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Ohio MOU Summary

On December 12, the Centers for Medicare and Medicaid Services (CMS) entered into a Memorandum of Understanding with the Ohio Office of Medical Assistance to create an 'Integrated Care Delivery System' for dual eligibles (people eligible for Medicare and Medicaid).[1] The MOU is part of the Medicare-Medicaid Coordination Office's Financial Alignment demonstration. Ohio becomes the third state to execute a MOU under the demonstration and the second state to employ a risk-based capitated model.[2]

The MOU introduces three elements to the MOU that were absent in previous agreements: the requirement for an ombudsman program, a minimum medical loss ratio, and long-term services and supports quality measures. Under the MOU, beginning in September 2013, Ohio will enroll up to 115,000 dual eligibles into Integrated Care Delivery System (ICDS) plans, or managed care plans,[3] who will be responsible for delivering all covered Medicare and Medicaid services to plan enrollees.

This issue brief provides a brief summary of the Ohio MOU with an emphasis on elements related to beneficiary protections. As this is just the second MOU approving a capitated program, the Ohio agreement offers some insight into how state demonstration plans will vary, and the overall direction of the Financial Alignment demonstration.

[1] Memorandum of Understanding between CMS and the State of Ohio (Ohio MOU), available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/ownloads/OHMOU.pdf.

[2] The other two states with approved MOUs are Massachusetts (risk-based capitated model) and Washington (managed fee for service model). See www.dualsdemoadvocacy.org/state-profiles for summaries of these two MOUs.

[3] In August, Ohio selected the eight plans that will serve the ICDS market. *See* Ohio Integrated Care Delivery System Update (August 27, 2012), available at www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=CEnFHbwxoYg%3d&tabid=105.

Enrollment

Dual eligible individuals will be able to voluntarily enroll in an ICDS plan beginning in early June 2013 with coverage starting September 1.[4] After this initial voluntary enrollment period, Ohio will begin passively enrolling dual eligibles into plans.

Under the passive enrollment mechanism, beneficiaries will be automatically assigned to plans by the State unless they affirmatively opt out of the demonstration. The schedule for passive enrollment will vary by region with the first region, the Northeast, beginning on October 1, 2013. Notice will be sent to beneficiaries about the passive enrollment 60 days in advance. The notice will include information about opting out of the demonstration.[5]

Beneficiaries may opt out prior to the passive enrollment and may change ICDS plans or opt out of the demonstration at anytime. When a beneficiary requests to opt out of the demonstration, the State will send a letter confirming the opt-out and provide information on the benefits available to the beneficiary after opting out.[6] Opt-outs and plan changes will be effective on the first day of the month following the request. CMS and the State will develop uniform enrollment and disenrollment forms

It is important to note that the enrollment process described in the MOU is different than the one Ohio included in the demonstration proposal submitted in the Spring of 2012. Ohio had requested authority to prohibit dual eligibles from opting out of the demonstration for the first three months of enrollment. This request was denied.

Demonstration authority

In addition to Ohio's proposal to integrate Medicare and Medicaid services for dual eligibles via the demonstration, the state also proposed to require all dual eligibles to enroll in Medicaid managed care, regardless of their participation in the demonstration. The MOU does not grant authority for Ohio to require all dual eligibles to enroll in Medicaid managed care. Instead, it makes clear that Ohio must apply for a 1915(b) and 1915(c) Medicaid waiver from the Center

[4] Ohio MOU at 50: ICDS plans will be required to accept opt-in enrollments no earlier than 90-days prior to the initial effective date of September 1, 2013, and begin providing coverage for enrolled individuals on September 1, 2013.
[5] Ohio MOU at 50: "The State will provide notice of the requirement to select an ICDS plan at least 60 days prior to the effective date of a passive enrollment period, and will accept opt-out requests prior to the effective date of enrollment. This notice will explain the beneficiary's options, including the option to opt-out of the Demonstration."
[6] Ohio MOU at 50.

for Medicaid at CMS to make this change to its Medicaid program. As of the date the MOU was executed, Ohio had not applied for the required waiver.

Ombudsman

This is the first MOU to include a specific provision related to an ombuds program. Under the MOU, the existing LTC Ombudsman program in Ohio will also serve as the ombudsman program for demonstration enrollees, providing individual advocacy and independent, systemic oversight for the demonstration.[7] The MOU indicates that this will mean an expansion for the program from focusing activity and resources on long term care facilities to a greater emphasis on home and community-based care. It is unclear, however, whether CMS or the State will provide additional resources to the LTC Ombudsman to expand its focus, expertise and capacity to play the role of ombuds program for the demonstration. The MOU does make clear that CMS will provide training on the demonstration to the LTC Ombudsman program, and CMS and the State will provide ongoing technical assistance.

Americans with Disabilities Act and Civil Rights Act of 1964

The Ohio MOU makes several references to ADA and *Olmstead* compliance. The MOU requires that all plans and providers demonstrate a commitment and ability to accommodate an individual's physical access and flexible scheduling needs, and commit to communicating with individuals in a manner that accommodates their individual needs. The state and CMS agree that ongoing surveys, readiness and implementation reviews will address *Olmstead* compliance.[8] ICDS plan training will include ADA and *Olmstead* requirements.[9] The plans are also required to provide all medically necessary services in compliance with the ADA, as specified by the *Olmstead* decision.[10]

Stakeholder Engagement

The Ohio MOU establishes a process for continued stakeholder engagement during the implementation of the ICDS, which includes continuing the process of public meetings, as well

[7] Ohio MOU at 8-9. The MOU says the Ombudsman will "focus on compliance with principles of community integration, independent living, and person-centered care" in the HCBS context. The ombudsman will also gather and report data to CMS and the State through the contract management team.
[8] Ohio MOU at 9.
[9] Ohio MOU at 55.
[10] Ohio MOU at 58.

as monitoring individual and provider experiences through surveys, focus groups, website updates and data analysis.[11]

In addition to the State's work with stakeholders, each ICDS plan will be required to establish a beneficiary advisory committee and a process for the committee to provide input to the plan governing board. The establishment of a beneficiary advisory committee or inclusion of beneficiaries on a plan's governance board is also one of the quality withhold measures.[12]

Baseline spending and plan payments

In May 2012, CMS issued guidance to states on the rate setting process for plan payments under the demonstration.[13] The Ohio MOU follows this process with Medicare and Medicaid each contributing to a total capitation payment. The contributions each program makes will be determined by following a series of steps.

First, baseline spending contributions will be set for Medicare and Medicaid. CMS will determine the Medicare baseline spending amount based on what Medicare would have spent on Part A and B services for beneficiaries in the absence of the demonstration.[14] Ohio will set the Medicaid baseline for state spending in the 1915(b) waiver program.[15] Payment rules for Part D services will be made under existing Part D rules.

After establishing the baseline costs, the rate estimate will be reduced by a predetermined savings amount, guaranteeing state and federal savings. For the first year, both the Medicare and Medicaid baseline rates will be reduced by 1%, the predetermined savings percentage. For the second and third year, that amount is 2% and 4%, respectively. The savings percentages will not be applied to the Part D component of the rate.[16]

In addition, Medicare and Medicaid rates will be risk adjusted to account for the acuity levels of the enrolled population. The Medicare rate will be risk adjusted using the current Medicare Advantage risk adjustment model. The Medicaid rate will be adjusted through the use of rating

[11] Ohio MOU at 90.
[12] Ohio MOU at 41.
[13] CMS Memo, "Joint Rate-Setting Process Under the Capitated Financial Alignment Initiative," available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf.
[14] Ohio MOU at 37. This rate will be based on a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year. It will be weighted by the proportion of the target population that will be transitioning from each program into the Demonstration.
[15] Ohio MOU at 37.
[16] Ohio MOU at 39.

categories. The ICDS plans will receive a different Medicaid rate depending on which category each beneficiary falls into. The two categories are: community well and nursing facility level of care (NFLOC).[17] The community well rate will be for individuals who do not meet a nursing facility level of care, with some additional variance based on age and region.[18] The NFLOC rate will be for individuals meeting a NFLOC as determined initially through waiver enrollment or 100 or more consecutive days in a nursing home.[19] When an individual is found to no longer meet a NFLOC, either nursing facility or HCBS, the plan will continue to receive the higher NFLOC rate for three months.

Finally, a quality withhold will be applied. Both Medicare and Medicaid will withhold a portion of the payment rate until the plan has satisfied certain quality requirements. The quality measures include acute measures, such as AHRQ, NCQA, and HEDIS measures, as well as state specific measures, like a Nursing Facility Diversion Measure[20] and a Long Term Care Overall Balance Measure.[21] For the first year, the withhold is 1%, and then 2% and 3% for the second and third year respectively.[22]

Minimum Medical Loss Ratio

In a feature that is, so far, unique to Ohio, beginning in calendar year 2014, each plan will be required to meet a Minimum Medical Loss Ratio (MMLR) requirement. The MMLR sets a minimum percentage of the plan's capitated payment that must be used for providing care (i.e. paying claims) and addressing quality. Under the MOU, if an ICDS plan has an MLR above 90%, meaning, a minimum of 90% of the gross joint Medicare and Medicaid payments are used to pay for beneficiary care, the plan is in compliance with the MMLR requirement. CMS and the State will not take any monetary action against the plan.[23] If the plan spends 85%-90% of its rate on services, the State and CMS may issue a corrective action plan or levy a fine. If the plan spends less than 85% of its rate on services, resulting in an MLR below 85%, the plan will be

[17] Ohio MOU at 36.
[18] Ohio MOU at 36.
[19] Ohio MOU at 36.
[20] Ohio MOU at 43. The Nursing Facility Diversion Measure requires the plan to report the number of enrollees who live outside the nursing facility during the current year, compared to the number of enrollees who lived outside of a nursing facility in the previous year.
[21] Ohio MOU at 44. The Long Term Care Overall Balance Measure requires the plan to report the number of enrollees who did not reside in a nursing facility, compared to the total number of enrollees in the plan.
[22] Ohio MOU at 40.
[23] Ohio MOU at 45.

required to return any of the funds it acquired above the 85% mark, multiplied by the total applicable contract revenue, back to Medicare and Medicaid.[24]

ICDS Care Plan

The MOU outlines at a high level the process that plans must use to assess and develop care plans for enrollees. For all enrollees, the plan must conduct an initial care assessment within 90 days of enrollment in the plan.[25] High-need beneficiaries will receive an in-person assessment, while low or medium risk beneficiaries will receive a telephonic assessment. The MOU does not specify how the plan will determine a beneficiary's level of risk prior to the initial assessment. Based on the initial assessment, for each enrollee, the plan will assemble a care management team, called a Trans-disciplinary Care Management Team (the team). The team will work with the beneficiary to create the person-centered care plan. The team will be led by an accountable care manager, and also include the beneficiary, the primary care provider, the waiver services coordinator, and, as appropriate, specialists, and the individual's family and caregiver supports.[26] If the beneficiary requires 1915(c) waiver services, the waiver services coordinator designated by the ICDS plan will also serve as the care manager.

Network Adequacy Standards

The MOU indicates that Ohio is still finalizing its network adequacy standards based on administrative data and stakeholder input. The MOU does include the minimum LTSS network standards that CMS and the State will require each plan to meet. The standards include:

- At least two community LTSS Providers in each region for the following services: Enhanced Community Living, Homemaker, Waiver, Transportation, Nutritional Consultation, Assisted Living, Social Work Counseling, Out of Home Respite, Home Medical Equipment and Supplemental Adaptive and Assistive Devices, Independent Living Assistance and Community Transition.
- At least two community LTSS agency providers in each region for Personal Care and Waiver Nursing.
- At least one adult day health and one assisted living provider within 30 miles of each zip code within the region.

[24] Ohio MOU at 45.
[25] Ohio MOU at 54.
[26] Ohio MOU at 54.

- At least five LTSS independent providers (in addition to self-directed care options) in each region for the following services: Personal Care, Home Care Attendant, and Waiver Nursing.
- At least one community LTSS provider in each ICDS region for the following services: pest control, home delivered meals, emergency response, home modification maintenance and repairs and chores services.[27]

Medically Necessary Determinations and Supplemental Services

Plans will use existing Medicare and Medicaid medical necessity definitions when making coverage determinations for enrollees in the demonstration. When there is an overlap between definitions for medical necessity, plans "will be required to abide by the more generous of the applicable Medicare and Ohio Medicaid standards."[28]

The MOU indicates that, in addition to services currently covered under the state plan, plans must provide several additional services. Planned ICDS waiver services that were not previously offered under the state plan include: adult day health, personal care, homemaker, emergency response system service, home delivered meals, home modification, maintenance and repair, out-of-home respite, home care attendant services, chore services, community transition service, enhanced community living, independent living assistance, nutritional consultation, home care attendant service, alternative meals service, pest control, assisted living service. Services that are currently offered under the state plan, but will be expanded under the waiver, include: transportation, nursing service, home medical equipment and supplemental adaptive device services, and social work counseling.[29]

Appeals

The MOU does not change the Medicare Part D appeals process but it does make significant changes to Medicare A and B and Medicaid appeals. Plan enrollees will be notified of all Medicare and Medicaid appeals rights in a single, integrated notice.[30]

If a beneficiary elects to appeal a Medicare service denial, the beneficiary must file the initial appeal with the ICDS plan. Medicaid service denials, terminations, and reductions may be

[27] MOU at 57. The draft standards include at least two community LTSS providers, at least one adult day health and one assisted living provider within 30 miles of each zip code, at least two community LTSS agency providers for Personal Care and Waiver Nursing, and at least five LTSS independent providers.
[28] MOU at 58.
[29] MOU at 59.
[30] Ohio MOU at 67.

initially filed with the ICDS plan and/or the Bureau of State Hearings (BSH).[31] The beneficiary has 90 days to file an appeal through either route. Plan Medicare appeal decisions that are unfavorable to the beneficiary will be auto-forwarded to the Independent Review Entity (IRE). Unfavorable ICDS plan decisions on Medicaid will not be auto-forwarded to the BSH, but the beneficiary may appeal to the BSH.

All ICDS plan level appeals must be resolved within 15 days for standard appeals, and 72 hours for requested expedited appeals. If a beneficiary files a timely appeal, the plan must continue to pay for services pending the appeal. Continuation of benefits pending appeal has always been a right under Medicaid law. The MOU maintains this right for internal plan appeals and state hearing requests and extends this protection to Medicare appeals, but only at the internal plan level of review.

In the event that both the BSH and the IRE issue a ruling, the ICDS plan will be bound by the ruling that is most favorable to the beneficiary.[32]

Quality Measures

Plans will be required to report measures that examine access and availability, care coordination, health and well-being, mental and behavioral health, patient/caregiver experience, screening and prevention and quality of life.[33]

CMS and the state will utilize the reported measures for implementation and ongoing monitoring, assessing plan performance, and plan comparison. While further details of the measures will be determined in the contracts between the plan, CMS and the state (the three way contract), the MOU details core measures the plans will be required to report. The MOU also includes some LTSS measures aimed at evaluating rebalancing and care management.[34] For example, under the Long-Term Care Rebalancing Measure, plans will be required to report the number of enrollees who were discharged to a community setting from a nursing facility and who did not return, as a proportion of the number of enrollees who resided in the nursing

[31] Ohio MOU at 68.
[32] Ohio MOU at 68.
[33] Ohio MOU at 76. The measures include HEDIS, HOS and CAHPS measures, consistent with Medicare reporting requirements, plus any additional Medicaid measures identified by the State.
[34] Ohio MOU 88-90. The state specific LTSS measures include: Documentation of Care Goals, Assessments, Individualized Care Plan, Real Time Hospital Admission Notifications, Risk Stratification based on LTSS or other Factors, Discharge follow up, Self-Direction, LTC overall balance measure, Nursing Facility Diversion Measure, LTC rebalancing measure, and a LTC transition measure.

facility in the previous year. Plans will also be required to report the percent of enrollees with a documented discussion of care goals.

What's next

Now that CMS and Ohio have approved the MOU, the next step is the three-way contracts between CMS, the state and the ICDS plans. The contracts will likely provide additional detail on State and CMS responsibilities, marketing and outreach requirements, payment rates, network capacity requirements, subcontracts, utilization management and service authorization, and grievances and appeals. In addition, each ICDS plan will undergo a joint CMS-State readiness review process that will ensure the plans are prepared to perform the requirements established under the MOU and the contracts.

Before enrollment begins in the Fall of 2013, the State must complete these contracts and readiness reviews, distribute notices to affected beneficiaries, train state staff, prepare enrollment brokers, conduct outreach to beneficiaries, providers and community based organizations, establish oversight and monitoring structures, develop the ombuds program, prepare the SHIPs and ADRCs that will assist with enrollment counseling and more.

A tremendous amount of work must be completed by CMS, the State, the plans and the community organizations in the next several months in order to ensure that beneficiaries maintain access to services, and the goal of seamless integration of the Medicare and Medicaid program is realized.

More information on the dual eligible demonstration, other state MOUs and proposals can be found at www.dualsdemoadvocacy.org.