Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of Ohio

Regarding A Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees

Demonstration to Develop an Integrated Care Delivery System

TABLE OF CONTENTS

I. STATEMENT OF INITIATIVE

The Centers for Medicare & Medicaid Services (CMS) and the State of Ohio, Office of Medical Assistance (State/ Ohio Medicaid) will establish a Federal-State partnership to implement the Demonstration to Develop an Integrated Care Delivery System (Demonstration) to better serve individuals eligible for both Medicare and Medicaid ("Medicare-Medicaid Enrollees" or "dual eligibles"). The Federal-State partnership will include a three-way contract with Integrated Care Delivery System (ICDS) Plans that will provide integrated benefits to Medicare-Medicaid Enrollees in the targeted geographic area(s). The Demonstration will begin on September 1, 2013 and continue until December 31, 2016, unless terminated pursuant to section L or continued pursuant to section K of this Memorandum of Understanding (MOU). The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care and reduce costs for both the State and the Federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

The population that will be eligible to participate in the ICDS program is limited to "Full Benefit" Medicare-Medicaid Enrollees who are age 18 or older. Section C.1 below provides more information on individuals who are not eligible for the program as well as individuals who are eligible if they disenroll from an existing program.

Under this initiative, ICDS Plans will be required to provide for, either directly or through subcontracts, Medicare and Medicaid-covered services, as well as additional items and services, under a capitated model of financing. CMS, the State, and the ICDS Plans will ensure that beneficiaries have access to an adequate network of medical and supportive services.

CMS and the State shall jointly select and monitor the ICDS Plans. CMS will implement this initiative under Demonstration authority for Medicare and Demonstration or State Plan authority or waiver for Medicaid as described in section IIIA and detailed in Appendices 4 and 5.

Key objectives of the initiative are to improve the beneficiary experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid and achieve cost savings for the State and Federal government through improvements in care and coordination. CMS and the State expect this model of integrated care and financing to, among other things, improve quality of care and reduce health disparities, meet both health and functional needs, and improve transitions among care settings. Meeting beneficiary needs, including the ability to self-direct care, be involved in one's care, and live independently in the community, are central goals of this initiative. CMS and the State expect ICDS Plans and provider implementation of the

independent living and recovery philosophy, wellness principles, and cultural competence to contribute to achieving these goals.

The initiative will test the effect of an integrated care and payment model on serving both community and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency, and oversight standards. Contract management will focus on performance measurement and continuous quality improvement. Except as otherwise specified in this MOU, ICDS Plans will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as program specific and evaluation requirements, as will be further specified in a three-way contract to be executed among the ICDS Plans, the State, and CMS.

As part of this initiative, CMS and the State will test a new Medicare and Medicaid payment methodology designed to support ICDS Plans in serving Medicare-Medicaid Enrollees in the Demonstration. This financing approach will minimize cost-shifting, align incentives between Medicare and Medicaid, and support the best possible health and functional outcomes for Enrollees.

CMS and the State will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid Enrollees, utilizing a simplified and unified set of rules, as detailed in the sections below. Flexibilities will be coupled with specific beneficiary safeguards and will be included in this MOU and the three-way contract. ICDS Plans will have full accountability for managing the capitated payment to best meet the needs of Enrollees according to Individualized Care Plans developed by Enrollees, their caregivers, and Trans-disciplinary Care Management Teams using a person-centered planning process. CMS and the State expect ICDS Plans to achieve savings through better integrated and coordinated care. Subject to CMS and State oversight, ICDS Plans will have significant flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to or means to avoid high-cost services if indicated by the Enrollees' wishes, needs, and Individualized Care Plan.

Preceding the signing of this MOU, the State has undergone necessary planning activities consistent with the CMS standards and conditions for participation, as detailed through supporting documentation provided in Appendix 2. This includes a robust beneficiary- and stakeholder- engagement process.

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document details the principles under which CMS and Ohio plan to implement and operate

the aforementioned Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute a three-way contract with ICDS Plans setting forth the terms and conditions of the Demonstration and initiate the Demonstration. Further detail about ICDS Plan responsibilities will be included in and appended to the three-way contract.

Following the signing of this MOU and prior to the implementation of the Demonstration, the State and CMS will ultimately enter into three-way contracts with selected plans, which will have also met the Medicare components of the Plan selection process, including submission of a successful Medicare Part C and Part D application to CMS, and adherence to any annual contract renewal requirements and guidance updates, as specified in Appendix 7. These three-way contracts will include the additional operational and technical requirements pertinent to the implementation of the Demonstration.

III. DEMONSTRATION DESIGN / OPERATIONAL PLAN

A. DEMONSTRATION AUTHORITY

The following is a summary of the terms and conditions the parties intend to incorporate into the three-way contracts, as well as those activities the parties intend to conduct prior to entering into the three way contracts and initiating the Demonstration. This section and any appendices referenced herein are not intended to create contractual or other legal rights between the parties.

1. **Medicare Authority:** The Medicare elements of the initiative shall operate according to existing Medicare Parts C and D laws and regulations, as amended or modified, except to the extent these requirements are waived or modified as provided for in Appendix 4. As a term and condition of the initiative, ICDS Plans will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act, and 42 C.F.R. 422 and 423, and applicable sub-regulatory guidance, as amended from time to time, except to the extent specified in this MOU, including Appendix 4 and, for waivers of sub-regulatory guidance, the three-way contract.

2. **Medicaid Authority:** The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, including but not limited to all requirements of the 1915(c) waivers for those ICDS Enrollees in a 1915(c) waiver, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the initiative, ICDS Plans will be required to comply with Medicaid managed care requirements under Title XIX and 42 C.F.R. 438 et. seq., and applicable sub-

regulatory guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5 and, for waivers of sub-regulatory guidance, the three-way contract.

B. CONTRACTING PROCESS

1. **ICDS Plan Procurement Document:** The State has issued an RFA that, consistent with applicable State law and regulations, includes purchasing specifications that reflect the integration of Medicare and Medicaid payment and benefits. As articulated in January 25, 2012 and March 29, 2012 guidance from CMS, ICDS Plans are also required to submit a Capitated Financial Alignment Demonstration application to CMS and meet all of the Medicare components of the plan selection process.

   All applicable Medicare Advantage/ Part D requirements and Medicaid managed care requirements are cited in the RFA, and will apply as specified by CMS and the State herein or in the three-way contract.

2. **ICDS Plan Selection:** The State procurement and CMS plan selection process has been utilized to select entities that will be eligible to contract with CMS and the State. CMS and the State shall contract with qualified ICDS Plans on a selective basis. See Appendix 7 for more information on the plan selection process.

3. **Medicare Waiver Approval:** CMS approval of Medicare waivers is reflected in Appendix 4. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XVIII. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Social Security Act, afford the State a reasonable opportunity to request reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.

4. **Medicaid Waiver and/or Medicaid State Plan Approval:** CMS approval of any new Medicaid waivers pursuant to Sections 1115, 1115A, or 1915 of the Social Security Act authority and processes is reflected in Appendix 5. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities for the purpose of this Demonstration would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the State in

writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Social Security Act, afford the State an opportunity to request a hearing to appeal CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.

5. **Readiness Review:** CMS and the State, either directly or with contractor support, shall conduct a readiness review of each selected ICDS Plan. Following the signing of the three-way contract, CMS and the State must agree that an ICDS Plan has passed readiness prior to that Plan accepting any enrollment. CMS and the State will collaborate in the design and implementation of the readiness review process and requirements. This readiness review shall include an evaluation of the capacity of each potential ICDS Plan and its ability to meet all program requirements, including having an adequate network that addresses the full range of beneficiary needs, and the capacity to uphold all beneficiary safeguards and protections.

6. **Three-way contract:** CMS and the State shall develop a single three-way contract and contract negotiation process that both parties agree is administratively effective and ensures coordinated and comprehensive program operation, enforcement, monitoring, and oversight.

7. **Medicaid Managed Care Outside of this Demonstration:** Outside of this MOU, underlying Medicaid authorities in Ohio may require individuals to enroll in a managed care plan for Medicaid services if not otherwise enrolled in this Demonstration. In that scenario, the State will establish separate contracts with the plans, in compliance with all CMS rules, outside of this Demonstration. Those contracts will specify program requirements applicable for individuals who have elected to opt out of the Demonstration. Ohio must obtain necessary Medicaid authority completely separate from this Demonstration.

C. ENROLLMENT

1. Eligible Populations:

The Demonstration will be available to individuals who meet all of the following criteria:

- Age 18 and older at the time of enrollment;
- Eligible for full Medicare Parts A, B, and D and full Medicaid, and
- Reside in an ICDS Demonstration county.

The following populations will be excluded from enrollment:

- Individuals under the age of 18;
- Individuals who are Medicare and Medicaid eligible and are on a delayed Medicaid spend down;
- Individuals enrolled in both Medicare and Medicaid who have other third party creditable health care coverage;
- Individuals with Intellectual Disabilities (ID) and other Developmental Disabilities (DD) who are otherwise served through an IDD 1915(c) HCBS waiver or an ICF-IDD;
- Individuals enrolled in PACE; and
- Individuals participating in the CMS Independence at Home (IAH) demonstration.

2. **Enrollment and Disenrollment Processes:** Eligible individuals will be notified of their right to select among contracted ICDS Plans no fewer than sixty (60) days prior to the effective date of enrollment. When no active choice has been made, enrollment into an ICDS Plan may be conducted using a seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the ICDS Plan at any time. Prior to the effective date of their enrollment, individuals who would be passively enrolled will have the opportunity to opt-out and will receive sufficient notice and information with which to do so, as further detailed in Appendix 7. Disenrollment from ICDS Plans and transfers between ICDS Plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month. CMS and the State will monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing and enrollment laws regulations and CMS policies, for the purposes of identifying any inappropriate or illegal marketing practices. As part of this analysis, CMS and the State will monitor any unusual shifts in enrollment by individuals identified for passive enrollment into a particular ICDS plan to a Medicare Advantage plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS and the State may discontinue further passive enrollment into an ICDS plan. Any illegal marketing practices will be referred to appropriate agencies for investigation. As mutually agreed upon, and as discussed further in Appendix 7 and the three-way contract, CMS and the State will utilize an independent third party entity to facilitate all enrollment into the ICDS Plans. ICDS Plan enrollments, transfers and opt-outs shall become effective on the same day for both Medicare and Medicaid (the first day of the following month). For those who lose Medicaid eligibility during the month, coverage and Federal financial participation will continue through the end of that month.

3. **Uniform Enrollment/Disenrollment Documents:** CMS and the State shall develop uniform enrollment and disenrollment forms and other documents.

4. **Outreach and Education:** ICDS Plan outreach and marketing materials will be subject to a single set of marketing rules by CMS and the State, as further detailed in Appendix 7.

5. **Single Identification Card:** CMS and the State shall work with ICDS Plans to develop a single identification card that can be used to access all care needs, as further detailed in Appendix 7.

6. **Interaction with other Demonstrations:** To best ensure continuity of beneficiary care and provider relationships, CMS will work with the State to address beneficiary or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). A beneficiary enrolled in the Demonstration will not be enrolled in, or have costs attributed to, an ACO or any other shared savings initiative for the purposes of calculating shared Medicare savings under those initiatives.

D. DELIVERY SYSTEMS AND BENEFITS

1. **ICDS Plan Service Capacity:** CMS and the State shall contract with ICDS Plans that demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to Enrollees, in accordance with this MOU, CMS guidance, and the three-way contract. Medicare covered benefits shall be provided in accordance with 42 CFR 422 and 42 CFR 423 et seq. Medicaid covered benefits shall be provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments, 1915 (b) and/or 1915 (c) waivers, and in accordance with the requirements specified by the State RFA and this MOU. In accordance with the three-way contract and this MOU, CMS and the State may choose to allow for greater flexibility in offering additional benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, the State, and ICDS Plans will ensure that beneficiaries have access to an adequate network of medical, drug, behavioral health, and Long-Term Services and Supports (LTSS) providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.

2. **ICDS Plan Risk Arrangements:** CMS and the State shall require each ICDS Plan to provide a detailed description of its risk arrangements with providers under subcontract with the ICDS Plan. This description shall be made available to Plan Enrollees upon request. It will not be permissible for any incentive arrangements to include any payment or other inducement that serves to withhold, limit or reduce necessary medical or non-medical services to Enrollees.

3. **ICDS Plan Financial Solvency Arrangements:** CMS and the State have established a standard for all ICDS Plans, as articulated in Appendix 7.

E. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

1. **Choice of Plans and Providers:** As referenced in section C.2, Medicare-Medicaid beneficiaries will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose a different Demonstration Plan, a Medicare Advantage Plan, to receive care through Medicare Fee-For-Service (FFS) and a Prescription Drug Plan, and to receive Medicaid services in accordance with the State's approved State Plan services and any approved 1915 (b) and (c) waivers.

2. **Continuity of Care:** CMS and the State will require ICDS Plans to ensure that individuals continue to have access to medically necessary items, services, and medical and long-term service and support providers for the transition period as specified in Appendix 7. In addition, ICDS Plans will advise beneficiaries and providers that they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, and as appropriate, ICDS Plans must also contact providers not already members of their network with information on becoming credentialed as in-network providers. Part D transition rules and rights will continue as provided for in current law and regulation.

3. **Enrollment Assistance and Options Counseling:** As referenced in section C.2 and Appendix 7, the State will provide Medicaid-Medicare beneficiaries with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs. The State will work with the Ohio Senior Health Insurance Information Program (OSHIIP), Aging and Disability Resource Networks (ADRNs), and other local partners to ensure ongoing outreach, education and support to beneficiaries eligible for ICDS.

4. **Ombudsman:** The Ohio Office of the State Long-term Care Ombudsman Program is statutorily authorized to advocate and investigate on behalf of Ohio's home and community based care and nursing facility-based recipients to safeguard due process, and serve as the early and consistent means of identifying systematic problems. As the ICDS is implemented, the Ombudsman activity and resources will expand from long term care facilities, as that is the current origin of most complaints, to a greater role for the Ombudsman in home and community based care. CMS will support Ombudsman training on the Demonstration and its objectives, and CMS and the State will provide ongoing technical assistance to the

Ombudsman. The Ombudsman will support individual advocacy and independent systematic oversight for ICDS, with a focus on compliance with principles of community integration, independent living, and person-centered care in the home and community based care context. The Ombudsman will be responsible for gathering and reporting data to the State and CMS via the contract management team described in Appendix 7 of this MOU.

5. **Person-Centered**, **Appropriate Care:** CMS, the State, and ICDS Plans shall ensure that all medically necessary covered benefits are provided to Enrollees and are provided in a manner that is sensitive to the beneficiary's functional and cognitive needs, language and culture, allows for involvement of the beneficiary and caregivers, and is in a care setting appropriate to the beneficiary's needs, with a preference for the home and the community. CMS, the State, and ICDS Plans shall ensure that care is person-centered and can accommodate and support self-direction. ICDS Plans shall also ensure that medically necessary covered services are provided to Enrollee, in the least restrictive community setting, and in accordance with the Enrollee's wishes and Care Plan.

6. **Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and Ohio Medicaid expect Plan and provider compliance with the ADA and the Civil Rights Act of 1964 to promote the success of the ICDS Plan model and will support better health outcomes for ICDS Plan Enrollees. In particular, CMS and Ohio Medicaid recognize that successful person-centered care requires physical access to buildings, services and equipment and flexibility in scheduling and processes. Ohio Medicaid and CMS will require ICDS Plans to contract with providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their Enrollees. Ohio Medicaid and CMS also recognize that access includes effective communication. Ohio Medicaid and CMS will require ICDS Plans and their providers to communicate with their Enrollees in a manner that accommodates their individual needs, including providing interpreters for those who are deaf or hard of hearing, accommodations for members with cognitive limitations, and interpreters for those who do not speak English. Also, CMS and Ohio Medicaid recognize the importance of staff training on accessibility and accommodation, independent living and recovery models, cultural competency, and wellness philosophies. CMS and Ohio Medicaid will continue to work with stakeholders, including Demonstration participants, to further develop learning opportunities, monitoring mechanisms and quality measures to ensure that ICDS Plans and their providers comply with all requirements of the ADA. Finally, CMS and Ohio Medicaid are committed to compliance with the ADA, including application of the Supreme Court's *Olmstead* decision, and agree to ensure, through ongoing surveys and readiness and implementation monitoring, that ICDS Plans provide for Demonstration Enrollees' long-term services and supports in care settings appropriate to their needs.

7. **Enrollee Communications:** CMS and the State agree that Enrollee and prospective Enrollee materials, in all forms, shall require prior approval by CMS and the State unless CMS and the State agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and the State. CMS and the State will also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or State approval. All materials shall be integrated and include, but not be limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable to the beneficiaries that will be enrolled in the ICDS Plans, and their caregivers. This includes individuals with disabilities, including, but not limited to, those with cognitive and functional limitations, and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard providing the greatest access to individuals with disabilities or limited English proficiency will apply.

8. **Beneficiary Participation on Governing and Advisory Boards:** As part of the three-way contract, CMS and the State shall require ICDS Plans to obtain beneficiary and community input on issues of program management and Enrollee care through a range of approaches. The ICDS Plan must establish at least one beneficiary advisory committee and a process for that committee to provide input to the governing board. The ICDS Plan must also demonstrate that the advisory committee composition reflects the diversity of the ICDS enrollee population, and participation of individuals with disabilities, including Enrollees, within the governance structure of the ICDS Plan. The State will maintain additional processes for ongoing stakeholder participation and public comment, as discussed in Appendix 7.

9. **ICDS Plan Customer Service Representatives:** CMS and the State shall require ICDS Plans to employ or contract with sufficient numbers of customer service representatives who shall answer all inquiries and respond to Enrollee complaints and concerns. In addition, CMS and the State shall themselves employ or contract with sufficient call center and customer service representatives to address Enrollee questions and concerns. ICDS Plans, CMS, and the State shall work to assure the language and cultural competency of customer service representatives to adequately meet the needs of the Enrollee population. All services must be culturally and linguistically appropriate and accessible. More detailed information about customer service requirements is included in Appendix 7.

10. **Privacy and Security:** CMS and the State shall require all ICDS Plans to ensure privacy and security of Enrollee health records, and provide for access by Enrollees to such records as specified in the three-way contract.

11. **Integrated Appeals and Grievances:** As referenced in section F and Appendix 7, Medicare-Medicaid beneficiaries will have access to an integrated appeals and grievance process.

12. **Limited Cost Sharing:** ICDS Plans will not charge Medicare Parts C or D premiums, nor assess any cost sharing for Medicare Parts A and B services. For drugs and pharmacy products (including both those covered by both Medicare Part D and Ohio Medicaid), Plans will be permitted to charge co-pays to individuals currently eligible to make such payments. Co-pays charged by ICDS Plans for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy, although plans may elect to reduce this cost sharing for all Enrollees as a way of testing whether reducing Enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the Demonstration. ICDS Plans will not assess any cost sharing for Ohio Medicaid services, beyond the pharmacy cost sharing described herein.

13. **No Balance Billing:** No Enrollee may be balance billed by any provider for any reason for covered services.

F. INTEGRATED APPEALS AND GRIEVANCES

1. **ICDS Plan Grievances and Internal Appeals Processes:** CMS and the State agree to utilize a unified set of requirements for ICDS Plan grievances and internal appeals processes that incorporate relevant Medicare Advantage, and Medicaid managed care requirements, to create a more beneficiary-friendly and easily navigable system, which is discussed in further detail in Appendix 7 and will be specified in the three-way contract. All ICDS Plan Grievances and Internal Appeals procedures shall be subject to the review and prior approval of CMS and the State. Part D appeals and grievances will continue to be managed under existing Part D rules, and Medicaid non-Part D pharmacy appeals will be managed by Ohio Medicaid. CMS and Ohio Medicaid will work to continue to coordinate grievances and appeals for all services.

2. **External Appeals Processes:** CMS and the State agree to utilize a streamlined Appeals process that will conform to both Medicare and Medicaid requirements, to create a more beneficiary friendly and easily navigable system. Protocols will be developed to assure coordinated access to the appeals mechanism. This process and these protocols are discussed in further detail in Appendix 7. Part D appeals and grievances will continue to be managed under existing Part D rules.

G. ADMINISTRATION AND REPORTING

1. **ICDS Plan Contract Management:** As more fully discussed in Appendix 7, CMS and the State agree to designate representatives to serve on a CMS-State Contract Management team which shall conduct ICDS Plan contract management activities related to ensuring access, quality, program integrity, program compliance, and financial solvency.

   These activities shall include but not be limited to:

   - Reviewing and analyzing Health Care Effectiveness Data and Information Set (HEDIS) data, Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey data, Health Outcomes Survey (HOS) data, enrollment and disenrollment reports.
   - Reviewing any other performance metrics applied for quality withhold or other purposes.
   - Reviewing reports of Enrollee complaints, reviewing compliance with applicable CMS and/or State Medicaid Agency standards, and initiating programmatic changes and/or changes in clinical protocols, as appropriate.
   - Reviewing and analyzing reports on ICDS Plans' fiscal operations and financial solvency, conducting program integrity studies to monitor fraud, waste and abuse as may be agreed upon by CMS and the State, and ensuring that ICDS Plans take corrective action, as appropriate.
   - Reviewing and analyzing reports on ICDS Plans' network adequacy, including the Plans' ongoing efforts to replenish their networks and to continually enroll qualified providers.
   - Reviewing any other applicable ratings and measures.
   - Reviewing reports from the Ombudsman.
   - Reviewing direct stakeholder input on both plan-specific and systematic performance.
   - Responding to and investigating beneficiary complaints and quality of care issues.

2. **Day-to-Day ICDS Plan Monitoring:** CMS and the State will establish procedures for ICDS Plan daily monitoring, as described in Appendix 7. Oversight shall generally be conducted in line with the following principles:
   - The State and CMS will each retain, yet coordinate, current responsibilities toward the beneficiary such that beneficiaries maintain access to their benefits across both programs.

- CMS and the State will leverage existing protocols (for example, in responding to beneficiary complaints, conducting account management, and analyzing enrollment data) to identify and solve beneficiary access problems in real-time.

- Oversight will be coordinated and subject to a unified set of requirements. CMS-State contract management teams, as described in Appendix 7, will be established. Oversight will build on areas of expertise and capacity of the State and CMS.

- Oversight of the ICDS Plans and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and the State's Medicaid 1915(c) waiver and managed care programs.

- Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the State. Demonstration Plans will be included in all existing Medicare Advantage and Part D oversight activities, including (but not limited to) data-driven monitoring, secret shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and possibly audits.

- CMS and the State will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poor performers from the program, leveraging existing CMS tools, such as the Complaints Tracking Module or the Part D Critical Incidence Reporting System, and existing State oversight and tracking tools. Standards for removal on the grounds of poor performance will be articulated in the three-way contract.

3. **Consolidated Reporting Requirements:** CMS and the State shall define and specify in the three-way contract a Consolidated Reporting Process for ICDS Plans that ensures the provision of the necessary data on diagnosis, HEDIS and other quality measures, Enrollee satisfaction and evidence-based measures, and other information as may be beneficial in order to monitor each ICDS Plan's performance. ICDS Plans will be required to meet the encounter reporting requirements that are established for the Initiative. See Appendix 7 for more detail.

4. **Accept and Process Data:** CMS, or its designated agent(s), and the State shall accept and process uniform person-level Enrollee Data, for the purposes of program eligibility, payment, and evaluation. Submission of data to the State and CMS must comply with all relevant Federal and State laws and regulations, including, but not limited to, regulations related to HIPAA and to electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation.

This is discussed in more detail in Appendix 7. CMS and the State shall streamline data submissions for ICDS Plans wherever practicable.

H. QUALITY MANAGEMENT

1. **Quality Management and Monitoring:** As a model conducted under the authority of Section 1115A of the Social Security Act, the Demonstration and independent evaluation will include and assess quality measures designed to ensure beneficiaries are receiving high quality care. In addition, CMS and the State shall conduct a joint comprehensive performance and quality monitoring process that is at least as rigorous as Medicare Advantage, Medicare Prescription Drug, and Medicaid managed care requirements. The reporting frequency and monitoring process will be specified in the three-way contract.

2. **External Quality Reviews:** CMS and the State shall coordinate the ICDS Plan external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).

3. **Determination of Applicable Quality Standards:** CMS and the State shall determine applicable quality standards and monitor the ICDS Plans' compliance with those standards. These standards are articulated in Appendix 7 and the ICDS Plan three-way contract.

I. FINANCING AND PAYMENT

1. **Rates and Financial Terms:** For each calendar year of the Demonstration, before rates are offered to ICDS Plans, CMS shall share with the State the amount of the Medicare portion of the capitated rate, as well as collaborate to establish the data and documentation needed to assure that the Medicaid portion of the capitation rate is consistent with all applicable Federal requirements.

2. **Blended Medicare and Medicaid Payment:** CMS will make separate payments to the ICDS Plans for the Medicare A/B and Part D components of the rate. The State will make a payment to the ICDS Plans for the Medicaid component of the rate, as more fully detailed in Appendix 6.

J. EVALUATION

1. **Evaluation Data to be Collected:** CMS and the State have developed processes and protocols, as specified in Appendix 7 and as will be further detailed in the three-way

contract, for collecting or ensuring the ICDS Plans or their contractors collect and report to CMS and the State the data needed for evaluation.

2. **Monitoring and Evaluation:** CMS will fund an external evaluation. The Demonstration will be evaluated in accordance with Section 1115A(b)(4) of the Social Security Act. As further detailed in Appendix 7, CMS or its contractor will measure, monitor, and evaluate the overall impact of the Demonstration including the impacts on program expenditures and service utilization changes, including monitoring any shifting of services between medical and non-medical services. The evaluation will include changes in person-level health outcomes, experience of care, and costs by sub-population(s), and changes in patterns of primary, acute, and long-term care and support services use and expenditures, using principles of rapid-cycle evaluation and feedback. Key aspects and administrative features of the Demonstration, including but not limited to enrollment, marketing, and appeals and grievances will also be examined per qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives, and seek to isolate the effect of this Demonstration as appropriate. The State will collaborate with CMS or its designated agent during all monitoring and evaluation activities. The State and ICDS Plans will submit all data required for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements listed in the three-way contract with ICDS Plans. The State and ICDS Plans will submit both historical data relevant to the evaluation, including MSIS data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

K. EXTENSION OF AGREEMENT

The State may request an extension of this Demonstration, which will be evaluated consistent with terms specified under Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any extension request will be subject to CMS approval.

L. MODIFICATION OR TERMINATION OF MOU

The State agrees to provide notice to CMS of any State Plan or waiver changes that may have an impact on the Demonstration.

1. **Limitations of MOU**: This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the United States, its agencies, instrumentalities, or entities, its officers, employees, or

agents, or any other person. Nothing in this MOU may be construed to obligate the parties to any current or future expenditure of resources. This MOU does not obligate any funds by either of the parties. Each party acknowledges that it is entering into this MOU under its own authority.

2. **Modification**: Either CMS or the State may seek to modify or amend this MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any material modification shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.

3. **Termination**: The parties may terminate this MOU under the following circumstances:

    a. Termination without cause - Except as otherwise permitted below, a termination by CMS or the State for any reason will require that CMS or the State provides a minimum of 90 days advance notice to the other entity and 60 days advance notice is given to beneficiaries and the general public.

    b. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

    c. Termination for cause - Either party may terminate this MOU upon 30 days' notice due to a material breach of a provision of this MOU.

    d. Termination due to a Change in Law - In addition, CMS or the State may terminate this MOU upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

    If the Demonstration is terminated as set forth above, CMS shall provide the State with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Demonstration Enrollees, and, to the extent that timing permits, adheres to the phase-out plan requirements detailed below. All Enrollees must be successfully enrolled in a Part D plan prior to termination of the Demonstration.

4. **Demonstration phase-out.** Termination at the end of the Demonstration must follow the following procedures:

    a. Notification – Unless CMS and the State agree to extend the Demonstration, the State must submit a draft phase-out plan to CMS no less than 5 months before the end date of this MOU. Prior to submitting the draft phase-out plan the State must publish on

its website the draft phase-out plan for a 30-day public comment period. The State shall summarize comments received and share such summary with CMS. Both parties must agree to phase-out activities and implement such activities within 14 days of CMS approval of such agreement.

b. Phase-out Plan Requirements - The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on how beneficiary appeal rights will continue to operate during the phase-out and any plan transition), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, including plans for enrollment of all Enrollees in a Part D Plan, as well as any community outreach activities. In addition, such plan must include any ongoing ICDS Plan and State responsibilities and close-out costs.

c. Phase-out Procedures - The State must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR 431.230. If applicable, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d. FFP - If the Demonstration is terminated by either party or any relevant waivers are suspended or withdrawn by CMS, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including covered services and administrative costs of disenrolling participants.

M. SIGNATURES

This MOU is effective on this day forward December 11, 2012 through the end of the Demonstration period December 31, 2016. Additionally, the terms of this MOU shall continue

to apply to the State and ICDS Plans as they implement associated phase-out activities beyond the end of the Demonstration period.

In Witness Whereof, CMS and the State of Ohio have caused this Agreement to be executed by their respective authorized officers:

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

Marilyn Tavenner

DEC 1 1 2012

Marilyn Tavenner

Acting Administrator

December 11, 2012

John B. McCarthy

12-11-12

John B. McCarthy

Medicaid Director, Ohio Office of Medical Assistance

December 11, 2012

Appendix 1: Definitions

Appeals - An Enrollee's request for review of an ICDS Plan's (Integrated Care Delivery System health plan's) coverage or payment determination.

Beneficiaries – See covered individuals.

Care Manager – An appropriately qualified professional who is the ICDS Plan's designated accountable point of contact for each Enrollee receiving care management services. The Care Manager is responsible for directing and delegating care management duties, as needed, and may include the following: facilitating assessment of needs; developing, implementing and monitoring the care plan; and serving as the lead of the trans-disciplinary care management team.

Care Management – A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet an Enrollee's needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost effective, positive outcomes.

Center for Medicare and Medicaid Innovation (CMMI) - Established by Section 3021 of the Affordable Care Act, CMMI was established to test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under such titles.

CMS – The Centers for Medicare & Medicaid Services.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) - Beneficiary survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care.

Three-way Contract - The three-way agreement that CMS and Ohio Medicaid enters into with an ICDS Plan specifying the terms and conditions pursuant to which a participating ICDS Plan may participate in this Demonstration.

Contract Management Team - A group of CMS and Ohio Medicaid representatives responsible for overseeing the contract.

Covered Individuals - Individuals enrolled in the Demonstration, including the duration of any month in which their eligibility for the Demonstration ends.

Covered Services - The set of required services offered by the ICDS Plans.

Cultural Competence - Understanding those values, beliefs, and needs that are associated with an individuals' age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

Enrollee - See Covered Individuals.

Enrollment - The processes by which an individual who is eligible for the Demonstration is enrolled in an ICDS Plan.

Enrollee Communications - Materials designed to communicate to Enrollees plan benefits, policies, processes and/or Enrollee rights.

External Quality Review Organization (EQRO) – An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by managed care organizations to their Medicaid Enrollees.

Health Insuring Corporation (HIC)—A corporation licensed by the state that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

Healthcare Effectiveness Data and Information Set (**HEDIS)** - Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

Health Outcomes Survey (HOS) - Beneficiary survey used by the Centers for Medicare and Medicaid Services to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

Individualized Care Plan An integrated, individualized, person-centered care plan developed by the Enrollee and his or her ICDS Plan's trans-disciplinary care management team that

addresses clinical and non-clinical needs identified in the comprehensive assessment and includes goals, interventions and expected outcomes.

Integrated Care Delivery System Plan (ICDS Plan) – A HIC contracted to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees including long term services and supports.

Intermediate Care Facility for Persons with Intellectual and Developmental Disabilities (ICF-IDD) – An intermediate care facility for persons with intellectual disabilities as in compliance with applicable standards for the medical assistance program by the director of health in accordance with Title XIX of the Social Security Act.

Long Term Care Institutional Services: Long-term nursing facility services which are designed to meet an individual's needs.

Long Term Services and Supports (LTSS): A range of home and community services and supports designed to meet an individual's needs as an alternative to long term nursing facility care to enable a person to live as independently as possible.

Medically Necessary Services - Services must be provided in a way that provides all protections to covered individuals provided by Medicare and Ohio Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y. In accordance with Medicaid law and regulations, and per Ohio Medicaid, services must be covered in accordance with clinical coverage guidelines specified in Ohio Administrative Code Division 5101:3.

Medicare-Medicaid Coordination Office - Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

Medicare-Medicaid Enrollees - For the purposes of this Demonstration, individuals who are enrolled in Medicare Parts A and B and Medicaid and no other comprehensive private or public health coverage.

Medicaid - The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and Waivers thereof.

Medicare - Title XVIII of the Social Security Act, the Federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage

Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

Medicare Waiver - Generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.

Medicaid Waiver - Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act.

Ohio Department of Insurance (ODI)—The agency responsible for regulation of all insurers operating in the state of Ohio.

Ohio Medicaid – The Office of Medical Assistance (OMA), the agency responsible for administering the Medicaid program in the state of Ohio.

Ohio Revised Code (ORC)—Contains all Ohio statutes of a general and permanent nature passed by the Ohio General Assembly and signed by the governor.

Opt Out – A process by which a beneficiary can choose not to participate in the Demonstration and receive their Medicare benefits through Fee for Service (FFS) Medicare and a standalone Part D Plan; Program of All-inclusive Care for the Elderly (PACE); or Medicare Advantage.

Passive Enrollment - The process through which an eligible individual is enrolled in an ICDS Plan, when not otherwise affirmatively electing one, following a minimum 60-day notice prior to the effective date.

Privacy - Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 CFR 431.300 through 431.307, as well as relevant Ohio privacy laws.

Quality Improvement Organization (QIO) – A statewide organization that contracts with CMS to evaluate the appropriateness, effectiveness, and quality of care provided to Medicare beneficiaries.

Readiness Review - Prior to entering into a three way agreement with the State and CMS, each ICDS Plan selected to participate in the Demonstration will undergo a readiness review. The readiness review will evaluate each ICDS Plan's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new members, and provide adequate access to all Medicare- and Medicaid-covered medically necessary services. CMS and the State will use

the results to inform their decision of whether the ICDS Plan is ready to participate in the Demonstration. At a minimum, each readiness review will include a desk review and potentially a site visit to the ICDS Plan's headquarters.

Solvency - Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by the State and agreed to by CMS.

State - The State of Ohio.

Trans-disciplinary care management team – A team of appropriately qualified professionals comprised of the Enrollee, the Enrollee's family/caregiver, the ICDS Plan care manager, the waiver service coordinator, if appropriate, the primary care provider, specialists, and other providers, as applicable, that is designed to effectively meet the Enrollee's needs.

Appendix 2: CMS Standards and Conditions and Supporting State Documentation

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Integration of Benefits	Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services.	pp. 6; Addendum
Care Model	Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.	pp. 6-16
Stakeholder Engagement	State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss proposed model with relevant stakeholders. Stakeholders include, but are not limited to, beneficiaries and their families, consumer organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model.	pp. 16-19; Cover memo listing changes to proposal
	State has also established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis for the duration of the Demonstration (i.e., implementation, monitoring and evaluation), including a process for informing beneficiaries (and their representatives) of the changes related to this initiative.	p. 20

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Beneficiary Protections	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary's needs. At a minimum, States will be required to:	p. 19-20
	· Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model (e.g., participation on Participating Plan governing boards and/or establishment of beneficiary advisory boards).	p.20- 21
	· Develop, in conjunction with CMS, uniform/integrated Enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency.	pp. 21, 27
	· Ensure privacy of Enrollee health records and provide for access by Enrollees to such records.	p. 12
	· Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community.	pp. 12, 19-20
	· Ensure access to services in a manner that is sensitive to the beneficiary's language and culture, including customer service representatives that are able to answer Enrollee questions and respond to complaints/concerns appropriately.	pp. 10-12

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	· Ensure an adequate and appropriate provider network, as detailed below.	pp. 22-23
Beneficiary Protections (continued)	· Ensure that beneficiaries are meaningfully informed about their care options.	pp. 26-27
	· Ensure access to grievance and appeals rights under Medicare and/or Medicaid.	Addendum
	o *For Capitated Model*, this includes development of a unified set of requirements for Participating Plan complaints and internal appeals processes.	pp. 21
	o *For Managed FFS Model*, the State will ensure a mechanism is in place for assisting the participant in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable.	N/A
State Capacity	State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.	pp.25-27
Network Adequacy	The Demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.	pp. 22-23

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Measurement/ Reporting	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality and cost outcomes for the target population. These metrics may include, but are not limited to beneficiary experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote beneficiaries receiving high quality care and for purposes of the evaluation.	pp. 14, 23-24, 26, Addendum
Data	State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:	
	· Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models;	Addendum
	· Description of any changes to the State Plan that would affect Medicare-Medicaid Enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and	Addendum
	· State supplemental payments to providers (e.g., DSH, UPL) during the three-year period.	Addendum
Enrollment	State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting beneficiary education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.	pp. 26

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Expected Savings	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	Addendum (pending)
Public Notice	State has provided sufficient public notice, including:	
	· At least a 30-day public notice process and comment period;	p. 16-18, Proposal Appendices H and J
	· At least two public meetings prior to submission of a proposal; and	p. 16-18, Proposal Appendices H and J
	· Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals.	Addendum
Implementation	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation:	
	· Meaningful stakeholder engagement.	p. 16-18, Proposal Appendices H and J
	· Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments.	Addendum (pending)
	· Receipt of any necessary State legislative or budget authority.	N/A, no State legislative or budget authority

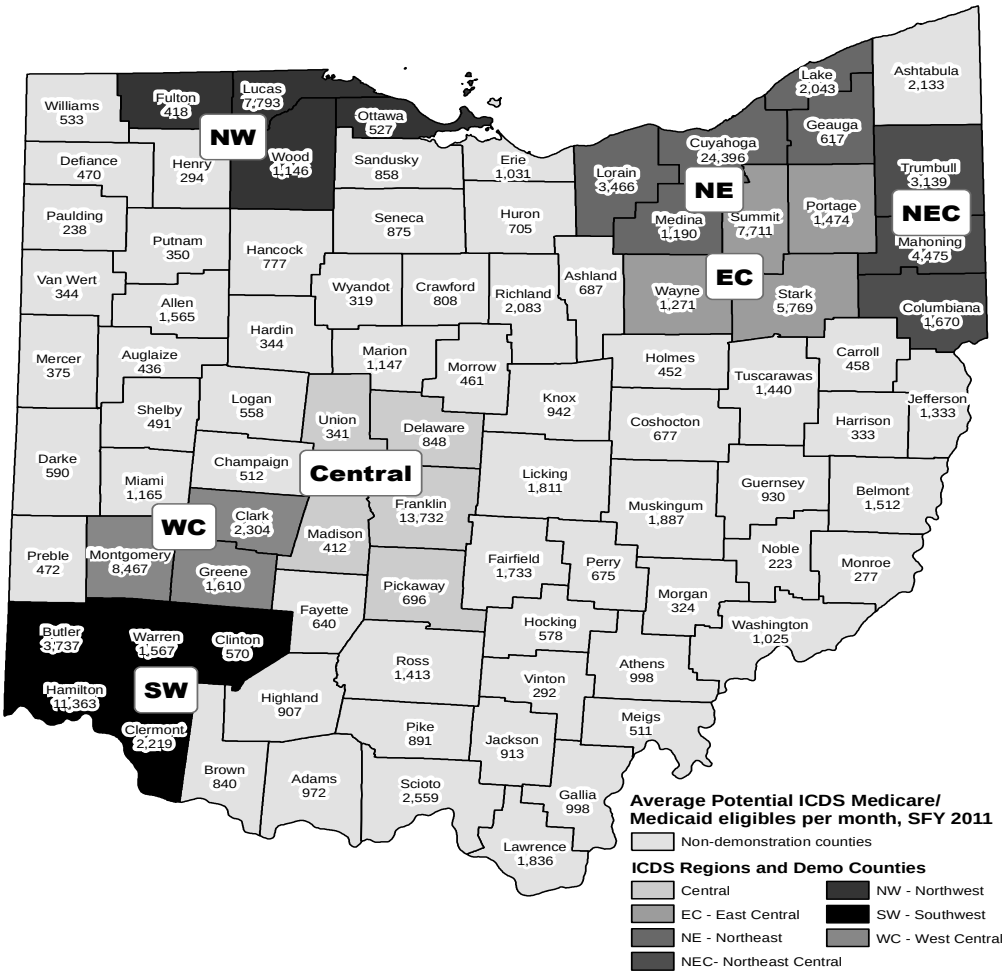
Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
		necessary
	· Joint procurement process (for capitated models only).	p. 28, Addendum
	· Beneficiary outreach/notification of enrollment processes, etc.	pp. 26-27

Appendix 3: Details of State Demonstration Area

The Demonstration Area consists of 29 counties grouped into seven regions , as highlighted in the map below.

Central: Delaware, Franklin, Madison, Pickaway, and Union counties
East Central: Portage, Stark, Summit, and Wayne counties
Northeast: Cuyahoga, Geauga, Lake, Lorain, and Medina counties
Northeast Central: Columbiana, Mahoning, and Trumbull counties
Northwest: Fulton, Lucas, Ottawa, and Wood counties
West Central: Clark, Greene, and Montgomery counties
Southwest: Butler, Clermont, Clinton, Hamilton, and Warren counties

Ohio ICDS Regions



Appendix 4: Medicare Authorities and Waivers

Medicare provisions described below are waived as necessary to allow for implementation of the Demonstration. Except as waived, Medicare Advantage and Medicare Part D provide the authority and statutory and regulatory framework for the operation of the Demonstration to the extent that Medicare (versus Medicaid) authority applies. Unless waived, all applicable statutory and regulatory requirements of the Medicare program for Medicare Advantage plans that provide qualified Medicare Part D prescription coverage, including Medicare Parts A, B, C, and D, shall apply to ICDS Plans and their sponsoring organizations for the Demonstration period beginning September 1, 2013 through December 31, 2016, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing Medicare manuals will be noted and reflected in an appendix to the three-way contracts.

Under the authority at Section 1115A of the Social Security Act, codified at 42 U.S.C. 1315a, the Center for Medicare and Medicaid Innovation is authorized to "…test payment and service delivery models …to determine the effect of applying such models under [Medicare and Medicaid]." 42 U.S.C. 1315a(b)(1). One of the models listed in Section 1315a(b)(2)(B) that the Center for Medicare and Medicaid Innovation is permitted to test is "[a]llowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals." § 1315a(b)(2)(B)(x). Section 1315a(d)(1) provides that "The Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) [of the Social Security Act] as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b)."

Pursuant to the foregoing authority, CMS will waive the following Statutory and Regulatory requirements:

- Section 1851(a), (c), (e), and (g) of the Social Security Act, and implementing regulations at 42 CFR 422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in ICDS Plans to Medicare-Medicaid beneficiaries who are over the age of 18, including beneficiaries who may have end-stage renal disease, and (2) the passive enrollment process provided for under the Demonstration.

- Sections 1853, 1854, 1857(e), 1860D-11, 1860D-13, 1860D-14, and 1860D-15 of the Social Security Act, and implementing regulations at 42 CFR 422, Subparts F and G, and 423, Subparts F and G, only insofar as such provisions are inconsistent with the

methodology for determining payments, medical loss ratios and Enrollee liability under the Demonstration as specified in this MOU, including Appendix 6, which differs as to the method for calculating payment amounts and medical loss ratio requirements, and does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under Sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.

- The provisions regarding deemed approval of marketing materials in Sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 CFR 422.2266 and 423.2266, with respect to marketing and Enrollee communications materials in categories of materials that CMS and the State have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and the State have agreed to approval.

- Sections 1852 (f) and (g) and implementing regulations at 42 CFR 422, Subpart M, only insofar as such provisions are inconsistent with the grievance and appeals processes provided for under the Demonstration.

- Section 1860D-14(a)(1)(D) and implementing regulations at 42 CFR 423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the low-income subsidy be greater than $0, to permit ICDS Plans to reduce Part D cost sharing below the levels required under Section 1860D-14(a)(1)(D)(ii) and (iii).

Appendix 5: Medicaid Authorities and Waivers

All requirements of the Medicaid program expressed in law and regulation, not expressly waived in this list, shall apply to the Demonstration beginning September 1, 2013 through December 31, 2016, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing sub-regulatory guidance will be noted and reflected in an appendix to the three-way contracts.

This Demonstration and the additional authority referenced below are contingent upon CMS-approved Social Security Act Section 1915(b) and 1915(c) authority. The State must meet all requirements of any approved Medicaid waiver authority as expressed in the terms of those waivers, including, but not limited to, all financial, quality, reporting and monitoring requirements of the waiver, and State financing contained in the State's waiver must be in compliance with Federal requirements. To date, CMS has not received from the State a 1915(b) or 1915(c) waiver application. This MOU does not indicate or guarantee CMS approval of the Section 1915(b) and 1915(c) waivers.

Assessment of actuarial soundness under 42 CFR 438.6, in the context of this Demonstration, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration.

1115A Medicaid Waivers

Under the authority of Section 1115A of the Social Security Act the following waivers of State Plan requirements contained in Section 1902 and 1903 of the Social Security Act are granted to enable the State of Ohio (State) to carry out the State Demonstration to Develop an Integrated Care Delivery System for dual eligible individuals. These authorities shall be in addition to those in the State Plan and the Section 1915(b) and 1915(c) waivers.

Provisions Related to Contract Requirements - Section 1903(m)(2)(A)(iii) (as implemented in 42 C.F.R. 438.6)

- Waiver of contract requirement rules at 42 CFR 438.6(a), insofar as its provisions are inconsistent with methods used for prior approval under this Demonstration.

Appendix 6: Payments to ICDS Plans

The Centers for Medicare and Medicaid Services and the State of Ohio will enter into a joint rate-setting process based on the following principles:

(1) Medicare and Medicaid will each contribute to the total capitation payment consistent with baseline spending contributions;
(2) Demonstration savings percentages assume that ICDS Plans are responsible for the full range of services covered under the Demonstration;
(3) Aggregate savings percentages will be applied equally to the Medicaid and Medicare A/B components; and
(4) Both CMS and the State will contribute to the methodologies used to develop their respective components of the overall blended rate as summarized in Figure 6-2 and further described below.

Figure 6-1 below outlines how the Demonstration Years will be defined for the purposes of this effort. (Note: rate updates will take place on January 1st of each calendar year, with changes to savings percentages and quality withholds applicable on a Demonstration Year basis.)

Figure 6-1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1	September 1, 2013 – December 31, 2014
2	January 1, 2015 – December 31, 2015
3	January 1, 2016 – December 31, 2016

Figure 6-2: Summary of Payment Methodology under Ohio Integrated Care Delivery System

Rate Element	Medicare A/B	Medicare D	Medicaid
2013 Baseline costs for the purposes of setting payment rates Medicare baseline spending will be	Blend of Medicare Advantage payments and Medicare standardized Fee-For-Service weighted by where Medicare-Medicaid Enrollees who meet the criteria and who are expected	National average monthly bid amount (NAMBA) will be used as the baseline for the direct subsidy portion of Part D spending.	Medicaid capitation rates through the 1915(b) waiver program that would apply for beneficiaries in the target population but not enrolled in the Demonstration.

Rate Element	Medicare A/B	Medicare D	Medicaid
established prospectively on a calendar year basis for each Demonstration county. Medicaid baseline spending amounts shall be set up front and will be applied in future years unless more recent historical data are available and/or CMS' actuaries and the State determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.	to transition into the Demonstration are enrolled in the prior year. Baseline costs will be calculated as a per member per month (PMPM) standardized cost.	Note that additional costs associated with low-income subsidy payments, reinsurance payments, and risk-sharing are included in the Part D baseline for the purposes of tracking and evaluating Part D costs but not for the purposes of setting payment rates. These amounts will be factored into plan payments, but these amounts are subject to reconciliation consistent with Part D reconciliation rules.	
Responsible for producing data	CMS	CMS	Ohio Medicaid
Savings percentages	Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 4%	Not Applicable	Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 4%
Risk adjustment	Medicare Advantage CMS-HCC Model	Part D RxHCC Model	State developed risk adjustment methodology using a member enrollment mix adjustment (MEMA), as referenced in section I.

Rate Element	Medicare A/B	Medicare D	Medicaid
Quality withhold	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3%	Not applied	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3%
Risk Sharing	Minimum Medical Loss Ratio (MMLR)	Existing Part D processes will apply	MMLR

I. Underlying Rate Structure for Medicaid Components of the Rates

The rating categories to be utilized for the Medicaid component of the rates in the Demonstration are described below.

Rating Category Rate Cell	Description
Community Well	• Enrollees who do not meet a Nursing Facility Level of Care (NFLOC) standard • Rates will vary by the following age groups: 18–44; 45–64 and 65+ • Rates will vary for the seven contracting regions
Nursing Facility Level of Care	• Single rate cell for all individuals meeting a NFLOC as determined initially through waiver enrollment or 100 or more consecutive days in a nursing facility • Single rate cell for each contracting region, but there will be a member enrollment mix adjustment (MEMA) that will provide more revenue to Plans that have a greater proportion of high risk/cost individuals (e.g. nursing facility residents or high cost 1915(c) waiver participants) compared to Plans with a lower proportion of high risk/cost individuals • Once a NFLOC recipient is determined to no longer need NFLOC services, either nursing facility or HCBS, the Plan continues to receive the higher NFLOC capitation rate for three full months following the change in determination. Beginning with the fourth month, the Plan would receive the lower Community Well capitation rate.

II. Baseline spending and payment rates for target population in the Demonstration area.

Baseline spending is an estimate of what would have been spent in the payment year had the Demonstration not existed. Medicare baselines will be expressed as standardized (1.0) amounts and applicable on a calendar year basis. The baseline costs include three components: Medicaid, Medicare Parts A and B, and Medicare Part D. Payment rates will be determined by applying savings percentages (see sections III and IV) to the baseline spending amounts.

A. Medicaid:

   a. The State and its actuaries will establish actuarially sound capitation rates for the 1915(b) waiver program for beneficiaries in the target population for this Demonstration. Those rates will serve as the baseline Medicaid costs.

   b. CMS and its contractors will review the underlying Medicaid data and assumptions used to establish the rates.

   c. Upon request throughout the Demonstration, the State and its actuaries will provide the underlying data for 1915(b) rate calculations to the CMS contracted actuary for review and validation.

   d. Medicaid payment rates will be determined by applying annual savings percentages (see section III and IV) to the applicable 1915(b) capitation rates.

B. Medicare Part A/B:

   a. CMS will develop baseline spending (costs absent the Demonstration) and payment rates for Medicare A and B services using estimates of what Medicare would have spent on behalf of the beneficiaries absent the Demonstration.

   b. The Medicare baseline rate for A/B services will be a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

   c. Medicare A/B payment rates will be determined by applying the annual savings percentages (see section III and IV) to the baseline spending amounts.

d. Both baseline spending and payment rates under the Demonstration for Medicare A/B services will be calculated as PMPM standardized amounts for each county participating in the State's Demonstration for each year. Beneficiary risk scores will be applied to the standardized payment rates at the time of payment.

e. Depending on the definition of the Demonstration-eligible group, CMS may require the State to provide a data file for beneficiaries who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline spending. CMS will specify the format and layout of the file.

f. The Medicare portion of the baseline will be updated annually consistent with the annual Fee-For-Service (FFS) estimates and benchmarks released each year with the annual rate announcement.

g. CMS annually applies a coding intensity adjustment factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for 2013 is 3.41%. The majority of new ICDS Plan Enrollees will come from Medicare FFS, and 2013 ICDS Plan risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the ICDS Plans themselves. Therefore, CMS will not apply the coding intensity adjustment factor in calendar year 2013 to reflect the fact that a high percentage of Enrollees were receiving care in FFS Medicare and thus there should be no coding pattern differences for which to adjust. After calendar year 2013, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all ICDS Plan Enrollees.

C. Medicare Part D:

a. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

The CY 2013 Part D NAMBA is $79.64.

III. Aggregate savings percentages under the Demonstration.

A. Both parties agree that there is reasonable expectation for achieving savings while paying ICDS Plans capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to beneficiary needs.

B. For the State of Ohio, the savings percentages will be:

    a. Demonstration Year 1: 1%

    b. Demonstration Year 2: 2%

    c. Demonstration Year 3: 4%

    Rate updates will take place on January 1st of each calendar year, however savings percentages will be calculated and applied based on Demonstration Years.

IV. Apply aggregate savings percentages to Medicare A/B and Medicaid components of the integrated rate.

The aggregate savings percentages identified above will be applied to the Medicare A/B and Medicaid components of the rate. The Medicaid savings percentages may vary by Rating Category, but will in the aggregate equal the savings percentages identified above. Changes to the savings percentages under section III of Appendix 6 would only occur if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration.

Savings percentages will not be applied to the Part D component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

V. Risk adjustment methodology.

A. The Medicare A/B Demonstration county rate will be risk adjusted based on the risk profile of each enrolled beneficiary. The existing CMS-HCC risk adjustment methodology will be utilized for the Demonstration.

B. The Medicare Part D national average bid will be risk-adjusted in accordance with existing Part D RxHCC methodology.

C. The Medicaid component will employ the rating categories described in I above:

a. For the NFLOC members, the relative risk/cost differences of major and objectively identifiable sub-populations included in each base rate cell will be considered by using a member enrollment mix adjustment (MEMA). The MEMA utilizes the particular waiver enrollment and nursing facility placement of the NFLOC member to provide more revenue to plans that have a greater proportion of high risk/cost individuals and, conversely, less revenue to plans that have a lower proportion of high risk/cost individuals. The adjustment is budget neutral.

b. Rates will vary for the seven contracting regions, with a MEMA adjustment as mentioned above to account for enrollment variations by Plan.

VI. Quality withhold policy for Medicaid and Medicare A/B components of the integrated, risk-adjusted rate.

A. Under the Demonstration, both payers will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to ICDS Plans' performance consistent with established quality thresholds. These thresholds are based on a combination of certain core quality withhold measures (across all Demonstrations), as well as State-specified quality measures.

B. Withhold Measures in Demonstration Year 1.

a. Figure 6-3 below identifies core withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for the 1% withhold. Additional detail regarding the agreed upon measures will be included in the three-way contract.

b. Because Demonstration Year 1 crosses calendar/contract years, ICDS Plans will be evaluated to determine whether they have met required quality withhold requirements at the end of both CY 2013 and CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Figure 6-3: Quality Withhold Measures for Demonstration Year [1]

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of Enrollees with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Customer Service (for CY 2014 only)	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	AHRQ/CAHPS	X	
Documentation of care goals	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Nursing Facility Diversion Measure	Reporting of the number of Enrollees who lived outside the NF during the current measurement year as a proportion of the Enrollees who lived outside the NF during the previous year. Nursing Facility Diversion Rate: Numerator: of those Enrollees in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year. Denominator: Enrollees enrolled in ICDS plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any member with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.	State-defined measure		X

C. Withhold Measures in Demonstration Years 2 and 3.

a. The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3 and will be based on performance on the core Demonstration and State specified measures. Figure 6-4 below identifies the quality withhold measures for Demonstration Years 2 and 3.

Figure 6-4: Quality Withhold Measures for Demonstration Years 2 and 3

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Plan all-cause readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Follow-up after hospitalization for mental illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Screening for clinical depression and follow-up care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X
Part D medication adherence for oral diabetes medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	X
Nursing Facility Diversion Measure	Reporting of the number of Enrollees who lived outside the NF during the current measurement year as a proportion of the Enrollees who lived outside the NF during the previous year. Nursing Facility Diversion Rate: Numerator: of those Enrollees in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year. Denominator: Enrollees enrolled in ICDS plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any member with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.	State-defined measure		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Long Term Care Overall Balance Measure	Reporting of the number of Enrollees who did not reside in a NF as a proportion of the total number of Enrollees in an ICDS Plan. Numerator: of those Enrollees in the denominator, those who did not reside for more than 100 continuous days in a NF during the current measurement year. Denominator: Enrollees in an ICDS Plan eleven out of twelve months during the current measurement year. Exclusions: Any member with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.	State-defined measure		X

(Note: Part D payments will not be subject to a quality withhold, however ICDS Plans will be required to adhere to quality reporting requirements that currently exist under Part D.)

b. Additional detail regarding the agreed upon measures will be included in the three-way contract.

VII. Payments to ICDS Plans.

A. CMS will make separate monthly risk-adjusted payments to the ICDS Plans for the Medicare A/B and Part D components of the rate, based on standardized Demonstration payment rates. Medicare A/B payments and Part D payments will be subject to the same payment adjustments that are made for payments to Medicare Advantage and Part D plans, including but not limited to adjustments for user fees and Medicare Secondary Payer adjustment factors.

B. The State will make a payment to the ICDS Plans for the Medicaid component of the rate subject to the rate structure specified in Section I and adjusted for MEMA.

C. The capitated payment from CMS and the State is intended to be adequate to support access to and utilization of covered services, according to Enrollee Individualized Care Plans. CMS and the State will jointly monitor access to care and overall financial viability of Plans accordingly.

VIII. Evaluate and pay ICDS Plans relative to quality withhold requirements.

A. CMS and the State will evaluate Plan performance according to the specified metrics required in order to earn back the quality withhold for a given year. CMS and the State will share information as needed to determine whether quality requirements have been met and calculate final payments to each ICDS Plan from each payer.

B. Whether or not each Plan has met the quality requirements in a given year will be made public, as will relevant quality results of ICDS Plans in Demonstration Years 2 and 3.

IX. Minimum Loss Ratio, Reconciliation, and Rate Review

A. **Minimum Loss Ratio**: Beginning in calendar year 2014, each ICDS Plan will be required each year to meet a Minimum Medical Loss Ratio (MMLR) threshold which regulates the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments) that must be used for expenses either directly related to medical claims or those which are related to the care and quality of Enrollees.

   a. If an ICDS Plan has an MMLR between 85% and 90% of the joint Medicare and Medicaid payment to the ICDS Plans, the State and CMS may require a corrective action plan or levy a fine on the plan. Any collected fine would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis.

   b. If an ICDS Plan has an MMLR below 85% of the joint Medicare and Medicaid payment to the ICDS Plans, the ICDS plan must remit the amount by which the 85% threshold exceeds the plan's actual MMLR multiplied by the total applicable revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis.

   The three-way contracts will include additional specifications on the MMLR. To the maximum extent possible, the methodology for calculating the MMLR will conform to prevailing regulatory requirements applicable to the others products offered by organizations operating ICDS Plans.

B. **Cost Reconciliation**: Cost reconciliation under Part D will continue as-is under the Demonstration. CMS will monitor Part D costs closely on an ongoing basis. Any material increase in Part D costs relative to the baseline may be factored into future Demonstration Year savings percentages.

C. **Rate Review Process**: CMS and the State will review ICDS Plan financial reports, encounter data, and other information to assess the ongoing financial stability of the ICDS Plans and the appropriateness of capitation payments. At any point, the State may request that CMS staff review documentation from specific plans to assess financing issues.

In the event that two or more ICDS Plans show MMLRs below 90% over all regions in which those plans participate, or in the event that two or more ICDS Plans show annual losses exceeding 5% over all regions in which those plans participate, CMS will convene the following parties, or their designees, to assess the factors resulting in the payment or loss and, as warranted, evaluate the payment parameters, including the respective projected baselines, savings targets, and risk adjustment methodology: (1) CMS participants: Administrator, Chief Actuary or his/her designee, Director of the Center for Medicare, Director of the Center for Medicaid and CHIP Services, Director of the Medicare-Medicaid Coordination Office; (2) Office of Management and Budget participants: Medicare Branch Chief, Medicaid Branch Chief; (3) State participants: Medicaid Director and actuarial consultant. These parties will review available data, as applicable, including data on enrollment, utilization patterns, health plan expenditures, and risk adjustment to assess the appropriateness of capitation rates and identify any potential prospective adjustments that would ensure the rate-setting process is meeting the objective of Medicare and Medicaid jointly financing the costs and sharing in the savings.

X. Payments in Future Years and Mid-Year Rate Adjustments.

A. Rates will be updated using a similar process for each calendar year. Changes to the baseline outside of the annual Medicare Advantage rate announcement would occur only if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in enrollment assumptions; major changes in Federal law and/or State policy; and changes in coding intensity.

B. If Congress acts to delay or replace the Sustainable Growth Rate (SGR) formula used to adjust Medicare physician payment rates, CMS will adjust the Medicare baseline for beneficiaries who otherwise would have been enrolled in Original Fee-for-Service Medicare to reflect the revised current law physician payment rates. If Congress acts after the SGR cuts are scheduled to go in effect but applies changes retroactively, CMS will adjust the rates retroactively as well.

If other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and the State to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

C. Changes to the savings percentages would occur if and when CMS and the State jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

Appendix 7: Demonstration Parameters

The purpose of this appendix is to describe the parameters that will govern this Federal-State partnership; the parameters are based upon those articulated by CMS in its January 25, 2012 and March 29, 2012 Health Plan Management System (HPMS) guidance. CMS and the State have further negotiated these parameters, as specified below.

The following sections explain details of the Demonstration design, implementation and evaluation. Where waivers from current Medicare and Medicaid requirements are required, such waivers are indicated. Further detail on each of these areas will be provided in the three-way contract.

I. State of Ohio Delegation of Administrative Authority and Operational Roles and Responsibilities

The Ohio Office of Medical Assistance (OMA or Ohio Medicaid) is the single state agency for the Medicaid program. The Ohio Medicaid Director oversees Medicaid operations and will be involved with implementing and monitoring the Demonstration. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across Ohio Medicaid as described below.

Overall responsibility for development of the ICDS program model and implementation plan rests with the Ohio Medicaid Director, who will chair 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 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.

II. Plan or Qualified Entity Selection

In April 2012, in consultation with CMS, Ohio Medicaid released a Request for Applications (RFA) that included Ohio and CMS requirements to become an ICDS Plan under this Demonstration. Ohio's RFA is available for review at the following website: http://jfs.ohio.gov/rfp/R1213078038ICDS.stm.

Ohio received a total of ten (10) responses to the RFA. One applicant subsequently withdrew from consideration, leaving nine (9) responses to be evaluated. After a thorough and comprehensive review of the responses submitted by the applicants and, after responding to protests received from five (5) of the applicants, on August 27, 2012, Ohio selected five (5)

applicants to operate ICDS in the seven (7) regions to be included in the Demonstration[1]. Applicants were also required to meet the Medicare components of the plan selection process, including submission of a successful Medicare Part C and Part D application to CMS, and adherence to any annual contract renewal requirements and guidance updates, as specified in Appendix 7.

These selections are contingent on the selected entities passing a CMS and state sponsored readiness review. Upon final selection, the State and CMS will ultimately enter into a three-way contract with selected plans.

Any future revisions to the final selections will be presented to CMS for prior approval.

III. State Level Enrollment Operations Requirements

a. Eligible Populations/Excluded Populations - As described in the body of the MOU.

b. Enrollment, and Disenrollment Processes – All enrollment and disenrollment transactions will be processed through the Ohio Enrollment vendor, except those transactions related to non-Demonstration plans participating in Medicare Advantage. Ohio Medicaid (or its vendor) will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third party CMS designates to receive such transactions. CMS will also submit a file to Ohio Medicaid identifying individuals who have elected a Medicare Advantage plan that is not an ICDS Plan. Ohio Medicaid will share enrollment, disenrollment and opt-out transactions with contracted ICDS Plans.

c. Uniform Enrollment/ Transfer and Opt-Out Letter and Forms - Letters and forms will be made available to stakeholders by both CMS and the State.

d. Enrollment Effective Date(s) - All enrollment effective dates are prospective. Beneficiary-elected enrollment is the first day of the month following a beneficiary's request to enroll, or the first day of the month following the month in which the beneficiary is eligible, as applicable for an individual Enrollee. Passive enrollment is effective no sooner than 60 days after beneficiary notification of the right to select an ICDS Plan.

1 The selections are posted at the following web address:
http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=CEnFHbwxoYg%3d&tabid=105

i. ICDS Plans will be required to accept opt-in enrollments no earlier than 90-days prior to the initial effective date of September 1, 2013, and begin providing coverage for enrolled individuals on September 1, 2013.

ii. The State will initially conduct three passive enrollment periods for those beneficiaries who have not made a plan selection. The effective dates for the first three of these periods are tentatively as follows:

    1. Beneficiaries in the Northeast region will have an enrollment effective date of October 1, 2013.

    2. Beneficiaries in the Northwest, Northeast Central and Southwest regions will have an enrollment effective date of November 1, 2013.

    3. Beneficiaries in the East Central, Central and West Central regions will have an enrollment effective date of December 1, 2013.

The effective dates above are subject to ICDS Plans meeting CMS and State requirements including Plans' capacity to accept new Enrollees. Effective September 1, 2013, beneficiaries in any participating region may opt-in at any time prior to the regional phase-in dates above.

iii. The State will provide notice of the requirement to select an ICDS Plan at least 60 days prior to the effective date of a passive enrollment period, and will accept opt-out requests prior to the effective date of enrollment. This notice will explain the beneficiary's options, including the option to opt-out of the Demonstration.

iv. Thirty days prior to the enrollment effective dates above, a second notice will be provided to beneficiaries who have not responded to the initial notice. The notice will include the name of the ICDS Plan in which the beneficiary would be enrolled unless he/she selects another plan or reinforces the option to opt out of the Demonstration. Ohio will proceed with passive enrollment into the identified ICDS Plan for beneficiaries who do not make a different choice, with an effective date of the first day of the month referenced in section d.ii, above.

v. Requests to change ICDS Plans, opt out, or enroll with an ICDS Plan will be accepted at any point after enrollment occurs and are effective on the first of the following month. Any time an individual requests to opt out of the Demonstration, the State will send a letter confirming the opt-out and

providing information on the benefits available to the beneficiary once they have opted out.

vi. Beneficiaries who otherwise are included in Medicare reassignment effective January 1, 2013 or from their current (2012) Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP, will be eligible for passive enrollment, with an opportunity to opt-out, into an ICDS Plan effective, as follows:

1. Those reassigned to a new PDP effective January 1, 2013, will be eligible for passive enrollment into an ICDS Plan effective January 1, 2014.

   The State and CMS must agree in writing to any changes to the enrollment effective dates. CMS will provide identifying information to the State about eligible beneficiaries no later than 120 days prior to the date of the first passive enrollment period.

e. No enrollments will be accepted within 6 months (or less) of the end of the Demonstration.

f. Notification of plan selection and enrollment options will be provided by the State to each beneficiary not less than 60 calendar days prior to the effective date of the proposed enrollment.

g. Passive enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto-assignment for individuals with the Part D Low Income Subsidy.

h. The State will develop an "intelligent assignment" algorithm for passive enrollment (e.g. that prioritizes continuity of providers and/or services). The algorithm will consider beneficiaries' previous managed care enrollment and historic provider utilization.

i. The State will provide customer service, including mechanisms to counsel beneficiaries notified of passive enrollment and to receive and communicate beneficiary choice of opt out to CMS via transactions to CMS' MARx system. Beneficiaries will also be provided a notice upon the completion of the opt-out process. Medicare resources, including 1-800-Medicare, will remain a resource

for Medicare beneficiaries; calls related to ICDS enrollment will be referred to the State Enrollment Vendor for customer service and enrollment support.

j. CMS and the State will jointly approve all Demonstration notices to ensure complete and accurate information is provided in concert with other Medicare communications, such as the Medicare & You handbook. CMS may also send a jointly-approved notice to individuals, and will coordinate such notice with any State notice(s).

k. State and CMS systems will be reconciled on a timely basis to resolve discrepancies between systems.

IV. State Level Delivery System Requirements

a. State Requirements for Care Management - Care management services will be available to all ICDS Enrollees. ICDS Plans will be expected to address the following components as part of their comprehensive programs. Through the readiness review process, CMS and the State will review ICDS Plan capacity to deliver care management services. The State will also review and approve the ICDS plans' care management programs to ensure that all required components are adequately addressed.

    i. Identification strategy: The ICDS Plans will develop and implement an identification strategy that uses a combination of predictive-modeling software, health risk assessment tools, functional assessments, referrals, administrative claims data, etc. The plan's identification strategy will consider medical, mental health, substance use, long term care and social needs. Criteria and thresholds will be established by the plans and applied to the identification data in order to prioritize the timeframe by which Enrollees will receive a timely initial comprehensive assessment.

    ii. Risk or Acuity stratification level: ICDS Plans will develop a risk or acuity stratification level for the purposes of resource allocation and targeting interventions to beneficiaries at greatest risk. The risk or acuity stratification will consist of the following: the number of levels and if they are risk or acuity based; the criteria for each of the levels; how the assigned level will be communicated to the provider and the Enrollee; and a minimum contact schedule and staffing ratio for each level.

    iii. Comprehensive Assessment: Each Enrollee shall receive, and be an active participant in, a timely comprehensive assessment of medical, behavioral health, LTSS, and social needs completed by the ICDS care

management team. Assessment domains will include, but not be limited to, the following: social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as the Enrollees' preferences, strengths, and goals. Relevant and comprehensive data sources, including the Enrollee, providers, family/caregivers, etc., shall be used by the ICDS Plans. Results of the assessment will be used to confirm the appropriate acuity or risk stratification level for the Enrollee and as the basis for developing the integrated, individualized care plan. The Enrollee will continue to receive any LTSS in their existing care plan during this time period and all transition requirements for services, as outlined in the MOU, will be adhered to.

Upon enrollment in the ICDS, all Enrollees will receive a comprehensive assessment to be completed no later than 90 days from the individual's enrollment date. A comprehensive assessment will be completed at least once every twelve months after the initial assessment completion date. The assessment must be updated when there is a change in the Enrollee's health status or needs, a significant health care event (e.g., hospital admission or transition between care settings), or as requested by the Enrollee, his/her caregiver or his/her provider. Updates to the assessment may be triggered by a hospital admission, transition between care settings, change in functional status, loss of a caregiver, change in diagnosis, or as requested by a member of the care team who observes a change that requires further investigation.

Initial comprehensive assessments and the annual reassessments will be completed in person for the highest risk enrollees and for all enrollees receiving 1915 (c) home and community based waiver services. Initial comprehensive assessments and annual reassessments will be completed telephonically for Enrollees assigned to the low or medium risk levels unless an in person assessment is requested by the Enrollee, caregiver or provider. Updates to the assessment, as described previously, will be completed in person or by telephone. The Plan shall consider the reason why the assessment needs to be updated, the Enrollee's needs and health/functional status, and the preference of the Enrollee when determining if the updates will be completed in person or by telephone.

Assessments will be completed by qualified health professionals who possess an appropriate professional scope of practice, licensure, and/or credentials, and are appropriate for responding to or managing the Enrollee's needs. Examples of health professionals who may complete portions or all of the assessment include registered nurses, licensed practical nurses (under supervision of a registered nurse), social workers, mental health counselors, or certified community health workers. See Section IV.a.v. for more information related to the requirements for the trans-disciplinary team.

iv. Integrated, individualized care plan: A person-centered, individualized care plan will be developed by the ICDS care management team, with the Enrollee, his/her family members/supports, and providers, that addresses all of the clinical and non-clinical needs of the Enrollee, including integration of the waiver service plan, as appropriate, and as identified in the comprehensive assessment. Person centered care plans will contain measureable goals, interventions, and expected outcomes with completion timeframes. Continuous monitoring of the care plan will occur and any gaps in care will be addressed in an integrated manner by the ICDS Plan including any necessary revisions to the plan of care.

v. Trans-disciplinary Care Management Team: For each Enrollee, ICDS Plans will support a Trans-disciplinary Care Management Team (referred to hereafter as "the team"), led by an accountable care manager to ensure the integration of the member's medical, behavioral health, substance use, LTSS and social needs. Members of the team will consist of the Enrollee, the primary care provider, the care manager, the waiver service coordinator, others as requested by the Enrollee, and, as appropriate, specialists and the Enrollee's family/caregiver/supports. ICDS Plans will ensure that staff team members who are completing care management activities are operating within their professional scope of practice, are appropriate for responding to and meeting the individual's needs, and complying with the State's licensure/credentialing requirements. The team will be person-centered, built on the Enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

1. ICDS Plan members of the team must agree to participate in approved training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the State. This will include ADA/*Olmstead* requirements. ICDS Plans will offer similar trainings to additional members of the team: primary care providers, specialists, and the waiver service coordinator, as appropriate.

2. If an Enrollee requires 1915(c) waiver services, the waiver service coordinator identified by the ICDS Plan (i.e., either directly employed by the ICDS Plan or through a contracted, delegated arrangement with a qualified individual or community based entity) will be responsible for coordination of home- and community based services. The waiver service coordinator will be a full member of the team.

vi. Coordination with Medicaid Health Homes: Enrollees may be eligible to receive Health Home services if they meet state specified criteria and an approved Health Home operates in the Demonstration County. Enrollees may opt to receive their care management from either the ICDS Plan or the Health Home. Enrollees who opt to receive care management from the Health Home will have all of their behavioral, physical, social, and long term care needs coordinated by the Health Home. For Enrollees who receive 1915(c) home and community based services, and also choose to receive care management from a Health Home, the ICDS Plan's waiver service coordinator will be a member of the Health Home team. The waiver service plan will be integrated to the plan of care developed by the Health Home.

ICDS Plans will contract with a Health Home for the provision and payment of Health Home services. ICDS Plans and the Health Home will ensure there are no gaps or duplication in services provided to Enrollees. The approved Health Home state plan amendment(s) and the three-way contract will further specify the expectation of the Health Homes and the responsibilities of the ICDS Plans, respectively, to support and coordinate the Health Homes.

vii. Self Direction: Individuals enrolled in the 1915 (c) waiver component of the ICDS will have the opportunity to direct their own services which will include both employer and budget authority. Ohio plans to use one state-wide fiscal management services entity to assist with these activities.

viii. Area Agencies on Aging: ICDS Plans will be required to contract with Area Agencies on Aging for waiver service coordination for individuals over the age of 60. Additionally, ICDS Plans may contract with other entities to provide this service. Individuals will choose from among the waiver service coordination providers with which an ICDS Plan contracts. ICDS Plans may directly provide waiver service coordination for individuals under age 60 or may provide this by contract with a waiver service coordination entity.

b. Network Adequacy – State Medicaid standards shall be utilized for long-term supports and services, as described below, or for other services for which Medicaid is exclusive, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more stringent. Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to the more stringent of the applicable Medicare and Medicaid standards.

Ohio has developed transition requirements that specify continuation of existing providers for nursing facilities, long term supports and services and behavioral health providers (see Table 7-B, "ICDS Plan Transition Requirements at Enrollment" below). Ohio also requires that ICDS Plans provide and arrange for timely access to all medically-necessary services covered by Medicaid. Both the State and CMS will monitor access to services through survey, utilization, and complaints data to assess needs to ICDS Plan network corrective actions. In addition to these protections, minimum LTSS standards for ICDS Plans are below. Ohio will finalize the standards, based on administrative data and based on stakeholder input. CMS and the State will monitor access to care and the prevalence of needs indicated through Enrollee assessments, and, based on those findings, may require that ICDS Plans initiate further network expansion over the course of the Demonstration.

- At least two community LTSS Providers in each region for the following services: Enhanced Community Living, Homemaker, Waiver

Transportation, Nutritional Consultation, Assisted Living, Social Work Counseling, Out of Home Respite, Home Medical Equipment and Supplemental Adaptive and Assistive Devices, Independent Living Assistance and Community Transition.

- At least one adult day health and one assisted living provider within 30 miles of each zip code within the region.
- At least two community LTSS Agency Providers in each region for the following services: Personal Care and Waiver Nursing.
- At least five community LTSS Independent Providers, in addition to self-directed care options in which and Enrollee can choose his or her provider, in each region for the following services: Personal Care, Home Care Attendant, and Waiver Nursing.
- At least one community LTSS Provider in each ICDS region for the following services: Pest Control, Home Delivered Meals, Emergency Response, Home Modifications Maintenance and Repairs and Chore Services.

Networks will be subject to confirmation through readiness reviews and on an ongoing basis.

For any covered services for which Medicare requires a more rigorous network adequacy standard than Medicaid (including time, distance, and/or minimum number of providers or facilities), the ICDS Plan must meet the Medicare requirements.

Medicare network standards account for the type of service area (rural, urban, suburban, etc.), travel time, and minimum number of the type of providers, as well as distance in certain circumstances. The State and CMS may grant exceptions to these general rules to account for patterns of care for Medicare-Medicaid beneficiaries, but will not do so in a manner that will dilute access to care for Medicare-Medicaid beneficiaries. Networks will be subject to confirmation through readiness reviews.

c. Solvency—ICDS health plans will be required to meet solvency requirements:

    i. consistent with section 1903 (m) of the Social Security Act, and regulations found at 42 CFR 43 and 438.116, and;

ii. as specified in the State procurement, including rules developed by the Ohio Department of Insurance (ODI). The ODI is responsible for the licensing and monitoring of the financial solvency of health insuring corporations (HICs). All Medicaid managed care providers are required by the Managed Care Provider Agreement to be licensed by ODI as HICs pursuant to ORC Chapter 1751. Plans must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid Enrollees will not be liable for the entity's debts if the entity becomes insolvent.

d. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts-

i. ICDS Plans must adhere to managed care standards at 42 CFR 438.214 and 42 CFR 422.204, and must be accredited by NCQA and follow NCQA procedural requirements for standards for credentialing and re-credentialing.

V. Benefits

a. Medical Necessity Determinations- Medically necessary services will be defined as services:

i. (per Medicare) that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y.

ii. (per Ohio Medicaid): that are provided in accordance with Ohio Medicaid medical necessity and benefits coverage requirements documented at Administrative Code Agency and Division-Level 5101:3;

iii. Where there is overlap between Medicare and Medicaid benefits, coverage and rules will be delineated in the three-way contract; the benefits will maintain coverage to at least the extent provided by Medicare and Ohio Medicaid as outlined in both State and Federal rules. ICDS Plans will be required to abide by the more generous of the applicable Medicare and Ohio Medicaid standards.

iv. All care must be provided in accordance and compliance with the ADA, as specified by the *Olmstead* decision.

b. As a term and condition of this Demonstration, in addition to all Medicare Parts A, B and D, and Medicaid State-plan services, the ICDS Plans will be required to provide services as defined in the approved 1915 (b) and 1915 (c) waivers.

Table 7-A: Planned ICDS Waiver Services

HCBS Waiver Service	Is this service currently available under the state plan?
Adult Day Health	No
Personal Care	No. Home Health is currently available under the state plan.
Homemaker	No
Emergency Response System Service	No
Home Delivered Meals	No
Home Modification, Maintenance and Repair	No
Waiver Transportation	Yes. Service is beyond what is available via the state plan.
Out-of-Home Respite	No
Waiver Nursing Service	Yes. Scope is broader and provider pool expanded than state plan nursing (home health and private duty nursing)
Home Care Attendant Services	No
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services	Yes. Service provides coverage beyond what is available on the state plan.
Chore Services	No
Community Transition Service	No
Enhanced Community Living Service	No
Independent Living Assistance	No
Nutritional Consultation	No
Social Work Counseling	Yes. Waiver service has increase scope and increased provider pool beyond what is available in state plan.
Choices - Home Care Attendant Service	No,although state plan home health is available. Ohio has no self directed state plan services.
Alternative Meals Service	No
Pest Control	No
Assisted Living Service	No

c. Flexible Benefits – ICDS health plans will have discretion to use the capitated payment to offer flexible benefits, as specified in the Enrollee's Individualized Care Plan, as appropriate to address the Enrollee's needs.

d. Excluded Services – Habilitation and targeted case management for individuals with developmental disabilities.

e. Election of Medicare Hospice Benefit - As in Medicare Advantage, if an Enrollee elects to receive the Medicare hospice benefit, the Enrollee will remain in the ICDS Plan, but will obtain the hospice service through the Medicare FFS benefit and the ICDS would no longer receive Medicare Part C payment for that Enrollee. Medicare hospice services and all other Original Medicare services would be paid for under Medicare fee-for-service. ICDS Plans and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care, including with Medicaid and Part D benefits and any additional benefits offered under the Plans. Plans would continue to receive Medicare Part D payment, for which no changes would occur. Medicaid services and payments for hospice Enrollees must comply with the ICDS Medicaid 1915(b) waiver requirements.

f. Continuity of Care

    i. ICDS Plans must allow Enrollees to maintain current providers and service levels at the time of enrollment as described in Table 7-B.

    ii. ICDS Plans are required to provide or arrange for all medically necessary services provided by the three-way contract, whether by sub-contract or by single-case agreement in order to meet the needs of the individual/beneficiary.

Table 7-B: ICDS Plan Transition Requirements at Enrollment

Transition Requirements[2]	HCBS Waiver Enrollees	Non-Waiver Enrollees with LTC Needs (HH and PDN use)	NF Enrollees AL Enrollees	Enrollees not identified for LTC Services[3]
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
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
Chemotherapy/ 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

[3]Requirements for all Medicare and Medicaid pharmacy transition will adhere to Medicare Part D pharmacy transition requirements.

[3]Individuals who do not fall into any of the other categories depicted on this table (e.g., HCBS waiver enrollees) would be included in the "community well" rate cell.

Transition Requirements[2]	HCBS Waiver Enrollees	Non-Waiver Enrollees with LTC Needs (HH and PDN use)	NF Enrollees AL Enrollees	Enrollees not identified for LTC Services[3]
Dialysis Treatment	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.
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
Medicaid Home Health and PDN	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless: 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.	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
Assisted Living Waiver Service			Provider maintained at current rate for the life of Demonstration.	

Transition Requirements[2]	HCBS Waiver Enrollees	Non-Waiver Enrollees with LTC Needs (HH and PDN use)	NF Enrollees AL Enrollees	Enrollees not identified for LTC Services[3]
Medicaid Nursing Facility Services			Provider maintained at current Medicaid rate for the life of Demonstration.	
Waiver Services-Direct Care • **Personal Care** • **Waiver Nursing** • **Home Care Attendant** • **Choice Home Care Attendant** • **Out of Home Respite** • **Enhanced Community Living** • **Adult Day Health Services** • **Social Work Counseling** • **Independent Living Assistance**	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Plan initiated changes may not occur unless: 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.	N/A	N/A	N/A

Transition Requirements[2]	HCBS Waiver Enrollees	Non-Waiver Enrollees with LTC Needs (HH and PDN use)	NF Enrollees AL Enrollees	Enrollees not identified for LTC Services[3]
Waiver Services-All other	Maintain service at current level for 365 days and existing service provider at existing rate 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
Medicaid Community Behavioral Health Organizations (Provider types 84 & 95).	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.

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

1) Enrollee requests a change;
2) The provider chooses to discontinue providing services to an Enrollee as currently allowed by Medicare or Medicaid; or
3) The ICDS Plan, CMS, or the State identify provider performance issues that affect an Enrollee's health and welfare.

g. Out of Network Reimbursement Rules – ICDS Plans must reimburse an out-of-network provider of emergent or urgent care at the Medicare or Medicaid FFS rate applicable for that service. Where this service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies.

VI. Model of Care- All ICDS health plans (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC) having explicit components consistent with the Special Needs Plan Model of Care. Ohio's comprehensive care management program requirements summarized in Section IV will also apply and be outlined in the three-way contract and the ICDS Plan provider agreement. CMS' Demonstration plan MOC approval process will be based on scoring each of the eleven clinical and non-clinical elements of the MOC. The scoring methodology is divided into three parts: (1) a standard; (2) elements; and (3) factors. These components of the MOC approval methodology are defined below:

(1) Standard: The standard is defined as a MOC that has achieved a score of 70 percent or greater based on the scoring methodology described in Appendix 2.

(2) Elements: The MOC has 11 clinical and non-clinical elements, as identified below, and each element will have a score that will be totaled and used to determine the final overall score. The 11 MOC elements are listed below:

- Description of the Plan-specific Target Population;
- Measurable Goals;
- Staff Structure and Care Management Goals;
- Interdisciplinary Care Team;
- Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
- MOC Training for Personnel and Provider Network;
- Health Risk Assessment;
- Individualized Care Plan;
- Integrated Communication Network;
- Care Management for the Most Vulnerable Subpopulations; and
- Performance and Health Outcomes Measurement.

(3) Factors: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the Demonstration plan application. The factors for each element will be scored using a system from 0 to 4, where 4 is the highest score for a factor. Interested organizations are required to provide a response that addresses every factor within each of the 11 elements. The scores for each factor within a specific element are totaled to provide the overall score for that element out of a total of 160 possible points. Interested organizations must achieve a minimum score of 70 percent to meet the CMS approval standard.

It is CMS' intent for MOC reviews and approvals to be a multi-year process that will allow Demonstration plans to be granted up to a three-year approval of their MOC based on higher MOC scores above the passing standard. The specific time periods for approvals are as follows:

- Plans that receive a score of eighty-five (85) percent or higher will be granted an approval of the CMS MOC requirement for three (3) years.

- Plans that receive a score in the seventy-five (75) percent to eighty-four (84) percent range will be granted an approval of the CMS MOC requirement for two (2) years.

- Plans that receive a score in the seventy (70) percent to seventy-four (74) percent range will be granted an approval of the CMS MOC requirement for one (1) year.

ICDS Plans will be permitted to cure problems with their MOC submissions after their initial submissions. ICDS Plans with MOCs scoring below 85 percent will have the opportunity to improve their scores based on CMS and State feedback on the elements and factors that need additional work. At the end of the review process, ICDS Plans with MOCs that do not meet CMS' standards for approval will not be eligible for selection as Demonstration plans.

VII. Prescription Drugs- Integrated formulary must include any Medicaid-covered drugs that are excluded by Medicare Part D. Plans must also cover drugs covered by Medicare Parts A or B. In all respects, unless stated otherwise in this MOU or the three-way contract, Part D requirements will continue to apply.

VIII. Grievances – Enrollees shall be entitled to file internal grievances directly with the ICDS Plan. Each ICDS Plan must track and resolve its grievances according to applicable Medicare and Medicaid rules, or if appropriate, re-route grievances to the coverage decision or appeals processes.

IX. Appeals—Other than Medicare Part D appeals, which shall remain unchanged, the following is the approach for an integrated Medicare-Medicaid appeals process:

a. Integrated/Unified Appeals Process:

i. Integrated Notice- ICDS Plan Enrollees will be notified of all applicable Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question, developed jointly by the State and CMS.

ii. Appeal time frames- Time frames for filing appeal related to benefits will be unified.

1. Individuals, their authorized representatives and providers for Medicare service appeals will have 90 days to file an appeal related to denial or reduction or termination of authorized Medicare benefit coverage.

2. Individuals or their authorized representatives will have 90 days to file an appeal related to denial, or reduction or termination of authorized Medicaid benefits covered by the ICDS plan. ICDS Plans will be directed in the three-way contract to toll applicable time frames for Medicare service appeals that have been inappropriately made to the Bureau of State Hearings within the State instead of the plan. Such appeals will be forwarded by the Bureau of State Hearings to the ICDS Plan for a determination.

iii. Appeal levels- Enrollees will continue to have full access to the Medicare and Medicaid appeals frameworks for benefit appeals. Initial appeals for Medicare service denials, reductions and terminations will be made to the ICDS Plan; sustained decisions will be auto-forwarded to the Independent Review Entity (IRE). Initial appeals for Medicaid service denials will be made to the ICDS Plan and/or the Bureau of State Hearings. Sustained ICDS Plan decisions will not be auto-forwarded to the Bureau of State Hearings, but may be appealed by beneficiaries to the Bureau of State Hearings.

iv. Appeal resolution time frames- All appeals must be resolved by the ICDS Plan as expeditiously as the patient's condition requires, but always within 15 calendar days of request for standard appeals, and within 72 hours of request for expedited appeals. The Bureau of State Hearings will resolve appeals as expeditiously as the patient's condition requires, but always within 90 days of request for the first year of the Demonstration, 60 days of request for the 2nd year of the Demonstration, and within 30 days of request in the 3rd year. Timeframe of less than 90 days will not apply when any of the following occurs: 1.) the Bureau requests a policy/legal clarification; 2.) an act of nature or unexpected disaster causes a delay; 3.) the Bureau's receipt of the request is more than 10 days after the initial request; 4.) the beneficiary requests a delay, postponement or reschedule

of the hearing; 5.) the hearing is reconvened; or 6.) the hearing record is left open pending additional information.

v. Continuation of Benefits Pending appeal - Continuation of all non-part D benefits will be required to be provided pending internal ICDS appeals, provided the appeal is requested to the ICDS plan within the latter of applicable timeframes for making such request or the effective date of the proposed action. As provided in 42 CFR 431.211 and 230, continuations of covered Medicaid services will continue to be required when a request is made to the Bureau of State Hearings within the applicable timeframes for making such request. This means that authorized benefits will continue to be provided by providers to beneficiaries, and that ICDS Plans must continue to pay providers for providing services pending an internal ICDS appeal or state hearing request. Payments will not be recouped based on the outcome of the appeal for services covered during pending appeals. This right to aid pending an appeal currently exists in Medicaid, but generally is not currently available in Medicare.

vi. In the case of a decision where both Bureau of State Hearings and the IRE issue a ruling, the ICDS Plan shall be bound by the ruling that is most favorable to the beneficiary.

X. ICDS Plan Marketing, Outreach, and Education Activity

As indicated in the CMS "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" released on April 2, 2012, CMS Medicare Marketing Guidelines do not apply to marketing done by State governments and marketing materials created by the State do not need to be reviewed or submitted in HPMS.

a. Marketing and Enrollee Communication Standards for ICDS Plans – ICDS Plans will be subject to rules governing their marketing and Enrollee communications as specified under section 1851(h) and 1932(d)(2) of the Social Security Act; 42 CFR 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, and 423.2260 et. seq., 438.104; and the Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual). The following exceptions apply:

i. ICDS Plans will not be allowed to market directly to individual potential ICDS Enrollees. Instead, plans may participate in group marketing events, provide general audience materials (such as general circulation brochures, and media and billboard advertisements), and provide responses to beneficiary initiated requests for enrollment.

ii. CMS and Ohio will develop a process to mitigate beneficiary shifting from ICDS Plans to other plans operated by the same parent company. At a minimum, the three-way contract will identify procedures to provide additional education to Enrollees that are considering opting out of an ICDS Plan for a non-ICDS plan that may be a part of the same corporate family. Beneficiary choices regarding enrollment will be honored by CMS and the State.

b. Review and Approval of Marketing and Enrollee Communications – ICDS Plans must receive prior approval of all marketing and Enrollee communications materials in categories of materials that CMS or the State requires to be prospectively reviewed. ICDS Plan materials may be designated as eligible for the File & Use process, as described in 42 CFR 422.2262(b) and 423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and the State. CMS and the State may agree to defer to one or the other party for review of certain types of marketing and Enrollee communications, as agreed in advance by both parties. ICDS Plans must submit all marketing and Enrollee communication materials, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

c. Permissible Start Date for ICDS Plan Marketing Activity – ICDS Plans may begin marketing activity, as limited by paragraph (i) above, no earlier than 90 days prior to the effective date of enrollment for the contract year.

d. CMS and Ohio will work together to educate individuals about their ICDS options. The State's independent enrollment broker will be responsible for educating Enrollees on all potential plan choices through a variety of mechanisms. Outreach and educational activities may include letters, outreach events, and/or outbound telephone calls and will take into account the prevalence of cognitive impairments, mental illness, and limited English proficiency.

e. Minimum Required Marketing and Enrollee Communications Materials – At a minimum, ICDS Plans will provide current and prospective Enrollees the following materials. These materials will be subject to the same rules

regarding content and timing of beneficiary receipt as applicable under section 1851(h) of the Social Security Act; 42 CFR§422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, and 423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual). ICDS Plans will use a Demonstration-specific Summary of Benefits.

ii. An Evidence of Coverage (EOC) document that includes information about all State-covered and plan-covered additional benefits, in addition to the required Medicare benefits information. Additional content will be required by the State., e.g. eligibility requirements for ICDS enrollment; excluded services; member rights and responsibilities; services requiring prior authorization; self-referral services; explanation that the ICDS Plan ID card replaces the Medicare and Medicaid cards; the Enrollee's requirement to select a PCP and how to change PCP; out of network policies; the availability of 911 services; a description of the EPSDT program for members under 21 years; the right to change plans and the procedure for requesting a change; appeal, grievance and state hearing rights and required standard and expedited resolution timeframes; non-discrimination requirements; information on members' right to execute advance directives; how to contact the Office of Medical Assistance with concerns about the ICDS Plan; the structure and operation of any physician incentive plans the ICDS Plan may have in place; detailed information on co-payments required for any service; how to access additional information in alternative formats or languages; how to access the ICDS Plan provider directory; the name of the ICDS Plan's parent company and any DBA that may be used; toll-free member services and care management and nurse advice 24-hour service lines; and any other content required by state or federal regulation.

iii. An Annual Notice of Change (ANOC) summarizing all major changes to the plan's covered benefits from one contract year to the next, starting in the second year of the Demonstration.

iv. A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including co-pays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.

v. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits.

vi. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs provided under the ICDS Plan.

vii. A single identification (ID) card for accessing all covered services under the plan.

viii. All Part D required notices, with the exception of the LIS Rider, the creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the late enrollment penalty notice requirements required under Chapter 13 of the Prescription Drug Benefit Manual.

f. Notification of Formulary Changes – The requirement at 42 CFR 423.120(b)(5) that ICDS Plans provide at least 60 days advance notice regarding Part D formulary changes also applies to ICDS Plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits.

XI. Administration and Oversight

a. Oversight Framework

i. Under the Demonstration, there will be a CMS-State Contract Management Team that will ensure access, quality, program integrity, compliance with applicable laws, including but not limited to Emergency Medical Treatment and Active Labor Act (EMTALA) and ADA, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and the State will require ICDS Plans to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. ICDS Plans must have policies and procedures in place to identify and address fraud, waste, and abuse at both the plan and the third-party levels in the delivery of ICDS benefits, including prescription drugs, medical care, and long term services and supports. In addition, all Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to ICDS Plans by CMS in the same way they are currently applied for Prescription Drug Plan (PDP) sponsors and Medicare Advantage organizations.

These responsibilities are not meant to detract from or weaken any current State or CMS oversight responsibilities, including oversight by the Medicare Drug Benefit Group and other relevant CMS groups and divisions, as those responsibilities continue to apply, but rather to assure that such responsibilities are undertaken in a coordinated manner. Neither party shall take a unilateral enforcement action relating to day-to-day oversight without notifying the other party in advance.

b. The Contract Management Team

i. Structure - The Contract Management Team will include representatives from CMS and the State, authorized and empowered to represent CMS and the State about aspects of the three-way contract. Generally, the CMS members of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office Lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The precise makeup will include individuals who are knowledgeable about the full range of services and supports utilized by the target population, particularly long-term supports and services.

ii. Reporting – Data reporting to CMS and the State will be coordinated and unified to the extent possible. Specific reporting requirements and processes for the following areas will be detailed in the three-way contract.

1. Quality (including HEDIS); core measures will be articulated in the MOU.
2. Rebalancing from Institutional to HCBS Settings
3. Utilization
4. Encounter Reporting
5. Enrollee Satisfaction (including CAHPS)
6. Complaints and Appeals
7. Enrollment/ Disenrollment Rates
8. Part C and Part D Reporting Requirements, as negotiated and applicable

9. All required 1915 (b) and (c) waiver reporting

c. Day-to-Day Oversight and Coordination

The Contract Management Team will be responsible for day-to-day monitoring of each ICDS Plan. These responsibilities include, but are not limited to:

- Monitoring compliance with the terms of the three-way contract, including issuance of joint notices of non-compliance/enforcement;
- Coordination of periodic audits and surveys of the ICDS Plan;
- Receipt and response to complaints;
- Review reports from the Ombudsman;
- Reviewing direct stakeholder input on both plan-specific and systematic performance;
- Regular meetings with each ICDS Plan;
- Coordination of requests for assistance from contractors, and assignment of appropriate State and CMS staff to provide technical assistance;
- Coordinate review of marketing materials and procedures; and
- Coordinate review of grievance and appeals data, procedures, and materials.

d. Centralized Program-Wide Monitoring, Surveillance, Compliance, and Enforcement

CMS' central office conducts a wide array of data analyses, monitoring studies, and audits. Demonstration contracts will be included in these activities, just as all Medicare Advantage and Part D organizations will be included. Demonstration contracts will be treated in the same manner, which includes analysis of their performance based on CMS internal data, active collection of additional information, and CMS issuance of compliance notices, where applicable. The State and Contract Management team will be informed

about these activities and copied on notices, but will not take an active part in these ongoing projects or activities.

e. Emergency/ Urgent Situations

Both CMS and the State shall retain discretion to take immediate action where the health, safety or welfare of any Enrollee is imperiled or where significant financial risk is indicated. In such situations, CMS and the State shall notify a member of the Contract Management Team no more than 24 hours from the date of such action, and the Contract Management Team will undertake subsequent action and coordination.

f. ICDS Plan Call Center Requirements

In addition to current requirements for Medicare Advantage Plans, the following will be required call center elements:

- ICDS Plans shall operate a toll-free Enrollee services telephone line for administrative purposes. The line will be available nationwide for a minimum of twelve hours per day, Monday through Friday, except major holidays.
- To support care management, ICDS Plans shall operate a twenty-four hour, seven days a week, toll free call in system available nationwide that is staffed by appropriately trained and qualified health professionals who are able to access the Enrollee's records, assess the Enrollee's issues, and provide an appropriate course of action (i.e., medical advice, direct the Enrollee to an appropriate care setting, referral to a member of the care management team, etc.). The ICDS Plan must ensure that if care management needs are identified for an enrollee that the ICDS staff person facilitating the Enrollee's issue has access to, and is familiar with, the Enrollee's plan of care. ICDS Plans must ensure that follow-up is timely and appropriate to assure the Enrollee's health and welfare.
- Operators must be available in sufficient numbers to support Enrollees and meet CMS and Ohio specified standards.

- Plans must ensure that customer service department representatives shall, upon request, make available to Enrollees and potential Enrollees information including, but not limited to, the following:
    - The identity, locations, qualifications, and availability of providers;
    - Enrollees' rights and responsibilities;
    - The procedures available to an Enrollee and/ or provider(s) to challenge or appeal the failure of the contractor to provide a requested service and to appeal any adverse actions (denials);
    - How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;
    - Information on all ICDS Plan covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and
    - The procedures for an Enrollee to change plans or to opt out of the Demonstration.

g. Data System Specifications, Reporting Requirements, and Interoperability

    i. Data system description and architecture and performance requirements

    ii. Current information system upgrades and development plans and resource commitments necessary for implementation

    iii. Consolidated reporting requirements

    iv. Encounter reporting

    v. Reporting data for evaluation and program integrity

    vi. Data Exchange among CMS, State of Ohio Providers and Contractors, and Health Insurance Exchanges (2014)

h. Unified Quality Metrics and Reporting

ICDS Plans will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, patient/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report Medicare HEDIS, HOS and CAHPS data, as well as measures related to long term supports and services. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS plus any additional Medicaid measures identified by the State. All existing Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures. The State will also be required to report on long term supports and services as delineated in approved waivers and will coordinate the quality requirements as feasible.

A combined set of core metrics is described below in Table 7-C; more detail on the measures will be provided in the three-way contract. CMS and the State will utilize the reported measures in the combined set of core metrics for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and to allow quality to be evaluated and compared with other plans in the model. A subset of these will also be used for calculating the quality withhold payment as addressed in section VI of Appendix 6 in this MOU.

In addition, the State will apply progressive monetary sanctions tied to premium payments for not meeting minimum performance standards, as specified by the State, using a subset of the measures below in Table 7-C (denoted by the Xs in the State Specified Measure Column). This subset consists of a combination of national and State-specific metrics appropriate for Ohio's ICDS population, including measures for acute care, nursing facility care, and rebalancing and diversion from nursing facilities.

ICDS Plans must submit data consistent with requirements established by CMS and/or the State as further described below and in the three-way contract. ICDS Plans will also be subject to monitoring efforts consistent with the requirements of Medicare Advantage and Part D as described in section XII of this appendix.

Table 7-C: Core Quality Measures under the Demonstration

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Antidepressant medication management	Percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS	X	
Follow-up After Hospitalization for Mental Illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	X
Screening for Clinical Depression and Follow-up Care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
SNP1: Complex Case Management	The organization coordinates services for members with complex conditions and helps them access needed resources. Element A: Identifying Members for Case Management Element B: Access to Case Management Element C: Case Management Systems Element D: Frequency of Member Identification Element E: Providing Members with Information Element F: Case Management Assessment Process Element G: Individualized Care Plan Element H: Informing and Educating Practitioners Element I: Satisfaction with Case Management Element J: Analyzing Effectiveness/Identifying Opportunities Element K: Implementing Interventions and Follow-up Evaluation	NCQA/ SNP Structure & Process Measures	X	
SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members. Element A: Coordination of Benefits for Dual Eligible Members Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) Element D: Service Coordination Element E: Network Adequacy Assessment	NCQA/ SNP Structure & Process Measures	X	
Care Transition Record Transmitted to Health Care Professional	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	X	
Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions Element B: Supporting Members through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E; Analyzing Transitions Element F: Reducing Transitions	NCQA/ SNP Structure & Process Measures	X	
CAHPS, various settings including: -Health Plan plus supplemental items/questions, including: -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home	Depends on Survey.	AHRQ/CAHPS	X	
Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the drug plan's pharmacy help desk.	CMS Call Center data	X	
Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number.	CMS Call Center data	X	
Part D Appeals Auto–Forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.	IRE	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Part D Appeals Upheld	How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100.	IRE	X	
Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 days.	Medicare Advantage Prescription Drug System (MARx)	X	
Part D Complaints about the Drug Plan	How many complaints Medicare received about the drug plan. For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data	X	
Part D Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Administrative data	X	
Part D Members Choosing to Leave the Plan	The percent of drug plan members who chose to leave the plan in 2013.	CMS Medicare Beneficiary Database Suite of Systems	X	
Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan	X	
Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Part D Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X	
Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	X
Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
Plan Makes Timely Decisions about Appeals	Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage.	IRE	X	
Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	IRE	X	
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.	CMS Call Center data	X	
Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X	
Tracking of Demographic Information	Percent of all Demonstration participants for whom specific demographic data is collected and maintained in the ICDS Plan Centralized Enrollee Record, including race, ethnicity, disability type, primary language, and homelessness, in compliance with contract requirements.	CMS/State defined process measure		X
Documentation of Care Goals	Percent of Enrollees with documented discussion of care goals	CMS/State defined process measure		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Beneficiary Governance Board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.	CMS/State defined process measure	X	X
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	X
Assessments	Percent of Enrollees with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X	
Individualized care plans	Percent of members with care plans by specified timeframe.	CMS/State defined process measure	X	
Real time hospital admission notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure	X	
Risk stratification based on LTSS or other factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/State defined process measure	X	
Discharge follow-up	Percent of members with specified timeframe between discharge to first follow-up visit.	CMS/State defined process measure	X	
Self-direction	Percent of care coordinators that have undergone State-based training for supporting self-direction under the Demonstration.	CMS/State defined process measure	X	
Care for Older Adults – Medication Review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/ HEDIS	X	X
Care for Older Adults – Functional Status Assessment	Percent of plan members whose doctor has done a ―functional status assessment‖ to see how well they are doing ―activities of daily living‖ (such as dressing, eating, and bathing).	NCQA/HEDIS	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Care for Older Adults – Pain Screening	Percent of plan members who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS	X	X
Diabetes Care – Eye Exam	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS	X	
Diabetes Care – Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS	X	
Diabetes Care – Blood Sugar Controlled	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS	X	X
Rheumatoid Arthritis Management	Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS	X	
Reducing the Risk of Falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	X
Plan All-Cause Readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	X
Controlling Blood Pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X
Comprehensive medication review	Percentage of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA) Part D Reporting Data	X	
Complaints about the Health Plan	How many complaints Medicare received about the health plan. Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Beneficiary database	X	
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2013.	CMS	X	
Getting Information From Drug Plan	The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? • In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? • In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? • In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?	AHRQ/CAHPS	X	
Rating of Drug Plan	The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs. • Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	AHRQ/CAHPS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Getting Needed Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan. • In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? • In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	AHRQ/CAHPS	X	
Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists. • In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members can get appointments and care. • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	AHRQ/CAHPS	X	X*
Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received. • Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	AHRQ/CAHPS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Overall Rating of Plan	Percent of best possible score the plan earned from plan members who rated the overall plan. • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	AHRQ/CAHPS	X	
Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X	X
Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X	
Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for ―bad‖ (LDL) cholesterol within the past year.	NCQA/HEDIS	X	X
Diabetes Care – Cholesterol Screening	Percent of plan members with diabetes who have had a test for ―bad‖ (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	X	X*
Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	CMS HOS	X	
Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS	X	
Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS	X	X
Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X	
Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS	X	
Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS	X	
Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X	
Health Status/Function Status	Percent of members who report their health as excellent.	AHRQ/CAHPS	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Percent of residents whose need for help with daily activities has increased	This measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents in a nursing facility whose need for help with late-loss Activities of Daily Living (ADLs), as reported in the target quarter's assessment, increased when compared with a previous assessment. The four late-loss ADLs are: bed mobility, transferring, eating, and toileting. This measure is calculated by comparing the change in each item between the target MDS assessment (OBRA, PPS or discharge) and a previous assessment (OBRA, PPS or discharge).	NQF/CMS		X
Percent of residents who have/had a catheter inserted and left in their bladder	This measure updates CMS' MDS 2.0 QM on catheter insertions. It is based on data from Minimum Data Set (MDS) 3.0 assessments of long-stay nursing home residents (with cumulative days in the facility greater than 100 days). This measure captures the percentage of low risk long-stay residents who have had an indwelling catheter in the last seven days noted on the most recent MDS 3.0 assessment, OBRA, PPS or discharge during the selected quarter (3-month period). Long stay residents are those residents who have been in nursing care for over 100 days. The measure is restricted to this population, which has long-term care needs, rather than the short-stay population, who are discharged within 100 days of admission.	NQF/CMS		X
Percent of residents who were physically restrained	Measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents who were physically restrained. The measure reports the percentage of all long-stay residents in nursing facilities with an annual, quarterly, significant change, or significant correction MDS 3.0 assessment during the selected quarter (3-month period) who were physically restrained daily during the 7 days prior to the MDS assessment (which may be annual, quarterly, significant change, or significant correction MDS 3.0 assessment).	NQF/CMS		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Percent of residents experiencing one or more falls with a major injury	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	NQF/CMS		X
Percent of residents with urinary tract infection	This measure updates CMS' MDS 2.0 QM on Urinary Tract Infections in the nursing facility population. It is based on MDS 3.0 data and measures the percentage of long-stay residents who have a urinary tract infection on the target MDS assessment (OBRA, PPS or discharge). In order to address seasonal variation, the proposed measure uses a 6-month average for the facility. Long-stay nursing facility residents are those with cumulative days in the facility over 100 days.	State-specified measure		X
Long Term Care Overall Balance Measure*	Reporting of the number of Enrollees who did not reside in a NF as a proportion of the total number of Enrollees in an ICDS Plan. Numerator: of those Enrollees in the denominator, those who did not reside for more than 100 continuous days in a NF during the current measurement year. Denominator: Enrollees in an ICDS Plan eleven out of twelve months during the current measurement year. Exclusions: Any member with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.	State-specified measure		X*

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Nursing Facility Diversion Measure*	Reporting of the number of Enrollees who lived outside the NF during the current measurement year as a proportion of the Enrollees who lived outside the NF during the previous year. Nursing Facility Diversion Rate: Numerator: of those Enrollees in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year. Denominator: Enrollees enrolled in ICDS plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any member with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.	State-specified measure		X*
Long Term Care Rebalancing Measure	Reporting of the number of Enrollees who were discharged to a community setting from a NF and who did not return to the NF during the current measurement year as a proportion of the number of Enrollees who resided in a NF during the previous year. Long Term Care Rebalancing Rate: Numerator: of those Enrollees in the denominator, those who were discharged to a community setting from a NF and did not return to the NF during the current measurement year. Denominator: Enrollees enrolled in ICDS plan eleven out of twelve months during the current measurement year who resided in a NF for 100 continuous days or more during the previous year and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any member with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.	State-specified measure		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Long Term Care Transition Measure	Reporting of the number of Enrollees who were in a NF during the current measurement year, the previous year, or a combination of both years who were discharged to a community setting for at least 9 months during the current measurement year as a proportion of the number of Enrollees who resided in a NF during the current measurement year, the previous year, or a combination of both years. Numerator: of those Enrollees in the denominator, those who were discharged to a community setting from a NF and remained in the community for at least 9 continuous months during the current measurement year. Denominator: Enrollees enrolled in ICDS plan eleven out of twelve months during the current measurement year with a 100 continuous days or more in a NF during the current year, previous year, or a combination of both years. Exclusions: Any member with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.			

*Asterisks denote withhold measures specified in *Appendix 6: Payments to ICDS Plans*

CMS will work closely with the State to monitor other measures related to community integration. CMS and the State will continue to work jointly to refine and update these quality measures in years two and three of the Demonstration.

XII. 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 beneficiary 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 CMS and the State.

XIII. Evaluation

CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the State Demonstrations to Integrate Care for Dual Eligibles and the Financial Alignment Demonstrations, including the Ohio capitated Demonstration, on cost, quality, utilization, and beneficiary experience of care. The evaluator will also explore how the Ohio initiative operates, how it transforms and evolves over time, and beneficiaries' perspectives and experiences. The key issues targeted by the evaluation will include (but are not limited to):

- Beneficiary health status and outcomes;
- Quality of care provided across care settings;
- Beneficiary access to and utilization of care across care settings;
- Beneficiary satisfaction and experience;
- Administrative and systems changes and efficiencies;
- Long-term care rebalancing and diversion effectiveness; and,
- Overall costs or savings for Medicare and Medicaid.

The evaluator will design a State-specific evaluation plan for the Ohio Demonstration, and will also conduct a meta-analysis that will look at the State Demonstrations overall. A mixed methods approach will be used to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative analyses will consist of tracking changes in selected utilization, cost, and quality measures over the course of the Demonstration; evaluating the impact of the Demonstration on cost, quality, and utilization measures; and calculating savings attributable to the Demonstration. The evaluator will use a comparison group for the impact analysis. The comparison group methodology will be detailed in the State-specific evaluation plan. Quarterly reports will provide rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit Ohio-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

Ohio is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. Ohio and ICDS Plans must submit all required data for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements to be listed in the three-way contract. Ohio will collect data on case management and care coordination, including identification of beneficiaries who receive care coordination, frequency of contacts, and classification of beneficiaries into risk tiers. Ohio will also maintain the capability to track beneficiaries eligible for the Demonstration, including which beneficiaries choose to enroll, disenroll, or opt out of the Demonstration, enabling the evaluation to identify differences in outcomes for these groups.