful use of data". This includes the development of policies and procedures to collect appropriate data on race and ethnicity, access to healthcare, quality of healthcare and evidence of healthcare disparities. We must also improve the manner in which we turn data into information to make data-driven decisions. This includes using evaluation strategies to assess the extent that Ohio is making process to eliminate healthcare disparities in pursuit of health equity.



## Advancing Health Equity through Implementation of Health Reform State Health Equity Work Plan October 2011- May 2012

The purpose of the State Health Equity Workplan is to guide your state team's efforts to advance health equity throughout your participation in the NASHP Health Equity Learning Collaborative. During the 8-month technical assistance period, you will participate in peer-learning activities and expert conference calls that will help you progress on your health equity work.

With this is mind, and considering your state's priorities as they relate to advancing health equity, please use this work plan to indicate the health equity action steps your state will to take over the 8-month period of the Learning Collaborative. Your team is free to draw upon the proposed activities described in your RFA application, but please keep in mind that the Learning Collaborative's technical assistance activities will be focused on the following policy areas:

- 1) Building Provider and Health Systems Capacity: Cultural Competency Training to Improve Providers' and/or Policymakers' Capacity to Implement the ACA through a Health Equity Lens
- 2) Improving Eligibility and Enrollment Systems to Foster Participation of Racially and Ethnically Diverse Populations
- 3) Engaging Racial and Ethnic Minority Communities in Policy Development and Implementation
- 4) Cultural Competency in Establishing Health Homes to Improve Health Outcomes for Racial and Ethnic Minorities
- 5) Use Your Data: Measuring Health Equity
- 6) Medicaid Managed Care Contract Standards that Advance Health Equity

Please consider the above topics as your team develops your work plan for the 8-month TA period. We hope that you will include at least 3 of these policy initiatives in your work plan. Using the template below, please:

- Provide a timeline by which you plan to accomplish your team's policy priorities
- A brief description of the project activity/action step your state will take to advance health equity in your state
- Any milestones/deliverables that will be used to document your progress on the project activity/action step, and
- A designated member of your team responsible for the project activity and accompanying deliverable

State of Ohio NASHP Health Equity Workplan



### State of Ohio NASHP Workplan

Policy Initiative	Project Activity/Action Step	Timeline (Ex: Oct 2011- Jan 2012)	Milestone/Outcome	State Team Member Responsible
1) Medicaid Managed Care Contract Standards that Advance Health Equity	Review contracts with Equity/Disparity lens and subsequent regional culturally competent approach	New contracts for July 2012	OUTCOME: Development/implementation of effective, standard contract language/ deliverables which compel Medicaid Managed Care Organizations to explicitly address health care disparities with a focus on metrics and improving health outcomes	Jon Barley, Carol Ware, Dale Lehmann
1) Improving Eligibility and Enrollment Systems to Foster Participation of Racially and Ethnically Diverse Populations and mandate the reporting of quality indicators by race and ethnicity  Racial and ethnic minority consumer input into policy development.	Eligibility system replacement (CRIS-E): Upgrades/replacement to current information/technology systems to ensure we have accurate (and mandatory) data to proactively respond to health disparities and health care disparities.	Uncertain but in this next 18 months	OUTCOME: Enhanced ability to identify minority and impoverished populations who experience health disparities and health care disparities.  The interoperability of systems to facilitate the efficient sharing of information with sister service agencies. The ability to determine the impact (both positive and negative)—on disparities.	Jon Barley and Mary Applegate (with help from Patrick Beatty and Mel Borkan who specialize in this work at Ohio Medicaid) Angela Cornelius Dawson Chip Allen will enlist the help of Dr. Robert Campbell

	Develop a set of health	By July 2012	Metrics to identify progress on	Mary Applegate, Robyn
Agency Quality Strategy	disparity and health equity		addressing health care disparities.	Taylor
	metrics that can be tracked		RATIONALE: We may need other	
	in a visible way (e.g.,		ways to track this until the new	
	dashboard indicators) as		eligibility system is functional.	
	part of day-to-day		Several agencies are already	
	operations. This could		involved in the Family Health	
	include using the Agency for		Survey. If we cannot use claims	
	Healthcare Research &		data, TA could be helpful in how	
	Quality (AHRQ) 2010 Health		best to get at this information	
	Care Disparity Report as a		Each agency may need to target a	
	guide for metrics.		specific condition or population in	
			the short term to accomplish this	
			(E.g. Infant mortality or prematurity	
			by disparate population)	
Use Your Data: Measuring	Develop integrated metrics	July	Outcome: Capacity to determine	Core Team Members
Health Equity	which include Medicaid and		the impact of clinical services on	
	public health surveillance		health care disparities and the	
	data-sets to determine		effect of local social determinants of	
	future strategies to		health on health outcomes.	
	eliminate health disparities.			
			Outcome: Cross sector	
	Use of aggregated data		public/private partnerships to	
	extracted from electronic		develop integrated solutions which	
	medical records to identify		simultaneously address health care	
	geographic locations to		disparities and positively impact the	
	illustrate high		social, environmental and economic	
	concentrations of Medicaid		conditions.	
	recipients with disparate			
	health outcomes.			
Cultural	Make sure Health Homes	By July 2012	Outcomes:	Core Team
Competency in	(HH) and Patient Centered		Establishment of HH and PCMH in	
Establishing Health	Medical Homes (PCMH)		areas where there are persistant	
Homes to Improve	efforts are appropriately		health care and health disparities	

Health Outcomes	educated and provide		(Medical Hot Spots).	
for Racial and	services in a culturally			
Ethnic Minorities	sensitive manner		Patient Centered Medical Homes	
			and Health Homes that have the	
			capacity to serve diverse patient	
			populations:	
			Policies that ensure HH and PCMH	
			workforce routinely train in the area	
			of cultural and linguistic	
			competency.	
			Recruitment and retention of	
			minority physicians, certified	
			community health workers	
			Establish educational pipeline	
			policies to increase capacity to	
			reach diverse populations and to	
			improve patient/provider	
			relationships	
	Encourage the development		Routine /use of GIS Mapping tools	John McCarthy/Dr.
	of Health homes and PCMH		to help determine Hotspots and	Wymslo/Chip Allen/
	in high disparate population		incorporate social determinants of	Robyn Taylor
	neighborhoods		health data into decision-making for	
			the placement of Health Homes and	
			Patient Centered Medical Homes	
	Include/develop disparity		RATIONALE: TA related to disparity	Core Team
	elimination strategies &		measures that may be utilized	
	metrics as identified in the		throughout our program over a	
	IOM's Unequal Treatment		protracted period of time to	
	and AHRQ measures of		measure progress.	
	effectiveness in physical and			
	mental health homes			
	Identify health care service	By July 2012	Outcome: Increase diversity of the	Mina Chang & Angela

MEDTAPP Access Initiative	candidates (nurses, physicians and other health care workers) to represent and serve disparate populations and support their placement in high need areas		health care workforce as compared to predetermined baseline measurements.  RATIONALE: TA could be helpful with candidate identification, appropriate support to serve in a high need area.	Cornelius, Chip Allen & Robyn Taylor
Electronic Health Record Vendor Engagement	Systematically educate (and require) vendors to include data fields to race, ethnicity and income to capture disparities for regional improvement initiatives and evaluation that may inform policy  Examine vendor protocols for EMR and incorporate uniform data elements that would align the EMR to measure the impact of HH and PCMH on healthcare disparities	Ongoing	Outcome: Ability to extract aggregate summary measures on quality and health outcomes by race, ethnicity and income from EMRs on selected health disparity metrics.  RATIONALE: TA to gather national efforts and innovation around this topic would be helpful.	Mark Vidmar
Promote Quality and Efficiency from the Health Care System  Develop ACO Health Disparities Strike Teams (HDST)	Development of recruitment and payment reform strategies for Accountable Care Organizations that maintain high expectations for quality and ensure adequate representation of diverse patient Populations and health care		Outcome:  Development of HDST to work with ACOs who do not achieve target health disparity elimination outcomes.  Better quality and outcomes across the board without segregating	Core Team Members

systems.	patients to certain ACOs
	RATIONALE: ACO's which serve
	large minority populations or low
	income individuals will initially face
	challenges in containing costs and
	positively influencing better health
	outcomes because these
	populations they tend to be sicker
	and present more challenges. If
	outcomes and quality drive costs,
	ACOs may inadvertently segregate
	minority and/or low income
	patients into certain ACOs that do
	not have the capacity to lower costs
	and improve quality because of the
	inavailability of resources. Caring for
	patient populations who experience
	disparities may initially impact an
	ACO's health care outcomes. TA is
	needed to understand how to avoid
	segregating minorities in ACOs
	which are low-performing and/or
	unwilling to make investments to
	address/overcome health care
	disparities.