

Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees

Demonstration Proposal

Ohio

Summary: In July 2011, CMS released a State Medicaid Directors' letter regarding two new models CMS will test for States to better align the financing of the Medicare and Medicaid programs, and integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid enrollees. These two models include:

- **Capitated Model:** A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- **Managed Fee-for-Service Model:** A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

To participate, States must demonstrate their ability to meet or exceed certain CMS established standards and conditions in either/both of these models. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for the selected financial model(s). The Ohio Department of Job and Family Services has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time, interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m., May 4, 2012. You may submit comments on this proposal to OH-MedicareMedicaidCoordination@cms.hhs.gov.

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



April 2, 2012

A. Executive Summary

Over 182,000 Ohioans are enrolled in both Medicare and Medicaid, but the two programs are designed and managed with almost no connection to one another. With no single point of accountability, long-term care services and supports, behavioral health services, and physical health services are poorly coordinated. The result is diminished quality of care for Medicare-Medicaid enrollees and unnecessarily high costs for taxpayers. Medicare-Medicaid full benefit enrollees make up only 9 percent of total Ohio Medicaid enrollment, but they account for more than 30 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 System (ICDS) Program will be implemented in selected regions across the state, beginning in January 2013.

Under Ohio's Demonstration Proposal, competitively selected ICDS health plans will manage a comprehensive benefit package for Medicare-Medicaid enrollees, 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;
- use a person-centered care coordination model that promotes an individual's ability to live independently through a process that includes the individual in the development of their care plan; and
- utilize a payment structure that blends Medicare and Medicaid funding and mitigates the conflicting incentives that exist between Medicare and Medicaid.

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. Ohio anticipates that the reduction in costs through this model will enable more Medicare-Medicaid Enrollees 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 will demonstrate that its model of integrated care and financing will:

- keep people living in the community;
- increase individuals' independence;
- improve the delivery of quality care;
- reduce health disparities across all populations;
- improve health and functional outcomes;

- reduce costs for individuals by reducing or avoiding preventable hospital stays, nursing facility admissions, emergency room utilization; and
- improve transitions across care settings.

The reduction in costs through this model allows Ohio to continue to expand its investment in home- and community-based services as evidenced by the exclusion of enrollment caps on home- and community-based waiver participation in this proposal.

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 individual 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 individuals.

Overview of the Ohio Integrated Care Delivery System Demonstration

<i>Target population</i>	<i>Individuals fully eligible to receive Medicare and Medicaid benefits</i>
<i>Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide (Average dual eligibles per month, SFY 2011)</i>	182,328
<i>Total Number of Full Benefit Medicare-Medicaid Enrollees Living in the Geographic Service Area and eligible for the Demonstration (Average dual eligibles per month, SFY 2011)</i>	114,972
<i>Geographic Service Area</i>	<i>Seven regions of 3-5 counties each</i>
<i>Summary of Covered Benefits</i>	<i>Medicare Parts A,B, and D, Medicaid State Plan including all Community-based Behavioral Health Services and Nursing Facility Services, Medicaid Waiver Services</i>
<i>Financing Model</i>	<i>The capitated financial alignment model offered in the 7/8/11 State Medicaid Director Letter</i>
<i>Summary of Stakeholder Engagement/Input</i>	<ul style="list-style-type: none"> • Vision for ICDS released Feb 2011; • ICDS proposal submitted to CMS Feb 2011; • Request for Information Sep 2011; • Five statewide consumer- caregiver forums. Jan 24, Jan 31, Feb 3, Feb 7, Feb 14 • A statewide consumer conference call Feb 17; • An on-line consumer survey Feb 2012; • Two public hearings for Medicare-Medicaid enrollees, providers, and other stakeholders Mar 13 and Mar 20
<i>Proposed Implementation Date</i>	<i>January 2013</i>

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 LTSS, which supports people maximizing their independence and living in the setting of their choice. 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 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 settings, rather than in more costly institutional settings.

Ohio's ICDS program is one critical component of a broader effort underway to improve Ohio's 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, streamline health and human services, and improve overall system performance. 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.¹ 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.² 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 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 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 providing meaningful alternatives to institutional placements and coordinating long-term services and supports.

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.³ However, because of barriers in the current delivery system, certain subsets of the ABD population were exempted, including:

- Individuals who are institutionalized;
- Individuals who become Medicaid eligible through spending down their income;

¹ Ohio Office of Health Transformation, **Medicaid Program Background** at <http://www.healthtransformation.ohio.gov>.

² Ohio Office of Health Transformation, **Ohio's Demonstration Model to Integrate Care for Dual Eligibles**, February 1, 2011, found at: <http://www.healthtransformation.ohio.gov>.

³ Ohio 5111.16 Care Management System

- 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.⁴

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 182,000 full-benefit Medicare-Medicaid Enrollees in Ohio to be provided Medicare and Medicaid benefits primarily through the existing fee-for-service system.

Managed care for the Medicare-only population also is not a new concept in Ohio. According to The Kaiser Family Foundation's StateHealthFacts.org website, Ohio has the sixth highest Medicare enrollment in the United States (1,909,462 Medicare enrollees in 2011) and ranks fifth in Medicare Advantage (MA) enrollment (640,245 MA enrollees). Ohio's MA enrollment is presented in Appendix A. 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 MA 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.

Over the last ten years, with significant investments in Medicaid home- and community-based services (HCBS) waiver programs, Ohio has made considerable progress towards rebalancing its LTSS system.⁵ Ohio's HCBS waiver for individuals with a nursing facility level of care over the age of 60, called PASSPORT, 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 LTSS System remains out of balance, tilted heavily towards institutional service settings. Ohio lags behind 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 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

⁴ 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.

⁵ 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.

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 enrolled in both Medicare and Medicaid who have other third party creditable health care coverage;
- Individuals under the age of 18, and;
- Individuals who are Medicare and Medicaid eligible and are on a delayed Medicaid spend down.

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.

Individuals with serious and persistent mental illness (SPMI) will be included in the ICDS program. Ohio Medicaid is currently working with CMS on a Medicaid state plan amendment to create Medicaid Health Homes for individuals with SPMI that will enhance the traditional patient-centered medical home to better coordinate physical and behavioral health services. Community behavioral health centers (CBHCs) will be eligible to apply to become Medicaid health homes for individuals with SPMI. The assumption in this proposal is that the SPMI Health Home initiative will be implemented in October 2012. At a later date, Ohio Medicaid will implement Medicaid Health Homes focusing on individuals with qualifying chronic physical health conditions. Ohio is proposing that ICDS plans will be required to partner and collaborate with approved Medicaid Health Homes.

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 Appendix B. Based on the eligibility criteria stated above and the regions that are being proposed, Ohio estimates that approximately 114,972 Medicare-Medicaid Enrollees will be eligible to participate in the ICDS Program. Appendix C 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 \$2.5 billion providing services to Medicare-Medicaid Enrollees in the ICDS target population. Of this total, \$1.6 billion (65%) was for Medicaid-covered nursing home stays, while approximately \$560 million (another 23%) was spent for PASSPORT and other home- and community-based services. The remaining \$307 million (12%) was spent on Medicare cost-sharing services and other Medicaid benefits not available through the Medicare program. Thus, in all, 88% 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.

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 except for the Northeast Region where three plans will be chosen. Medicare-Medicaid Enrollees will be able to choose to enroll in an ICDS plan in the region where they reside. In order to improve health outcomes and promote independent living the model:

- Emphasizes individual choice and control in the delivery of their care and services;
- Supports an individual's right to live independently, and;
- Recognizes an individual's right to dignity of risk.

(a) Geographic Service Areas

The ICDS program will be implemented in seven geographic regions of 3-5 counties each (see Appendix B). Each of the seven regions includes a metropolitan area, with most also serving a rural area. Six of the regions have at least four MA plans currently serving Medicare enrollees in the region, and the Northwest Region has at least three MA plans currently serving Medicare enrollees. The presence of established MA plans was influential in the choice of regions. All eligible Medicare-Medicaid Enrollees in the designated counties will be enrolled in the ICDS program in 2013.

(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 late summer of 2012 Medicare-Medicaid Enrollees in the targeted geographic regions will be notified of their selection for the ICDS program. Not less than 60 days prior to enrollment into the ICDS program, a 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. If the individual does not choose an ICDS plan, the individual will be auto-enrolled into one of the plans.

Once enrolled in one of the two ICDS plans, individuals will be offered the option of switching plans during the first 90 days of enrollment with an annual open enrollment period, consistent with the current Medicaid Managed Care enrollment process. While there is no "lock in" for the Medicare program, Medicaid services will be provided in all circumstances through the ICDS. Individuals may disenroll from ICDS plans for their Medicare-covered benefits after 90 days of enrollment in the ICDS. Individuals may re-enroll in the Medicare component of the ICDS at any time upon request.

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 fee-for-service Medicaid option in the ICDS program.

(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 nation's 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.

Selected ICDS plans will be required to demonstrate adequate provider capacity to meet the CMS Panel Adequacy requirements for the region(s) for which they have applied. Plans will be required to maintain a network adequate to provide for those Medicaid benefits that exceed Medicare, such as dental and vision services providers. Plans will also be required to include providers whose physical locations and diagnostic equipment will accommodate individuals with disabilities.

Also as part of Medicaid waiver programs, Medicaid currently enrolls both agencies and independent providers, who do not work for an agency, to provide in-home waiver services. Because these providers are not certified by traditional processes, Medicaid reviews applications against a set of Ohio-specific requirements. ICDS plans will be required to develop contractual relationships with home- and community-service providers certified by the Ohio Department of Health and/or the Department of Aging as well as those which Medicaid has approved for the provision of home- and community-based services. ICDS plans must accommodate individual preference when developing provider networks.

(d) LTSS Consumer Enrollment and Transition

The state recognizes that consumer enrollment and transition into the ICDS will differ between those individuals who are dually eligible for Medicaid and Medicare who present a need for LTSS, and those who do not require such interventions. The ICDS model represents a significant shift in the LTSS delivery system and Medicaid is sensitive to the magnitude of the proposed changes for individuals. Ohio is committed to implementing this program in a manner that allows for the safe transition of individuals, emphasizing continuity of care, and minimizing service disruption.

Individuals enrolling in the ICDS will first enroll and receive Medicaid state plan services through the traditional Medicaid fee-for-service program. HCBS waiver services will be obtained through an approved HCBS waiver serving consumers with a nursing facility Level of Care (LOC). As a result, individuals will follow the State's existing processes for enrollment in Medicaid and HCBS services. After Medicaid enrollment, these individuals will transition into the ICDS and begin receiving both care management and LTSS through the ICDS.

Prior to the individual's enrollment in the ICDS program, the following will be performed by the PASSPORT Administration Agencies (PAA) or a state contracted case management agency depending on the waiver in which the individual is applying for enrollment:

- Information, Assistance, & Referral;
- Screening;
- Pre-Admission and Resident Review (PAA's only);
- Long-Term Care Consultation (PAA's only);
- Initial Assessment for HCBS waiver services;
- LOC Determination;
- State Funded Waiver Program Administration (PASSPORT and Assisted Living only), and;
- Service Plan Development for new waiver enrollees.

During the initial fee-for-service enrollment period, if the individual is enrolled on a HCBS waiver, the case management entity under contract with the state will develop a service plan. Individuals will continue to receive services through fee-for-service until they are enrolled in the ICDS.

After enrollment in the ICDS, the ICDS plan will be responsible for performing future assessments of consumer need and modifying care plans according to assessed needs. Once enrolled, the ICDS plan will authorize, monitor and purchase LTSS according to the service plan in a manner consistent with Ohio's quality strategy and federal waiver assurances. Plans will provide LTSS coordination using mechanisms that maximize individual choice and control. ICDS plans will be required to offer continuation of LTSS coordination. Pre-admission and resident review activities and LOC determinations will be performed outside of the ICDS.

To effectively implement the ICDS and transition individuals, at the time of enrollment in the ICDS (beginning the month in which the ICDS plan assumes responsibility for care coordination of the beneficiary) the ICDS plans will be required to adhere to specific transition requirements outlined in the table in Appendix D.

ii. Description of Proposed Benefit Design

Ohio will implement a fully-integrated model delivering all Medicaid-covered services and Medicare-covered 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 including Medicare cost-sharing and,
- All Medicaid community-based behavioral health services (see Appendix E), and;
- All Medicaid home- and community-based services that are currently provided in one of the five nursing facility level of care HCBS waivers (see Appendix E).

The ICDS program will not cover habilitation services.

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. The purpose of the ICDS system is to create a "seamless" health care 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 medical system and the LTSS system would be greatly simplified through his or her affiliation with a single ICDS plan and care manager 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. Additionally, providers will send a claim to the ICDS plan for services rendered without the requirement of a secondary claim as is currently required for services covered by both Medicare and Medicaid.

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 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. 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 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 ICDS plans will utilize care management models that are culturally sensitive to the Medicare-Medicaid enrollees they serve. During the plan selection process, culturally sensitive care management models that build provider networks to reflect the cultural characteristics of the ICDS plan's membership, will be considered. The state will also be looking for models that recruit providers capable of communicating with individuals in their primary language.

ICDS plans will be expected to provide care management services to monitor and coordinate the care for individuals. Individuals will have varying needs and require differing levels of interventions, interactions, engagement, and services. The care management model must incorporate individuals residing in all care settings, such as nursing facilities, hospitals, assisted living facilities, and at home. ICDS plans will be expected to implement a care management model for Ohio's Medicare-Medicaid enrollees that includes the following components:

- Use of mechanisms to identify and prioritize the timeframe by which individuals will receive a comprehensive assessment;
- Completion of a comprehensive assessment of an enrollee's medical, condition-specific, behavioral health, LTSS, environmental and social needs with input from the enrollee, family members, caregiver, and providers;
- Assignment of the enrollee to an appropriate risk/acuity level based on the results of the identification and assessment processes;
- Development of an integrated, person-centered care plan by the individual, family members, caregiver(s) and provider(s) that addresses needs identified in the comprehensive assessment with corresponding goals, interventions, and expected outcomes;
- Ongoing monitoring of the care plan to determine adherence to evidence-based practice, barriers to care, transitions across settings, service utilization, and quality of services in order to achieve progress toward person-centered goals and outcomes;
- Formulation of a trans-disciplinary care management team designed to effectively manage the individual's services. The team shall consist of the individual, the primary care provider, the care manager, and other providers as appropriate;
- Use of innovative communication methods;
- A comprehensive approach to managing care transitions, including admissions and discharges from hospitals, nursing facilities, and other settings to ensure communication among providers,

primary care follow up, medication reconciliation, timely provision of formal and informal in-home supports, etc.

- Ongoing-medication reconciliation and employment of advanced pharmacy management programs, including medication therapy management, to increase adherence and eliminate contra-indicated drug use, and;
- Use of a care management system that captures the assessment and care plan content and is linked to other databases or systems that are used to maintain information about the individual.

Medicaid will assign care management staffing ratios using a risk stratification methodology. The expectation is the care management model will improve health outcomes as well as reduce unnecessary utilization of healthcare services. Ohio will implement a care management survey to assess quality and individual satisfaction with ICDS care management processes.

The coordination of home- and community-based services is extremely important to keeping an individual in the community. It has also been found that the relationship between the individual and their service coordinator has a large impact on outcomes. Ohio recognizes both the right for the individual to choose his or her service coordinator for home- and community-based services and the importance of the role entities in the state have already played in the coordination of these services. Thus, in order to maintain continuity of care and assist in transition, the ICDS plans will be required to subcontract with an outside entity to provide service coordination of what is known traditionally as 1915(c) home- and community-based waiver services. Furthermore, because of the role PASSPORT Administrative Agencies (PAA) have played in ensuring people are able to live in the community, the ICDS plan will be required to contract with the PAA in the region that is being served for service coordination of home- and community-based waiver services and may contract with other entities that provide this service (e.g. Centers for Independent Living).

Individuals will be given the right to choose both the entity that will provide service coordination for traditional 1915(c) home- and community-based waiver services, and who their service coordinator is. For individuals age sixty and older that do not choose a service coordinator, they will be assigned a service coordinator from the PAA that serves the region where the individual resides.

iii. Description of Supplemental Benefits and Ancillary Services.

Other features of the ICDS that will be required include:

- Expert wheelchair fitting, purchase, maintenance and repair, including professional evaluation, home assessment, skilled wheelchair technicians, pick-up and delivery, timely repairs (in the home or repair shop), training, demonstration, and loaner chairs.
- Specialists in pressure ulcer prevention and intervention, who assess all ICDS enrollees to identify those at risk and coordinate care.
- Promotion of social/education/artistic activities to combat isolation.
- A requirement to conduct 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 individuals, such that if a person calls at any time of day, a trained health care professional with access to the individual'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.
- 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 staff and resources to develop interventions for individuals with cognitive impairments and behavioral issues, including the ability to rapidly respond to acute episodes for individuals 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 individuals 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 individual, whose care is coordinated by the ICDS, that is accessible to each individual and all health care practitioners involved in managing the individual's care, so that all encounters with the individual by any practitioner can be shared across the ICDS.

While Ohio intends to provide specifications for the framework of the care management model for ICDS members in its Request for Applications and/or contracts, the state also recognizes that the organizations bidding for ICDS health plan contracts will 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 will evolve and improve over time as the ICDS program gains real world experience.

iv. Discussion of employment of evidence-based practices

Quality improvement efforts in Ohio are designed to close the gap between the latest research and practice. Evidence-based practices are the cornerstone of Ohio's Medicaid Quality Strategy (Quality

Strategy) which governs the Ohio Medicaid program. ICDS plans will be expected to fully participate in the state's efforts, and meet the associated requirements and expected outcomes established in the Quality Strategy, to improve the health and quality of care for Ohio's Medicaid population.

Ohio's Medicaid Quality Strategy is based on the U.S. Department of Health and Human Services' *National Strategy for Quality Improvement in Health Care* and is implemented across delivery systems in all of Ohio's Medicaid programs. The Quality Strategy (attached as Appendix F) serves as a framework to communicate Ohio's approach for ensuring that timely access to high quality health care is provided in a cost-effective, coordinated manner across the continuum of care for Medicaid individuals. The Quality Strategy is based on continuous quality improvement with evidence-based guidelines, transparency, accountability, informed choices, value and consistency/continuity. Ohio's efforts to improve the quality are consistent with the National Strategy's broad aims to: 1) improve the overall quality of care by making health care more person-centered, reliable, accessible and safe; 2) improve the health of the Ohio Medicaid population by supporting proven interventions to address behavioral, social, and environmental determinants of health; and 3) facilitate the implementation of best clinical practices to Medicaid providers through collaboration and improvement science approaches.

Priorities have been established to advance these broad aims and are based on the latest research to rapidly improve health outcomes and increase effectiveness of care. Goals have been selected in each of the priority areas and will focus Ohio's efforts in the next three years. Ohio Medicaid's key priorities and examples of supporting initiatives are described below:

Priority: Make care safer by eliminating preventable health-care acquired conditions and errors.

- The Ohio Hospital Association (OHA) in partnership with the Ohio Patient Safety Institute was awarded a two year contract in December 2011 by the U.S. Department of Health and Human Services to implement change packages related to improving patient care in eleven (11) clinical areas including pressure ulcers, surgical site infections, ventilator associated pneumonia, and catheter associated urinary tract infections. The OHA contract will bring together hospitals and providers in the state to participate in collaboratives and learning networks.
- Multiple state departments have come together to lead a consortium of public and private entities to address the escalating deaths and harms related to prescription pain medications. Numerous strategies have been employed to drive the appropriate utilization of these medications based on the analysis of state data and the evidence in medical and behavioral health literature. The development of Emergency Department Prescribing Guidelines, the formation of a Solace support group, the implementation of a lock-in program and a public awareness campaign are all outcomes of this effort. State subject matter experts are currently gathering to establish and clarify promising practices related to the prescribing of controlled substances including the role of Suboxone. Ongoing monitoring and feedback of the utilization of high risk medications are part of the continuous improvement cycle.

Priority: Improving care coordination 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.

- Ohio has developed a collaborative of Patient Centered Medical Homes (PCMHs) that meet regularly to accelerate adoption and disseminate innovation at the practice level. Existing and emerging PCMHs will be used as the foundation for the Medicaid Health Home initiative which is designed to better coordinate medical and behavioral health care consistent with the needs of the individuals with severe and/or multiple chronic illnesses. A Health Home will offer an intense form of care management across settings and the continuum of care which includes a comprehensive set of services and meaningful use of health information technology. Nationally recognized measures will be used to evaluate the Medicaid Health Home initiative including reductions in unnecessary hospital readmissions and inappropriate emergency department visits, improvements in chronic disease management and patient satisfaction, and increased access to preventive services.
- Ohio Medicaid initiated a quality improvement effort called IMPROVE (Implement Medicaid Programs for the Reduction of Avoidable Visits to the Emergency Department) that demonstrated promising results in the reduction of unnecessary emergency department visits in five major cities in Ohio. Community collaboratives consisting of a broad array of stakeholders were formed in each area that tackled local needs with person centered interventions. Ohio Medicaid is planning on building on this success by using the network to help develop other innovative models of care.

Priority: Promoting evidence-based prevention and treatment practices by preventing and reducing harm associated with high cost, prevalent conditions which include high risk pregnancy/premature births, behavioral health, cardiovascular disease, diabetes, asthma, upper respiratory infections and musculoskeletal health.

- Ohio Medicaid uses national performance measurement sets, like the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS), in order to assess health plan performance on important dimensions of care and service. Performance results are compared to national benchmarks and standards in order to hold health plans accountable for improving the quality of care. Ohio Medicaid uses a system of incentives and sanctions to ensure program compliance and continuous quality improvement.
- For the ICDS program, Ohio will select national measures, as appropriate and available, and consumer satisfaction surveys in order to monitor and evaluate the improvements in outcomes (e.g., health, satisfaction and functional status) experienced by Medicare-Medicaid individuals. As necessary, Ohio plans to develop several measures that reflect rebalancing, diversion, and long term services and supports. For a complete list of proposed quality measures for the ICDS program, please refer to Appendix G. In addition, Ohio will develop meaningful long-term care measures, including the ratio of individuals receiving services in long-term care facilities versus home- and community-based settings. All measures will be publicly reported.

Priority: Supporting person- and family-centered care by integrating patient/family feedback on preferences, desired outcomes, and experiences into all care settings and delivery.

- Meaningful engagement of individuals in the delivery of their health care—from selecting providers to choosing the best treatment option—has the amazing potential to transform

health care systems. Ohio Medicaid sponsors several surveys, like the CAHPS consumer satisfaction survey, quality of life survey, and the Ohio Family Health Survey, that are intended to collect information about individual's experiences with and perceptions of care. Survey results are provided to health plans and providers in order to modify and change care processes.

Priority: Ensuring effective and efficient administration by sustaining a quality-focused, continuous learning organization.

- Ohio Medicaid requires that contracting health plans obtain an acceptable level of accreditation from the National Committee for Quality Assurance. NCQA's accreditation is the industry "gold standard" for ensuring that health plan's structure, processes, and outcomes yield improvements in quality health care and consumer experiences. ICDS plans will be expected to achieve accreditation for the Medicare product line.
- Medicaid health plans are required to adhere to the Quality Assessment and Performance Improvement (QAPI) Program federal regulations (42 CFR 438) which are designed to help the plan establish an approach for assessing and improving quality. In its most basic form, the QAPI includes performance improvement projects, performance measure reporting, assessment of utilization of services, and an assessment of the quality and appropriateness of care furnished to individuals with special health care needs. The plan is expected to implement corrective actions or quality improvement initiatives when negative trends in health care are detected. ICDS plans will be expected to adhere to the QAPI regulations contained in 42 CFR 438.

As stated previously, the ICDS plans and their providers must apply national evidence-based clinical practice guidelines relevant to populations with chronic conditions, and relating to the detection and ongoing management of cardiovascular disease, diabetes, depression, obstructive lung disease and substance use. However, many individuals with complex needs may require flexibility in treatment approaches. In developing person-centered care plans, evidence-based practice will be appropriately balanced by an approach to care that considers an individual's needs.

v. How the proposed care model fits with:

(a) Current Medicaid waivers and state plan services

Ohio's current array of Medicaid State Plan and Waiver Services will be maintained in the ICDS and will be enhanced by the care coordination opportunities provided by this model.

(b) Existing managed long-term care programs.

As stated previously, Ohio has mandatory Medicaid managed care for health services for covered families and children (CFC) and aged, blind and disabled (ABD) populations excluding 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 currently contract with specialty behavioral health plans.

(d) Integrated Program via MA Special Needs Plans (SNPs) or PACE programs

Individuals will be required to choose one of the 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.

Individuals enrolled in the PACE 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 <http://www.catalyzepaymentreform.org/Principles.html>.

(f) Other Strategic Partnerships

Some organizations have more experience in providing acute care services to this target population, including hospital care, post-acute care, specialty services, physician services, and behavioral health services. Other organizations have more experience in providing LTSS 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.

D. Stakeholder Engagement and Individual Protections

i. Description of stakeholder engagement in planning.

Beginning in January 2011, Ohio formally sought internal and external stakeholder input into the design of an ICDS program. 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 individual 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.

Appendix H 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.⁶ The first formal step in stakeholder engagement was the release of a Request for Information (RFI) in September of 2011. Ohio 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. Ohio 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 September 2011, December 2011, and 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 2011, 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 hearings were held in March 2012, including a presentation of the demonstration proposal to the Unified Long-Term Care System Advisory Workgroup.

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

⁶Ohio Office of Health Transformation, **Ohio's Demonstration Model to Integrate Care for Dual Eligibles**, February 21, 2011.

settings, and gaps in services. The questionnaire also solicited comments on how services could be improved. The Ohio Olmstead Task Force and Ohio Association of Area Agencies on Aging helped the state disseminate the questionnaire to interested Ohioans. The questionnaire was posted online on the Governor's Office of Health Transformation website in early February, with options to 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 questionnaire responses were submitted, with Medicare-Medicaid Enrollees comprising roughly a quarter of the respondents. The Ohio Olmstead Task Force contributed specific recommendations regarding the ICDS design and continues to participate in ongoing design and discussions.

(a) Themes from Stakeholder Engagement Activities

Stakeholder feedback fell mainly into five major categories: delivery system structure; care management and other individual 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 MA Plans, 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 Individual 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 described a number of 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 waiver care management organizations, namely Area Agencies on Aging, have this responsibility.

Benefits and Groups Covered. Broad support was expressed for health management and prevention programs to encourage individuals 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 individuals 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, individuals, 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.

(b) 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 and will have access to the State's Health Home model targeted to this population when operational in the ICDS regions.

ii. Individual Protections

Ohio's approach to establishing a quality management infrastructure for the ICDS Program is to ensure that individuals 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 program will require strong quality management controls to offset any incentives for ICDS plans to reduce or limit access to medically necessary services or ability to live independently in the community. The individual protections provided in the ICDS program will be no less than the protections provided to members of MA plans, Medicaid-only plans, and individuals enrolled in 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. Individual protections that are built into the ICDS program model include the following:

Competitive Program Model. Individuals 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.

Individual Choice. Medicare-Medicaid individuals will be allowed to choose the ICDS plan which provides the higher quality service and which best meets their individualized needs. For Medicare, individuals will be allowed to receive their Medicare-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 or a MA plan. Further, if individuals are not satisfied with the quality of the services they are receiving in their current plan, they will be allowed to switch plans annually.

Provider Choice. Except as specified in Appendix D Medicare-Medicaid Enrollees will be required to receive services within the designated networks of each ICDS plan, individuals will be allowed to have freedom of choice of providers within the networks, including choice of LTSS providers such as personal care aides. Individual 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.

Cost Sharing Protections. ICDS plans must require that participating providers accept the payment from the ICDS as payment in full unless patient liability applies.

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. Ohio Medicaid 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.

Timely Approval of Prior Authorizations. Many of the individuals served by the ICDS plan will be receiving home- and community-based services. The ICDS plan will be required to have an expedited process to review changes in plans of care that must take into account the goal of having people live in the community as independently as possible. Thus, if an individual's needs change, a plan of care must be changed to meet those needs in an expeditious manner. Independent living may not be impeded by the ICDS plan's prior authorization timeframes. For example, an individual who uses a wheelchair for mobility in the community cannot wait three or more days on a prior authorization approval for a wheelchair repair.

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 ICDS plan members.

Meetings with ICDS Plan Members. Every ICDS plan will be required to convene meetings with their members at least semi-annually to fully document all grievances raised by individuals at the meetings, to keep comprehensive minutes of all member meetings that are made available to all individuals, and to provide written responses to all articulated grievances prior to the convening of the next member meeting. The ICDS will notify all members at least 15 days prior to each 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 Grievance and first-level Appeals process, by which individuals can appeal any decision made by the ICDS to reduce or deny access to covered benefits. An appeal filed within 15 days of a decision by the ICDS will require the continuation of benefits during the appeals process. Subsequent appeals will be filed according to procedures of the program having jurisdiction over the benefit.

Contact Information for Oversight Agencies. The ICDS health plan will provide each individual with contact information for regulatory agencies. In the case of individuals 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 individual 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 individuals. 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

Ongoing initiatives include:

Nursing and Aide Services rate reform. As a result of the passage of Ohio House Bill 153, Ohio's biennial budget bill for state fiscal year 2012/2013, Medicaid is engaged in a process of examining and revising the current rate structure for both state plan and waiver nursing and aide services. Stakeholder engagement is on-going as well as work with the state of Ohio's actuary. Changes to the rate setting methodology may take place as early as 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

Ohio Medicaid and Medicare will make prospective capitation payments to ICDS plans, which are responsible for providing all Medicare and Medicaid services and coordinating care. Capitation payments will include costs associated with the medical, behavioral health, and LTSS provided to individuals, as well as the non-medical expenses required to provide and coordinate those services. Any savings will be shared proportionately between the two programs. The capitation 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 ICDS Plans 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 with expected risk. Careful consideration will be given to ensure that the selected structure appropriately compensates ICDS Plans 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. While effective risk adjustment models for managed long-term care populations are in their infancy, 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.

Pay-for-performance. Ohio's philosophy that reimbursement should reward value will be incorporated into 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). 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 those providers whose performance led to improvements in quality measures. ICDS contracts with providers will establish this arrangement.

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.

iii. Payments to Providers

In order to maintain an adequate provider network and provide for continuity of care during the transition (as outlined in Appendix D), ICDS plans will be required to make arrangements to allow individuals to continue to receive services from their current or existing providers. This may be accomplished through a variety of mechanisms such as single case agreements, contracts, out-of-network authorization, etc.. Additionally, during the transition period, ICDS plans may not reduce reimbursement rates for services (unless agreed to by both the provider and the ICDS plan) for the following providers that are actively providing services to individuals enrolled in the ICDS program when the program goes live in the region: Medicaid 1915(c) waiver providers, state plan home health and private duty nursing providers, nursing facilities, primary care physicians, PASSPORT PAAs, and Department of Mental Health and Department of Alcohol and Drug Abuse Services certified behavioral health service providers. Additionally, the Medicaid program will have the authority to review all provider contracts and rates before they can be implemented.

Each ICDS will have a process to accept claims electronically and will provide electronic funds transfer for claims payment when requested. Prompt payment requirements will be developed and penalties will be assessed for any ICDS plan that does not comply with these standards. Providers must submit claims within 365 days of the date of service and ICDS plans will issue any overpayment findings within 365 days of the date of payment. However, shorter claims submission timeframes may be required for provider incentive programs. Claims submitted 90 days after the date of service do not have to be considered for provider incentive payments. ICDS Plans must locate provider relations and claims support staff in each region to educate and assist providers in claims submission processes and resolve issues with claims payment.

ICDS plans will be required to complete prior authorization requests in accordance with timeframes established by the state. If the ICDS plan does not meet the standards, the plan will first be assessed a monetary penalty. If the plan continues to not meet the standards, auto-enrollment into the plan will be halted. Additionally, plans will not be allowed to retroactively deny payments for services that were prior authorized, unless the individual's enrollment with the ICDS plan was retro-actively terminated by Ohio Medicaid or Medicare

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 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 to achieve these 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 nursing facilities and HCBS 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 long-term care services are provided. These consumer-based outcomes will be objectively measured as part of the state's overall Quality Strategy.

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 LTSS.

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."⁷ 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.

vi. Reporting Requirements

Monthly enrollment figures and other operational reporting (e.g., utilization data, incident reporting, nursing facility census) will be posted on Ohio's Medicaid website. For all data collected from ICDS plans, Ohio will present the information by plan and region.

The State will require each plan to submit comprehensive encounter data on all service utilization for enrolled individuals in a manner that enables the State to assess performance by plan, by region, and

⁷Centers for Medicare and Medicaid Services, **Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans**, January 25, 2012.

Statewide, and in a manner that permits aggregation of data to assess trends and to facilitate targeted and broad based quality improvement activities. The State will ensure that sufficient mechanisms and infrastructure is in place for the collection, reporting, and analysis of encounter data provided by the plans. The State will have a process in place to assure encounter data from each plan is timely, complete, and accurate, and take appropriate action to identify and correct deficiencies identified in the collection of encounter data. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion.

G. Infrastructure and Implementation

i. State capacity to implement and oversee the proposed demonstration

Overall responsibility for development of the ICDS program model and implementation plan rests with the Ohio Medicaid Director, who will Chair of the ICDS Management Team and serve as the main point of contact for the Medicare-Medicaid Coordination Office at CMS regarding CMS-Ohio collaboration in the ICDS program. The Governor's Office of Health Transformation (see Appendix I) will provide high-level policy input into the ICDS Program and serve as the primary communication channel to Governor Kasich, who named the ICDS program his Administration's number one health policy priority in 2012. Ohio Medicaid will establish an ICDS Management Team that includes staff from the program areas needed to design and implement the ICDS program:

- John McCarthy, Ohio Medicaid Director, is responsible for overall ICDS program development and implementation, and will serve as the chair of the ICDS Management Team and point of contact for the CMS Medicare-Medicaid Coordination Office;
- Patrick Beatty, Assistant Deputy Director for Medicaid Policy, has overarching responsibility for all of Ohio's Medicaid Managed Care Programs;
- Dr. Mary Applegate, Medical Director, is the lead on clinical policy and quality management;
- 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, Christi Pepe 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, individual enrollment and protections, IT systems modifications, rate development, quality management, and CMS collaborations (e.g. development of the Memorandum of Understanding).

In order to ensure oversight of the implementation and ongoing operations of the ICDS program, a Quality Oversight Committee (QOC) will be created that will meet monthly or more frequently if needed as decided by the Medicaid Director. The QOC membership will consist of:

1. Ohio Medicaid – The Medicaid Director, the Medical Director, and six staff members
2. Department of Aging – The Director (or designee) and three staff members
3. Department of Mental Health - The Director (or designee) and three staff members
4. Department of Alcohol and Drug Addiction Services - The Director (or designee) and three staff members
5. One enrollee from each plan in each region for a total of fifteen people
6. ICDS Plan – The Chief Executive Officer, the Chief Operation Officer, and the ICDS Program Director

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 and implementation of the model.

Ohio Medicaid has received Medicare data for Parts A, B and D for the Medicare-Medicaid enrollee population. 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 individuals.

ii. Implementation strategy and anticipated timeline

Appendix J presents a detailed implementation timeline for the ICDS program, including 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, Ohio is on track to begin enrollment of Medicare-Medicaid Enrollees beginning January 2013.

(a) Initial Enrollment of Medicare-Medicaid Enrollees into the ICDS Program

The initial enrollment of individuals into the ICDS Program is a significant undertaking, and must be conducted in a manner that results in minimal disruption of existing services and supports to ICDS members. Ohio Medicaid will establish an ICDS Enrollment Workgroup to develop 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 assure accurate information and enrollment processes for 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;
- 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-May 2012 and report directly to the Medicaid Director, 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 in January 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:

- 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. All informational and marketing procedures and materials will be jointly developed by Medicare and Medicaid during the summer of 2012.
- Letters will be mailed to all Medicare-Medicaid Enrollees no less than 60 days prior to the effective date of enrollment into the ICDS program, asking them to choose one of the 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 30 days prior to the effective date of enrollment will be mailed a reminder letter giving them 14 days to make a choice of plans.
- ICDS enrollees who have not made a plan selection will be automatically assigned to one of the ICDS health plans in their region.
- Medicare-Medicaid Enrollees will be transitioned into their chosen ICDS plan in the first two (2) quarters of 2013 in accordance with the following regional phase-in schedule:
 - February 1, 2013 – Northwest, Northeast Central and East Central;
 - April 1, 2013 – Northeast;
 - May 1, 2013 – Central, West Central and Southwest
- 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.

(b) 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 individuals. It is anticipated that Ohio Medicaid will issue a Request for Application (RFA) in April 2012. Potential bidders will be allowed to submit questions through an on-line process shortly after release of the RFA. Ohio Medicaid will also respond in writing to all technical and business questions submitted by potential bidders. Bidders will be given approximately five weeks to prepare a response to the RFA.

It is anticipated that the bid review process will be conducted in two phases. Proposals that adequately meet all of the criteria specified in the RFA will advance to phase two of the process. Ohio Medicaid may then direct additional technical and business questions to remaining applicants in each target region in order to support final selections. Applicants 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, Ohio Medicaid reserves the right to rebid or combine regions to facilitate implementation.

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 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 under the day-to-day direction of the state Medicaid Director. 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 understand their concerns regarding the ICDS program, and to 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 a manner that ensures 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 16, with a proposal due date from bidders on May 25, 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 60% 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 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.

v. Letters of Support

Please see appendix K for letters of support.

I. Additional Documentation

Ohio Medicaid will work with CMS to develop an administrative budget request for implementation and ongoing operational costs of the project during the development of the Memorandum of Understanding.

J. Interaction with Other HHS/CMS Initiatives

ICDS plans will be required to participate and include providers in their networks to coordinate HHS and CMS initiatives aimed at improving health and health care, including but not limited to the Partnership for Patients, Million Hearts Campaign, HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and Community Based Care Transition Program Grants. In addition, and 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, including a consolidated HCBS waiver initiative, front door reform, and a Money Follows the Person (MFP) Demonstration grant. This section discusses how these initiatives will be coordinated with the ICDS program.

(a) Reducing 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 joined the Ohio Department of Health in applying for a grant for technical assistance from the National Academy of State Health Policy (NASHP). NASHP chose Ohio for the project, and Ohio signed the agreement for the project in October 2011. Attached in Appendix L 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 that also addresses social determinants through integrated care services.
- Designing Health Homes to 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.

The ICDS will implement performance improvement plans to target areas of biggest variations and poor outcomes in disparate populations.

(b) Consolidated HCBS Waiver Initiative

In January 2011, the Governor's Office of Health Transformation initiated a consolidation of existing HCBS waiver programs that will be coordinated with the ICDS initiative.⁸ 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.

(c) Balancing Incentive Payment Program

Ohio is also contemplating how other LTSS structural reforms can be built into the LTSS delivery system. In support of these efforts, Ohio is considering applying for the federal Balancing Incentive Payment Program, which requires a single entry point system, a uniform assessment tool, and conflict free case management. 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 that will be used to determine eligibility for an array of Medicaid programs that serve individuals with a nursing facility LOC.

(d) Money Follows the Person Demonstration Grant

Ohio has a robust relocation program operated through its MFP demonstration grant. ICDS plans are expected to coordinate transition activities for individuals who are institutionalized with MFP efforts. Housing is an integral component of serving individuals in Ohio holistically. Because Medicaid cannot pay for housing directly, the agency (through its MFP 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 individuals 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

⁸ 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.

participants, including those who may be eligible for both 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.

APPENDIX A

Appendix A

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

APPENDIX B

APPENDIX C

Appendix C
Proposed ICDS Target Populations by Region

	NW Region		WC Region		SW Region		Central Region		NE Region		EC Region		NEC 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	11,117	8,742	13,418	3,692	21,506	2,867	18,158	30,374	34,642	4,146	18,224	5,468	9,975	127,040	55,288	182,328
Enrollees 65+	5,342	4,569	7,171	2,050	10,625	1,624	8,952	16,284	19,444	2,064	9,974	3,046	5,347	66,855	29,638	96,493
Enrollees 18-64	5,765	4,169	6,244	1,640	10,866	1,242	9,173	14,069	15,148	2,081	8,237	2,421	4,624	60,057	25,622	85,679
Enrollees with SMI over 18	1,162	740	1,292	258	2,287	198	1,624	2,311	3,601	495	1,670	402	691	12,326	4,405	16,731
Excluded Enrollees																
Enrollees with ID (DD waiver, ICF-MR)	1,223	920	1,034	441	2,035	133	2,096	1,919	2,881	255	1,986	488	686	11,941	4,156	16,097
Enrollees < 18	10	4	3	2	15	0	33	20	50	1	12	1	4	127	28	155
Total MMEs Eligible for ICDS Program	9,884	7,818	12,381	3,249	19,456	2,734	16,029	28,435	31,711	3,890	16,226	4,979	9,285	114,972	51,104	166,076

Source: ODJFS/DDS Average Enrollment March 30, 2012

Individuals enrolled in PACE, receiving delayed spend down, or with retroactive or backdated enrollment are excluded.

APPENDIX D

Appendix D

Transition Requirements

Transition Requirements	Waiver Consumers	Non-Waiver Consumers with LTC Needs (HH and PDN use)	NF Consumers AL Consumers	No LTC Need Consumers
Physician	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others
Pharmacy	90 day transition	90 day transition	90 day transition	90 day transition
Medicaid DME	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity
Scheduled Surgeries	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Chemo/Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Medicaid Vision and Dental	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered

Transition Requirements	Waiver Consumers	Non-Waiver Consumers with LTC Needs (HH and PDN use)	NF Consumers AL Consumers	No LTC Need Consumers
Home Health and PDN	<p>Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless:</p> <p>A significant change occurs as defined in OAC 5101:3-45-01 ; or Individuals expresses a desire to self-direct services; or after 365 days.</p>	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	N/A
Waiver Services-Direct Care <ul style="list-style-type: none"> • Personal Care Assistance • Waiver Nursing • Home Care Attendant • Respite • Enhanced Community Living • Adult Day Services • Social Work/Counseling • Independent Living Skills Training 	<p>Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless:</p> <p>A significant change occurs as defined in OAC 5101:3-45-01 ; or Individuals expresses a desire to self-direct services; or after 365 days.</p>	N/A	N/A	N/A

Transition Requirements	Waiver Consumers	Non-Waiver Consumers with LTC Needs (HH and PDN use)	NF Consumers AL Consumers	No LTC Need Consumers
Waiver Services-All other	Maintain service at current level for 365 days and existing service provider for 90 days. Plan initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider.	N/A	N/A	N/A

During the transition period referenced above, change from the existing provider can only occur in the following circumstances:

- 1) Consumer requests a change,
- 2) Provider gives appropriate notice of intent to discontinue services to a consumer or
- 3) Provider performance issues are identified that affect an individual's health and welfare.

APPENDIX E

Appendix E

Home- and Community-Based Services

And

Behavioral Health Services

Home- and Community-Based Services:

- Out of Home Respite Services
- Adult Day Health Services
- Supplemental Adaptive and Assistive Device Services/Specialized Medical Equipment and Supplies
- Supplemental Transportation Services/Non-Medical Transportation
- Transportation
- Chore Services
- Social Work Counseling
- Emergency Response Services/Personal Emergency Response Systems Home Modification Services/Environmental Accessibility Adaptations
- Personal Care Aide Services/Homemaker/Personal Care
- Waiver Nursing Services
- Home Delivered Meals Alternate meals service
- Pest Control
- Assisted Living Services
- Home Care Attendant Enhanced Community Living
- Nutritional Consultation
- Independent Living Assistance
- Community Transition

Behavioral Health Services:

- Comprehensive assessment and treatment planning
- Pharmacological management
- Case management services, including in-community case management
- Psychotherapy services
- Assertive Community Treatment (ACT)
- 24 hour on-call availability
- Emergency Services
- Inpatient Services – Including those provided in ODMH-operated psychiatric hospitals.
- Partial Hospital
- Day Treatment
- Treatment of substance use disorders, including individuals with co-morbid psychiatric and substance use disorders

Continuity of care will be assured to maintain patient and community well-being and safety. Any patient referred to a new provider shall have a minimum of ninety (90) days to transition to a new provider, and longer if transfer presents a substantial risk to the patient or community. New providers will receive and review records prior to commencing treatment and confirm ability to meet patient needs with minimal chance of decompensation and harm to patient and community.

In situations where patient and/or community needs and safety cannot be met with in-network resources (such as with court-ordered treatment or forensic patients), or if transfer to a new provider represents a substantial risk of clinical deterioration and consequent risk to the patient/community, provisions shall be made for the patient to continue in treatment with his/her existing provider and reimbursement shall be at standard Ohio Medicaid rates. Any treatment which is court-ordered shall be approved as a clinically necessary service.

APPENDIX F

**Appendix F
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

Priorities:				
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 7. Musculoskeletal Health (Duals)	Integrate patient/ family feedback on preferences, desired outcomes, and experiences into all care settings and delivery.	Sustain a quality focused, continuous learning organization.
Current Initiatives Supporting Goals*:				
<ul style="list-style-type: none"> • Change hospital payment policy for never events & hospital-acquired infections (P) • Eliminate blood stream catheter infections in Neonatal Intensive Care Units (QIS) • Human milk feeding to premature infants (QIS) • Solutions for Patient Safety (SPS) <ul style="list-style-type: none"> - Adverse Drug Events - Surgical Site Infections - Serious Safety Events (QIS) • Retrospective Drug Utilization Review (AF) • Meaningful Use: <ul style="list-style-type: none"> - Electronic Prescribing - Drug Interaction - Drug Allergies - Computerized Provider Order Entry (I) 	<ul style="list-style-type: none"> • Managed Care Plan Delivery System <ul style="list-style-type: none"> - Access to services in a timely manner - Availability of a robust provider network - Care management - 24/7 Nurse Advice Line (AF) - IMPROVE Collaborative (QIS) - Behavioral Health Collaborative (COL) • Health Homes – Intense care management of chronically ill consumers using <i>Patient-Centered Medical Homes</i> as the foundation (COL) • Integration of dual eligibles (UD) • Accountable Care Organizations (UD) • MC enrollment efficiency (P) • Presumptive eligibility for pregnant women and newborns (P) • Meaningful Use: <ul style="list-style-type: none"> - Facilitating appropriate medical information communication (DSS) 	<ul style="list-style-type: none"> • MCP Quality Accountability System: <ul style="list-style-type: none"> - Process & outcome measures for each of the six Clinical Focus Areas above (NRM) - Pay-for-Performance (I) • Age appropriate preventive services <ul style="list-style-type: none"> - Adult Preventive Visit Benefit (P) - EPSDT Performance Improvement Project (QIS) • Obstetrical <ul style="list-style-type: none"> - Eliminating scheduled deliveries prior to 39 weeks - Antenatal steroids for high-risk mothers (QIS) • Implementation and spread of Pediatric Psychiatric Network (QIS) • Safety net consortium to improve diabetes care and outcomes (QIS) • QI Infrastructure Investment <ul style="list-style-type: none"> - Information System for data collection, analysis, & feedback - Quality improvement coordinators (QIS) • Meaningful use: <ul style="list-style-type: none"> - Clinical Decision Support (DSS) 	<ul style="list-style-type: none"> • NCQA CAHPS Consumer Satisfaction Survey (CS) • Review MCP Grievance/ Appeals/ Complaints / State Hearings (AF) • MCP Consumer Quality of Life Surveys (CS) • MCP Consumer Care Management Survey (CS) • Ohio Family Health Survey (CS) • Engage Patient in QI Process (CS) <ul style="list-style-type: none"> - OPQC - SPS - IMPROVE • Meaningful use: <ul style="list-style-type: none"> - Patient empowerment/ access to medical information (DSS) 	<ul style="list-style-type: none"> • Quality Assessment and Performance Improvement (QAPI) Program: <ul style="list-style-type: none"> - Performance Improvement Projects (QIS) - Performance Measure reporting (NRM) - Over/under utilization Assessment (AF) - Special health care needs quality and appropriateness of care assessment (AF) • MCP Compliance Monitoring (AF) • Member Services (AF) • Provider Services (AF) • Program Integrity (AF) • MITS (AF) • Meaningful Use: <ul style="list-style-type: none"> - Consumer Decision Support - Provider Decision Support (DSS)
Cross Cutting Issues: Integration of Physical and Behavioral Health, Elimination of Health Care Disparities				
How:	P = Policy QIS = Quality Improvement Science COL = Collaborative	I = Incentives CS = Consumer Survey DSS = Decision Support System	NRM = Nationally Recognized Measurement Sets AF = Administrative Function UD = Under Development	

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

APPENDIX G

Appendix G

Integrated Care Delivery System Quality Measures

April 2, 2012

Description of Measure				Clinical Focus Area	Quality Strategy Priority Area	
Number	Name	Source of Nationally-Recognized Measure	Other Ohio Programs Using Measure*			
1	Follow-Up After Hospitalization for Mental Illness - 7-day Follow-Up	NCQA/HEDIS	AHRQ, CHIPRA, HH, MC	Behavioral Health	Promote Evidence Based Prevention and Treatment Practices	
2	Anti-Depressant Medication Management - New Episode of Depression: (a) Optimal Practitioner Contacts for Medication Management	NCQA/HEDIS				
3	Anti-Depressant Medication Management - New Episode of Depression: (b) Effective Acute Phase Treatment	NCQA/HEDIS	AHRQ, EHR			
4	Anti-Depressant Medication Management - New Episode of Depression: (c) Effective Continuation Phase Treatment	NCQA/HEDIS	AHRQ, EHR			
5	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment- Engagement of AOD Treatment, Total	NCQA/HEDIS	AHRQ, EHR, HH, MC			
6	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment- Initiation of AOD Treatment, Total	NCQA/HEDIS	AHRQ, EHR, HH			
7	Cholesterol Management for Patients With Cardiovascular Conditions - LDL-C Screening and LDL-C Control (<100 mg/dL)	NCQA/HEDIS	EHR, MC, HH	Cardiovascular Disease		
8	Persistence of Beta-Blocker Treatment After a Heart Attack	NCQA/HEDIS	MC			
9	Controlling High Blood Pressure	NCQA/HEDIS	AHRQ, EHR, HH, MC			
10	Comprehensive Diabetes Care - HbA1c Control (<8.0%)	NCQA/HEDIS	EHR, HH, MC	Diabetes		
11	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)	NCQA/HEDIS	EHR, MC			
12	Comprehensive Diabetes Care - LDL-C <100	NCQA/HEDIS	EHR, HH			
13	Pharmacotherapy Management of COPD Exacerbation (PCE), 40 and Older	NCQA/HEDIS		Asthma/COPD		
14	Osteoporosis Management in Women Who had a Fracture	NCQA/HEDIS		Musculoskeletal Health		
15	Pneumonia Vaccination Status for Older Adults ≥ 65 Years of Age (HEDIS CAHPS Survey)	NCQA/HEDIS	EHR			Improve Care Coordination
16	Medication Reconciliation Post-Discharge	NCQA/HEDIS	HH			
17	Use of High-risk Medications in the Elderly	NCQA/HEDIS				
18	Adults' Access to Preventive/Ambulatory Health Services - Total	NCQA/HEDIS	HH, MC			
19	Care for Older Adults - Medication Review, Advance Care Planning, Functional Status Assessment, Pain Screening, 66 & Older	NCQA/HEDIS				Support Person and Family Centered Care
20	Diversion measure TBD					
21	Rebalancing measure TBD					
22	Longterm Care measures TBD					

*** Other Program Key**

AHRQ AHRQ Adult Core
 CHIPRA CHIPRA
 HH Ohio's Health Homes Program
 MC Ohio's Medicaid Managed Care Program
 EHR Meaningful Use Electronic Health Records

APPENDIX H

Appendix H

Timeline of Stakeholder Activities

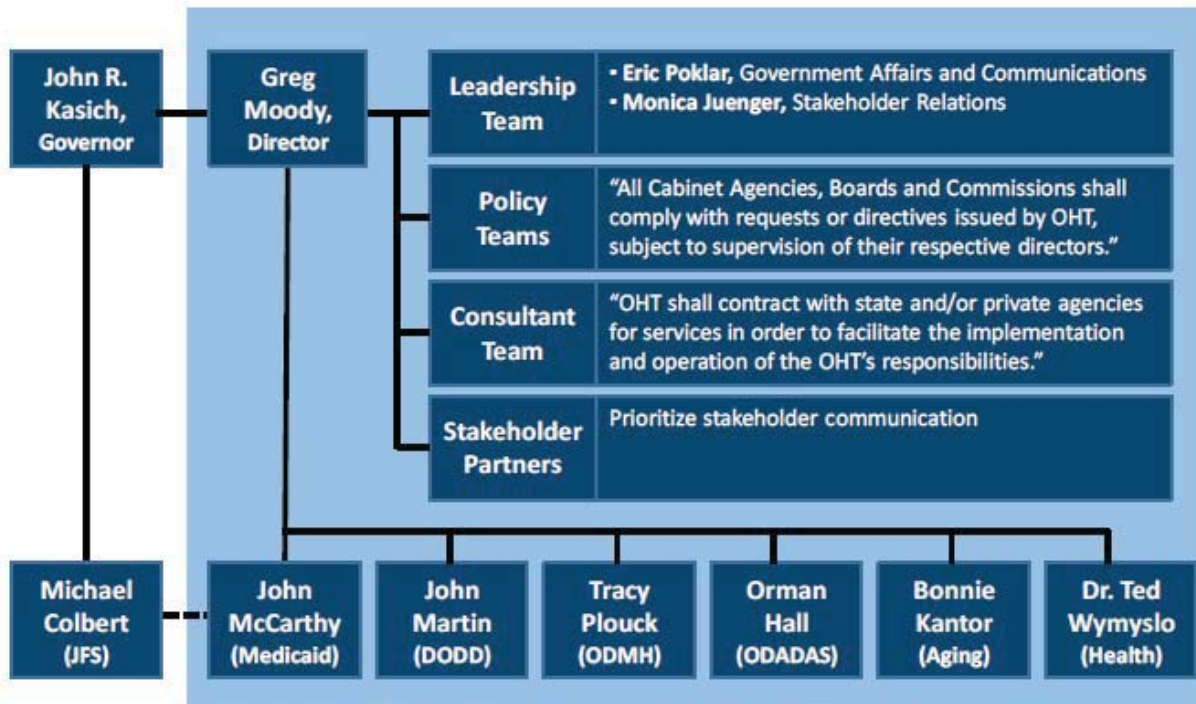
Stakeholder Engagement Activity	2011												2012				
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Vision for Integrated Healthcare Delivery System for Medicare-Medicaid Enrollees released by Governor Kasich's Office of Health Transformation		◆															
Proposal submitted 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 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 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													◆				
Public input meeting - Dayton														◆			
Public input meeting - Cleveland														◆			
Beneficiary Questionnaire														→			
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 Advisory Workgroup															◆		
2 additional public input meetings (locations TBD)														◆	◆		
CMS publishes ICDS proposal in federal register for public comment																■	

APPENDIX I

Appendix I



Governor's Office of Health Transformation



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

APPENDIX J

Appendix J
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- 02/14/2012	Regional meetings to facilitate consumer and family caregiver public comment held in Toledo (1/24), Columbus (1/31), Dayton (2/3), Cleveland (2/7), and Athens (2/14)	Yes
02/06/2012	Additional stakeholder meetings with LTC facilities and health plans	Yes
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	Yes
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	Yes
03/13/2012	First public hearing: Rhodes State Office Tower	Yes
03/20/2012	Second public hearing: Rhodes State Office Tower	Yes
03/27/2012	Public comments due and considered for incorporation into a final ICDS Proposal	Yes
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	

Target Date	Phase IV: ICDS Implementation	On Website
04/16/2012	Ohio releases a request for applications (RFA)	
04/23/2012	RFA questions are due on-line question & answer	
05/04/2012	CMS and Ohio begin negotiation on Memorandum of Understanding (MOU)	
05/25/2012	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 individuals in target regions	
60 days prior to enrollment	Notification letters sent to ICDS individuals	
30 days prior to enrollment	Second notification letter sent to ICDS individuals	
15 days prior to enrollment	Auto-assignment for individuals who have not enrolled in an ICDS plan	
During the month prior to enrollment	ICDS plans send enrollment packets to ICDS individuals	
02/01/2013	Initial enrollment into ICDS plans	
90 days after enrollment	Medicare opt-out option ongoing	

APPENDIX K



JOHN R. KASICH
GOVERNOR
STATE OF OHIO

February 21, 2012

Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Ms. Bella,

As Governor of the State of Ohio, one of my highest priorities is to improve overall health system performance. In January 2011, during my first week as Governor, I created the Office of Health Transformation to pursue an aggressive reform agenda, including the integration of care for Medicare-Medicaid enrollees.

Nearly 200,000 Ohioans are enrolled in both Medicare and Medicaid, but the two programs are designed and managed with almost no connection to each other. As a result of poor coordination among physical health, behavioral health and long-term care services, quality of care is diminished and costs are too high. Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, but they account for 46 percent of Medicaid long-term care spending.

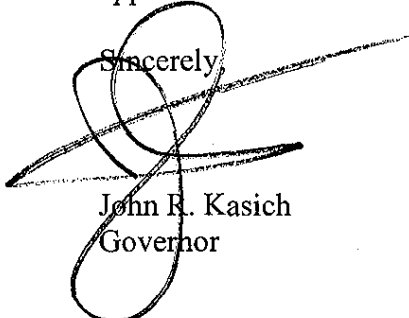
Ohio needs better and more flexible tools to reverse the trends of diminishing quality and increasing cost. For that reason, Medicare-Medicaid integration has been a priority from the outset of my Administration and I am committed to seeing it through.

On June 18, 2011, I met with President Obama and discussed Ohio's urgency to integrate care for Medicare-Medicaid enrollees. On November 30, 2011, I met with Republican Governors from around the country and singled out Medicare-Medicaid integration as our greatest opportunity for constructive engagement with the federal government.

Today, I am requesting your favorable consideration of Ohio's proposal to create an Integrated Care Delivery System for Medicare-Medicaid Eligibles (attached). I have committed the resources necessary to engage your office in program design, support a competitive procurement, and implement Ohio's demonstration in January 2013. John McCarthy, Ohio's Medicaid Director, can provide whatever you need to make your decision.

Thank you for your leadership in moving the states' integration projects forward. Without Medicare-Medicaid integration, Ohioans will continue to suffer the ill effects of a fragmented system and taxpayers will bear otherwise avoidable costs. I appreciate your working with us to approve Ohio's demonstration.

Sincerely,

A handwritten signature in black ink, appearing to be 'John R. Kasich', written over the word 'Sincerely,'. The signature is stylized with loops and a long horizontal stroke extending to the right.

John R. Kasich
Governor



Department of
Aging

John Kasich, Governor
Bonnie Kantor-Burman, Director

March 30, 2012

Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Ms. Bella:

I am writing to express my support for Ohio's proposal to create an Integrated Care Delivery System for Medicare-Medicaid enrollees. As Governor Kasich has stated, Ohio needs better, more flexible tools to reverse the trends of diminishing quality and increasing costs in our healthcare delivery system. In my capacity as the Director of the Ohio Department of Aging, I am acutely aware of the need for greater integration and coordination of healthcare services provided to beneficiaries by Medicare and Medicaid.

The existence of poor coordination among physical health, behavioral health and long-term care services, results in diminished quality of care and contributes to an upward spiral in cost growth. While Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, they account for 46 percent of Medicaid long-term care spending.

The integration of services provided by Medicare-Medicaid will significantly contribute to our goal of enhancing quality and decreasing costs. I am therefore requesting your favorable consideration of Ohio's Demonstration Proposal to create an Integrated Care Delivery System.

Thank you for your leadership on this critically important topic.

Sincerely,

Bonnie Kantor-Burman
Director



OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich / Governor

Theodore E. Wymyslo, M.D. / Director of Health

March 29, 2012

Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Ms. Bella:

I am writing to express support for Ohio's proposal to create and Integrated Care Delivery System for Medicare-Medicaid enrollees. As Governor Kasich has stated, Ohio needs better, more flexible tools to reverse the trends of diminishing quality and increasing costs in our healthcare delivery system. In my capacity as the Director of the Ohio Department of Health (ODH), I am acutely aware of the need for greater integration and coordination of healthcare services provided to beneficiaries eligible for services provided by Medicare and Medicaid. ODH has been encouraging the expansion of a Patient-Centered Medical Home model of care as one approach to facilitating partnerships that are structured to achieve the same effect.

The existence of poor coordination among physical health, behavioral health and long-term care services, results in diminished quality of care and contributes to an upward spiral in cost growth. While Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, they account for 46 percent of Medicaid long-term care spending.

The integration of services provided by Medicare-Medicaid will significantly contribute to our goal of enhancing quality and decreasing costs. , DP WKHUHIRUH UHTXHVWLQJ \RXU IDYRUDEOH FRQVLGHUDWLRQ RI 2KLRQV
Demonstration Proposal to create an Integrated Care Delivery System.

Thank you for your leadership on this critically important topic.

Sincerely

A handwritten signature in black ink that reads "Theodore E. Wymyslo M.D." with a stylized flourish at the end.

Theodore E. Wymyslo, M.D.
Director

John R. Kasich, Governor
Mary Taylor, Lieutenant Governor
Orman Hall, Director

March 30, 2012

Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Ms. Bella:

I am writing to express my support for Ohio's proposal to create an Integrated Care Delivery System for Medicare-Medicaid enrollees. As Governor Kasich has stated, Ohio needs better, more flexible tools to reverse the trends of diminishing quality and increasing costs in our healthcare delivery system. In my capacity as the Director of the Ohio Department of Alcohol and Drug Addiction Services, I am acutely aware of the need for greater integration and coordination of healthcare services provided to beneficiaries eligible for services provided by Medicare and Medicaid.

The existence of poor coordination among physical health, behavioral health and long-term care services, results in diminished quality of care and contributes to an upward spiral in cost growth. While Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, they account for 46 percent of Medicaid long-term care spending.

The integration of services provided by Medicare-Medicaid will significantly contribute to our goal of enhancing quality and decreasing costs. I am therefore requesting your favorable consideration of Ohio's Demonstration Proposal to create an Integrated Care Delivery System.

Thank you for your leadership on this critically important topic.

Sincerely,



Orman Hall, Director
Ohio Department of
Alcohol and Drug Addiction Services



Department of
Mental Health

John R. Kasich, Governor
Tracy J. Plouck, Director

March 30, 2012

Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Melanie
Dear Ms. Bella:

I am writing to express my support for Ohio's proposal to create an Integrated Care Delivery System for Medicare-Medicaid enrollees. As Governor Kasich has stated, Ohio needs better, more flexible tools to reverse the trends of diminishing quality and increasing costs in our healthcare delivery system. In my capacity as the Director of the Ohio Department of Mental Health, I am acutely aware of the need for greater integration and coordination of healthcare services provided to beneficiaries by Medicare and Medicaid, particularly those with mental illness.

The existence of poor coordination among physical health, behavioral health and long-term care services, results in diminished quality of care and contributes to an upward spiral in cost growth. While Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, they account for 46 percent of Medicaid long-term care spending.

The integration of services provided by Medicare-Medicaid will significantly contribute to our goal of enhancing quality and decreasing costs. I am therefore requesting your favorable consideration of Ohio's Demonstration Proposal to create an Integrated Care Delivery System.

Thank you for your leadership on this critically important topic.

Sincerely,

Tracy J. Plouck
Director
Ohio Department of Mental Health

Establishing mental health as a cornerstone of overall health

30 East Broad Street
Columbus, Ohio 43215
mentalhealth.ohio.gov

614 | 466-2297
614 | 752-9696 TTY
614 | 752-9453 Fax

APPENDIX L

State of Ohio

Advance Health Equity through State Implementation of Health Reform

Application for Technical Assistance

Ohio Core team

Team Member (Medicaid)

Name: **John McCarthy** Primary Contact: **Yes** No
Title: **Director, Ohio Medicaid** Phone: **(614) 752-3739**
Agency: **Ohio Dept. Job & Family Services** E-mail: **John.McCarthy@jfs.ohio.gov**
Assistant (if applicable): Assistant's e-mail:

Team member (Public Health)

Name: **Johnnie (Chip) Allen, MPH** Primary Contact: **Yes** No
Title: **Health Equity Coordinator** Phone: **(614) 728-6919**
Agency: **Ohio Department of Health** E-mail: **Chip.Allen@odh.ohio.gov**
Assistant (if applicable): Assistant's e-mail: **Robyn.Taylor@odh.ohio.gov**

Team member (Minority Health)

Name: **Angela C. Dawson, MS,LPC** Primary Contact: **Yes** No
Title: **Executive Director** Phone (614) **466-4000**
Agency: **Ohio Commission on Minority Health** E-mail: **Angela.Dawson@mih.ohio.gov**

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 all 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 it 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.

Promote Quality & Efficiency from the Health Care System

- 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 in 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 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

NATIONAL ACADEMY
for STATE HEALTH POLICY

State of Ohio NASHP Workplan

Policy Initiative	Project Activity/Action Step	Timeline (Ex: Oct 2011- Jan 2012)	Milestone/Outcome	State Team Member Responsible
1) <i>Medicaid Managed Care Contract Standards that Advance Health Equity</i>	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) <i>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</i> 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

NATIONAL ACADEMY
for STATE HEALTH POLICY

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

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

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MEDTAPP Access Initiative	<p>candidates (nurses, physicians and other health care workers) to represent and serve disparate populations and support their placement in high need areas</p>		<p>health care workforce as compared to predetermined baseline measurements.</p> <p>RATIONALE: TA could be helpful with candidate identification, appropriate support to serve in a high need area.</p>	Cornelius, Chip Allen & Robyn Taylor
Electronic Health Record Vendor Engagement	<p>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</p> <p>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</p>	Ongoing	<p>Outcome: Ability to extract aggregate summary measures on quality and health outcomes by race, ethnicity and income from EMRs on selected health disparity metrics.</p> <p>RATIONALE: TA to gather national efforts and innovation around this topic would be helpful.</p>	Mark Vidmar
<p>Promote Quality and Efficiency from the Health Care System</p> <p>Develop ACO Health Disparities Strike Teams (HDST)</p>	<p>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</p>		<p>Outcome:</p> <p>Development of HDST to work with ACOs who do not achieve target health disparity elimination outcomes.</p> <p>Better quality and outcomes across the board without segregating</p>	Core Team Members

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	systems.		<p>patients to certain ACOs</p> <p>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.</p>	
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