# Ohio's Demonstration Model to Integrate Care for Dual Eligibles
# February 1, 2011

## Introduction

Ohio recently initiated an aggressive new approach to health care within the state. The newly created Governor's Office of Health Transformation (OHT) is charged with planning for the long-term efficient administration of the Medicaid program and to improve overall health system performance. OHT is charged with coordinating Medicaid policy and budgeting for the Ohio Departments of Job and Family Services (Medicaid), Developmental Disabilities, Mental Health, Alcohol and Drug Addiction Services, Aging, and Health. OHT is focused on achieving the overall goals of better health, better care, and lower costs through policy innovations that rebalance Medicaid long-term care spending, integrate behavioral and physical health care, and result in better care coordination.

Currently in Ohio, long term care, home- and community-based services, behavioral health and physical health services are provided through eleven or more largely disconnected delivery systems and many of the individuals receiving the services are insured by both the Medicare and Medicaid programs. This fragmented system leads to higher costs, a lack of coordination, over utilization, poor health outcomes, and patient confusion. Ohio health policymakers believe what is needed is a new approach to health care: a person-centered total care management approach instead of a provider, program, or payer approach. It is Ohio's intention to implement a new Medicaid health care delivery model that reflects the following core values:

- Individuals will receive person-centered care through a delivery system designed to address all of the individual's physical health, behavioral health, long-term care, and social needs.
- Individuals will have access to the services they need in the setting they choose.
- The delivery system will be easy to navigate for both the individuals receiving services and the providers delivering the services.
- Individuals will be able to transition seamlessly among settings and programs as their needs change.
- Incentives in the system will be focused on performance outcomes related to better health, better care, and lower costs through improvement.

In order to make the changes necessary to improve health outcomes for individuals in Ohio that are duals or dual-like, bold new approaches are necessary. This proposal is far reaching and requires flexibility and a new way of thinking by Medicare, Medicaid, providers, and individuals. To make these changes Ohio is asking for the following innovations:

1. A limited housing support service be approved as a Medicaid covered service available through ICDS, and authority to use Medicaid funds to provide room and board for individuals receiving services in community based congregate settings;
2. Coordination of rate development between Medicare and Medicaid, including a shared savings initiative between Medicare and Medicaid;
3. Waiver of actuarial soundness requirements;
4. The creation of different level of care requirements for nursing facility and HCBS services to reduce the institutional bias.

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Ohio intends to pursue the objectives outlined in this document during the time period of July 2011 to June 2013. If awarded this contract, the funding will be used to support the planning, analysis, implementation, and evaluation design for this proposal.

## Problem Statement

Ohio's Medicaid program serves approximately 173,000 individuals with long term care needs each year. Those needs are met with nursing facility care, services in an intermediate care facility (ICF) for the intellectually or developmentally disabled, services provided through one of eight HCBS waivers, services through one of 2 PACE sites, and/or home health care and private duty nursing services through the Medicaid state plan. For most of these individuals, long term care services, behavioral health services, and physical health services are provided through separate delivery systems with little or no coordination of services. While only 7% of the Medicaid population uses long term services and supports, approximately 41% of annual Medicaid expenditures stem from services to this population.

In Ohio, dually eligible individuals (individuals covered by both Medicare and Medicaid) account for approximately 51% of all individuals that qualify for the Medicaid program under the Aged Blind and Disabled (ABD) eligibility category. Approximately 46% of dually eligible individuals utilize long-term care services each year. Approximately 16% of dually eligible individuals utilize behavioral health services each year. However, the Medicare and Medicaid programs are designed and managed with little or no connection to each other. The programs operate with conflicting incentives for both individuals and providers, and coordination to understand service utilization as a whole is non-existent. As a result, duplicate services may be provided, individual outcomes are impacted negatively, and the system is unnecessarily complex for individuals and providers to navigate.

In addition to dually eligible individuals, Ohio serves many individuals only enrolled in the Medicaid program with long-term care needs or severe persistent mental illness (SPMI). These "dual-like" individuals have similar physical health, behavioral health and long term care needs as dually eligible individuals. The current fragmented delivery system is cumbersome and results in over-utilization, unmet needs, and difficulty for individuals in moving among settings for care. These inefficiencies have been building toward a financial crisis. Since 2000, public funding for behavioral health services has not kept pace with individual demand and service costs. Because of the entitlement nature of the Medicaid program and Ohio's reliance on counties to provide the local matching funds for these services, increasingly, county Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards find most of their public funds allocated to support the local match Medicaid services. ADAMH Boards have little funding left to serve non-Medicaid enrollees (e.g. childless adults) or to provide services that are not part of the Medicaid benefit, such as housing. In 2009, this situation reached a breaking point, and behavioral health system advocates, providers, and ADAMH Boards initiated a discussion about disbanding and elevating the funding for the local match for Medicaid community behavioral health services to the state.

As of January 2011, 123,266 Aged Blind and Disabled (ABD) Medicaid recipients are enrolled in managed care plans (MCPs) through a mandatory statewide managed care program. In addition to receiving medically necessary Medicaid-covered services outlined in their benefit package, managed care members benefit from a focus on primary and preventive care accompanied by strong utilization management. Objective performance measurement and defined expectations for plan performance are

used to provide accountability for MCPs. Currently under state law, individuals using long term care services (whether in institutional or HCBS settings) and dually eligible individuals are excluded from managed care and receive health care services through the traditional Medicaid fee-for-service program.

## Proposed Model

Ohio will implement an individual-centered Integrated Care Delivery System (ICDS) to provide a Medicaid service package that meets the unique needs of dually eligible individuals, individuals with long term care needs, and individuals with SPMI. As described in more detail below, the individual-centered ICDS program will:

- Focus first on Ohio's 113,000 dually eligible individuals who are residents of nursing facilities, enrollees in Ohio's HCBS waivers who require a nursing facility level of care, and individuals with severe persistent mental illness;
- Explore alternative models for ICDS implementation, including managed care plans (MCPs), accountable care organizations (ACOs), health homes, and/or other integrated care models;
- Require ICDS providers to have ONE point of contact for an individual receiving services, regardless of payer;
- Require ICDS providers to pursue the triple quality aim of improving the experience of care, the health of populations, and reducing costs through improvement; and
- Require the development of innovative rate-setting methods including outcome based performance incentives and focused care coordination to achieve more efficient use of limited health care resources in the Medicare and Medicaid programs.

***Provider Models***

Ohio is exploring alternative models for ICDS implementation. As stated previously, those models include managed care plans, accountable care organizations, health homes, and other integrated care models. Different models may be implemented to serve different segments of the dually eligible and dual-like population or to maximize available delivery systems in different geographic areas in Ohio. In order to maximize care coordination opportunities for dually eligible individuals in Ohio who have elected coverage through a Medicare managed care plan, Ohio will consider requiring the individual to receive services through the ICDS.

Regardless of the chosen model, Ohio will seek ICDS providers with demonstrated experience in coordinating care for target populations (e.g., medically fragile children, seniors, physically disabled adults, individuals with SPMI). ICDS provider requirements will include the following:

- Providers offering services pursuant to ICDS must demonstrate that CCCs have comprehensive knowledge of Medicare program requirements, Ohio Medicaid program requirements, and the interaction between those programs.
- Providers must demonstrate experience in management of behavioral health services.
- Providers will be required to utilize the dispute resolution and individual appeal processes that apply to traditional Medicaid managed care plans.
- Providers must demonstrate experience with discharge planning in order to provide continuity of care from an array of settings.

- Providers must have the authority to direct Medicare services and providers in order to integrate benefits, in addition to financing.

Because Ohio is using both managed care an non-managed care delivery systems and every state has duals, the ICDS should be replicable in other states.

***Better Care Coordination***
ICDS providers will be required to have ONE point of contact for an individual receiving ICDS services, regardless of payer. Therefore, individuals receiving services in a NF, individuals receiving services through a Medicaid HCBS waiver, and individuals with SPMI will access physical health, behavioral health and long term care services through the ICDS which will be required to focus on the unique characteristics of the individual.

The ICDS provider will be required to use a team approach to care coordination and provide dually eligible and dual-like individuals with a single point of contact called the Complete Care Coordinator (CCC). The CCCs will work with individuals and providers to document all physical health, behavioral health, long-term care, and social needs in order to view the person holistically and in turn meet their needs and achieve positive individual outcomes. The CCCs will assist individuals to navigate the complexity of the Medicare and Medicaid programs, and instead work with the individual to better understand and self manage their health condition.

CCCs will assist individuals in accessing long term care services in the settings they choose. CCCs will be required to:

- Interact frequently with individuals;
- Assist individuals in understanding the alternative delivery mechanisms for long term services and supports;
- Support individuals as they choose the program that best meets their current needs and continuously work with them as they transition among the alternatives as their needs change;
- Serve as "Local Contact Agencies" for individuals in nursing facilities (Local Contact Agencies, implemented in conjunction with MDS 3.0, assist individuals identified through the assessment process as being interested in exploring community options in transition planning); and
- Serve as the waiver case manager for HCBS waivers.

***Reimbursement***
A key component of the successful implementation of ICDS is the development of a reimbursement system that ensures enough funds to provide high quality services and rewards providers that deliver those services. Today, because Medicare and Medicaid operate independently of each other, incentives in the delivery system may result in cost-shifting from one government program to the other. In order to use both state and federal dollars effectively, Ohio will ask that the Medicare and Medicaid actuaries collaborate to establish one rate for the ICDS. The result of this collaboration will be common data sets and assumptions so that rates are equitable reflections of the total cost of care, reflect coverage and benefits in each program and minimize opportunities for waste. The rate would developed using a risk sharing approach between Medicaid, Medicaid, and the provider and would include provider incentive

payments for increases in health outcomes along with a shared savings model between Medicare and Medicaid.

In addition, Ohio is asking that the requirement of actuarial soundness for capitated rates (if used) for any managed care plans selected as ICDS providers be waived. Because the impact of comprehensive care coordination and the aligning of incentives in Medicare and Medicaid is not known, it is difficult to project the impact ICDS will have on the cost of care. Instead of requiring an estimate of care be developed before care is provided (actuarial soundness), Ohio is asking to explore an alternative methodology which may examine financial impacts at standard reporting periods which could trigger changes in rate. Additionally, Ohio is interested in focusing resources during the design phase on the development of performance measures and incentive payments focused on patient outcomes and individual transitions to community settings.

Effective care coordination across the delivery systems for physical health services, behavioral health services and long term care services is expected to reduce total expenditures for health care costs. Ohio anticipates a reduction in hospital stays, shorter hospital stays, fewer hospital readmissions, and reduced nursing facility utilization as a result of ICDS implementation. Because these savings relate most directly to Medicare covered services, Ohio is asking that fifty percent of the savings resulting from a reduced PMPM for Medicare individuals in Ohio be returned to Ohio for further investment in improved care coordination and integrated delivery systems.

The short-term cost effectiveness will come from avoided Medicare Part A services, including reduced hospitalizations and lengths of stay; reduced post-acute discharges to skilled nursing facilities (rather than homes) and reduced lengths of stay. To support some of the additional supports (e.g. community-based services for adults with SPMI), Ohio intends to generate offsetting reductions in Medicare expenditures (and Medicaid).

As indicated previously, in addition to dually eligible individuals enrolled in Medicare managed care, Ohio will be enrolling dually eligible individuals who have not elected Medicare managed care and dual-like individuals in ICDS. Dependent on the result of the design phase, managed care plans, ACOs and other health home models may serve as the ICDS provider for those individuals. During the design phase, Ohio will focus on development of innovative reimbursement models that focus on performance incentives driven by individual outcomes to create incentives for effective care. Incentives considered will include opportunities for shared savings initiatives with ICDS providers.

***Benefit Changes***

In addition to implementing an intensive care coordination program for individuals using long term services and supports and with SPMI, a number of program changes impacting the delivery of long term care are necessary. These changes will clearly define services and facilitate effective care coordination. Those program changes include the following:

- A new waiver will be developed that will collapse the current five waivers into one waiver. This will include creating cost caps that vary according to the individual's level of need.
- The new waiver will incorporate a strong individual direction component. The individual direction component will provide additional flexibility in the delivery system and facilitate the transition from other waivers.

- The home health and private duty nursing (PDN) services will be redefined as short-term acute care benefits. Populations currently receiving these services on a long term basis will receive priority waiver enrollment and benefit from the management services provided to all waiver individuals. Individuals using PDN and home health care services on a long term care basis and enrolled in waivers that do not include nursing services will be transitioned to a waiver that does include nursing services.
- The nursing facility service provided through the Medicaid service will be analyzed (and modified as appropriate) so that the comprehensive rate is adjusted for any services that are provided separately to ICDS participants.
- A statewide program governing delivery and management of behavioral health services will be implemented.
- A request to allow for different level of care requirements for nursing facility services and HCBS services.

***Eliminate the Institutional Bias***

Medicaid requirements inherently limit options to meet individual needs and coordinate services effectively. For example, Medicaid funding for room and board is only available in institutional settings and Medicaid funding is not available for some institutional settings for individuals with SPMI. These limitations are especially troublesome in creating services for the dual-like population served by Medicaid and magnify the fragmentation in today's delivery systems and keep individuals in the most costly delivery settings, institutions.

In order to maximize the individual focus and flexibility in meeting each individuals needs in the setting of their choice, Ohio is seeking flexibility in designing Medicaid services offered to individuals through ICDS. Ohio has identified accessible housing as a primary barrier to transition from institutional settings to community settings through MFP and other transition efforts. In order to maximize community placements and cost effective service delivery, Ohio is asking that a limited housing support service be approved as a Medicaid covered service and the allowance to use Medicaid funds to provide room and board for individuals receiving services in community based congregate settings.

## State Capacity and Infrastructure

Ohio is in a strong position to begin actively integrating care for dually eligible and dual-like individuals through ICDS. Experience with different models of long term care delivery (institutional services, state plan home health services, waivers, MFP demonstration services, and PACE) provide a strong foundation as we move forward. The Medicaid managed care program has grown and is mandatory statewide for enrolled populations, serving approximately 75 percent of Medicaid individuals. The experience gained through successful implementation of the Money Follows the Person grant to transition individuals to the community has demonstrated the value of care coordination and support for individuals with long term care needs.

In addition, there are ten Medicare Advantage plans, including six special needs plans serving dual eligible individuals in Ohio. As part of a recent State of Ohio Unified Long Term Care Services workgroup, Medicaid long-term care system stakeholders recommended focusing on the integration of

care and supporting the role of special needs plans in service delivery in Ohio. Those recommendations state, in part:

> ". . . allow . . . Medicare Special Needs Plan (SNP) participants to enroll in a Medicaid managed care plan or continue enrollment in their Medicare plan. Continue to explore other options that would integrate the Medicaid acute benefit with dual Special Needs Plans (SNPs)."
>
> "Explore providing care coordination of the Medicaid acute benefit for Medicaid HCBS waiver participants."

The report also focused on the provision of services to individuals with mental illness. Recommendations included supporting "individuals with severe and persistent mental illness to relocate from nursing facilities to community settings. . ." with " the assistance of Medicaid and non-Medicaid services in those settings."

As demonstrated by these recommendations, developed by a diverse stakeholder group and intended to inform the upcoming biennial budget, integration of services is broadly recognized as a priority as the Medicaid program in Ohio evolves to meet the needs of individuals in a more cost-effective manner while improving health outcomes.

As we move forward with this initiative, Ohio will benefit from experienced staff with expertise in key policy areas to support development and implementation. Ohio will hire a project director with experience in and/or knowledge of Medicare and Medicaid program policy and experience in program design, payment methodologies, health information technology, managed care procurement and project management. In addition, program staff with expertise in managed care, long term care, benefit design, provider reimbursement and data analysis will make up the project team.

Capacity within program staff will be supported with consultant services to assist in the development of the demonstration project. Consultant services will focus on actuarial services, program design, reimbursement models considering services provided by Medicare and Medicaid, performance measurement and incentives specific to individuals with long term care and behavioral health needs, and the development of analytic tools so that future policy development impacting dual eligible individuals will be informed by a complete picture of physical health, long term care and behavioral health services used by this population.

***Analytic Capacity***

Ohio's primary analytical tool is its Decision Support System (DSS), a healthcare claims based analytic solution that contains seven years of Medicaid data. In addition to claims data (both fee for service and encounter), the DSS houses eligibility, provider, and financial data. The DSS solution has provided Ohio with a consistent, reliable, mechanism to support the reporting needs for 8 years. The DSS serves as the backbone for reporting and allows the state to forecast for the biennium budget, monitor Medicaid managed care plans, report on fraud, waste, and abuse and program integrity, and evaluate the Medicaid program (on an eligibility and expenditure basis). Additionally, DSS clinical capabilities, such as diagnostic cost groupers, episodes, and admissions, support disease management initiatives and evaluation health outcomes.

The DSS contains Medicare eligibility (i.e., eligibility information for Medicaid recipients) and cross-over claims information. Program eligibility data serves as the common link between the Medicare and the Medicaid data that is available in the DSS. The Medicare eligibility data coupled with the claim data provides analysts with the ability to understand the Medicaid population (e.g., the number of Ohioans who have dual eligibility, what type of services this population utilizes, how frequently this population access care, etc.). The Medicare cross-over claim information includes the Medicare provider number, the date the Medicare claim was paid, the amount Medicare paid for the claim, and the co-insurance or deductible amounts. This cross-over data is used to analyze the Medicaid pricing policies and to conduct program integrity reviews. The DSS also includes all of the Medicaid managed care encounter data. It allows analysts to complete program analysis, data quality analysis, and new program or population determinations. The encounter data is also used for capitation analysis and incentive determinations as well as Medicaid managed care plan performance monitoring.

However, because the Medicare data available to Medicaid is limited to crossover claims, Medicaid does not have the full spectrum of Medicare paid service information for the dual eligible population or to encounter data from Medicare Advantage plans. In order to successfully implement ICDS and establish rates for ICDS plans, Ohio will require the following additional Medicare eligibility and utilization data from CMS.

- A complete record of Medicare enrollment data for residents of Ohio for the most recent 5 years. The information provided must include enrollment spans for each Medicare coverage package.
- A complete claims file reflecting all claims for services paid by Medicare for Ohio residents for the most recent three years.
- A complete encounter data file reflecting all encounters reported by Medicare Part C plans, including SNPs, for the most recent three years.
- All additional data files used to establish Medicare Part C rates, including rates for special needs plans, for Ohio for the past three years.
- Complete claims and encounter files reflecting Medicare service utilization on a monthly basis for each month after the initial data is provided.

This data will be essential effectively coordinate care provided to individuals and to measure the effectiveness of ICDS in reducing the total cost of care.

We will use an outside evaluator to measure the change in utilization of services and individual experience. Positive outcomes will include measures such as greater individual satisfaction, an increase in self-directed care, and a reduction in institutional services. This is just a sample of possible measures that will be developed during program design.

## Stakeholder Participation

Stakeholder participation is an essential element of policy development in the Ohio Medicaid program. Trade associations representing acute care providers, long term care providers, and insurance plans, the Olmstead Task Force and other stakeholder representatives routinely participate in policy development

activities through workgroups, standing meetings, and resolution of specific issues. The development and implementation of the Money Follows the Person grant has been supported by a strong stakeholder process involving stakeholders representing providers, individuals, legislators and other stakeholders.

Ohio will build on these stakeholder relationships, and the Unified Long Term Care Services workgroup described earlier, by developing a Stakeholder Advisory Group to participate in the design phase of the ICDS model in a manner similar to that used to implement the Money Follows the Person grant. Participants will include representatives of trade associations for acute and long term care providers, the Ohio Olmstead Task Force, trade associations representing local government interests, AARP, the long term care ombudsman, the area agencies on aging, centers for independent living and state agencies administering Medicaid programs.

## Timeframe

ICDS will be implemented in phases, allowing time to modify program design to react to experience with the care coordination model and to reflect the challenges inherent in meeting the needs of a diverse population. The upcoming biennial budget process, expected to finish on or before June 30, 2011, provides an opportunity to obtain necessary changes in state law. Milestones for development and implementation are summarized below.

**Milestones in ICDS Development and Implementation**

| Milestone | Target Completion Date |
|---|---|
| Modify Ohio statute excluding dual eligible individuals and individuals in an institution or on a waiver from participation in managed care. | June 30, 2011 |
| Issue RFP for ICDS providers | February 1, 2012 |
| Submit new waiver(s) | March 1, 2012 |
| Award contracts for ICDS providers | May 1, 2012 |
| Modify Ohio Administrative Code rules, including those governing home health and private duty nursing policies | June 1, 2012 |
| Initial Implementation | September 4, 2012 |

The initial implementation, targeted for September 4, 2012, will focus on individuals receiving services in a nursing facility or through a HCBS waiver requiring a nursing facility level of care (e.g., PASSPORT, Choices, Assisted Living, Ohio Home Care, Ohio Home Care Transitions Carve-out) and to individuals with SPMI. Subsequent phases are planned to expand the ICDS model to dual eligible individuals without behavioral health or long term care needs. In addition, the implementation of ICDS will inform future efforts to integrate services and improve care coordination in Ohio.

## Budget

Ohio is requesting one million dollars for the design phase. The budgeted expenditure of those funds is set forth in the following table.

| Planned Expenditure | Amount |
|---|---|
| Department Staff - Project manager and policy support | $200,000 |
| Travel and Stakeholder Participation | $ 50,000 |
| Contracted Actuarial Services | $300,000 |
| Consultant Services for Program Design and Rate Methods | $300,000 |
| IT Development | $150,000 |
| **Total** | **$1,000,000** |