Contract Addendum

Between

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

In Partnership with

State of Ohio Department of Medicaid

and

[PLAN NAME]

Effective: May 1, 2021

This Contract, effective on July 1, 2019, amended by addendums effective February 1, 2020, January 1, 2021, and January 1, 2022, hereby amended by addendum effective May 1, 2021, is between the Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the State of Ohio, acting by and through the State of Ohio Department of Medicaid (ODM) and [PLAN NAME], the Integrated Care Delivery System (ICDS) Plan. The ICDS Plan's principal place of business is [PLAN ADDRESS].

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and Ohio Children's Health Insurance Programs under Title XVIII, Title IX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, the Ohio Department of Medicaid (ODM) is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and Title 51 of the Ohio Revised Code, designed to pay for medical services for eligible individuals;

WHEREAS, Section 1115A of the Social Security Act provides CMS the authority to test innovative payment and service delivery models to reduce program expenditures under Titles XVIII and XIX of the Social Security Act while preserving or enhancing the quality of care furnished to individuals under such titles, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the State;

WHEREAS, the ICDS Plan is in the business of providing coverage for medical services, and CMS and ODM desire to purchase such services from the ICDS Plan;

WHEREAS, in accordance with Section 5.8 of the Contract, CMS and the Contractor desire to amend the Contract;

WHEREAS, the ICDS Plan agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and Ohio laws and regulations;

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the parties agree as follows:

1. This Addendum deletes Subsection 2.7.9.2.2 and replaces it with the following Subsection 2.7.9.2.2:

   2.7.9.2.2 Adult Day Health/Assisted Living: Effective July 1, 2022, ninety percent (90%) of all members residing in a county must be within thirty (30) miles of at least one (1) adult day health and one (1) assisted living provider. Effective January 1, 2023, ninety percent (90%) of all members residing in a county must be within thirty (30) miles or forty-five (45) minutes of at least one (1) adult day health and one (1) assisted living provider.

2. This Addendum deletes Subsection 4.1.2.1 and replaces it with the following Subsection 4.1.2.1:

4.1.2.1 Capitation Rate updates will take place on January 1st of each calendar year. However, savings percentages and quality withhold percentages (see Sections 4.2.3 and 4.3.7 of this Contract) will be applied based on Demonstration Years, as follows:

Demonstration Year	Calendar Dates
1	First effective Enrollment date – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017
4	January 1, 2018 – December 31, 2018
5	January 1, 2019 – December 31, 2019
6	January 1, 2020 – December 31, 2020
7	January 1, 2021 – December 31, 2021
8	January 1, 2022 – December 31, 2022
9	January 1, 2023 – December 31, 2023

3. This Addendum deletes Subsection 4.2.3.1 and replaces it with the following Subsection 4.2.3.1:

4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare A/B Component and the Medicaid Component of the capitated rate herein. Beginning in Demonstration Year 6, the savings percentages listed below will not be applied directly to the Medicaid Component and instead will be applied to projected Medicaid costs absent the demonstration against which the Medicaid Component is evaluated as described at Section 4.2.1.3.4 of this Contract.

4.2.3.1.1. Demonstration Year 1: 1 %

4.2.3.1.2. Demonstration Year 2: 2 %

4.2.3.1.3. Demonstration Year 3: 4 %

4.2.3.1.4. Demonstration Year 4: 4%

4.2.3.1.5. Demonstration Year 5: 4%

4.2.3.1.6. Demonstration Year 6: 4%

4.2.3.1.7. Demonstration Year 7: 4%

4.2.3.1.8. Demonstration Year 8: 4%

4.2.3.1.9. Demonstration Year 9: 4%

4. This Addendum deletes Subsection 4.2.6.1 and replaces it with the following Subsection 4.2.6.1:

4.2.6.1 Medical loss ratio Guarantee: The ICDS Plan has a target MLR of eighty-five percent (85%) for Demonstration Years 1 through 5, eighty-six percent (86%) for Demonstration Year 6, eighty-seven percent (87%) for Demonstration Year 7, and eighty-eight percent (88%) for Demonstration Years 8 and 9. As described below, any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis. The MLR calculation shall be determined as set forth below; however, ODM and CMS may adopt NAIC reporting standards and protocols after giving written notice to the ICDS Plan.

4.2.6.1.1 For all Demonstration Years, if an ICDS Plan has an MLR between eighty-five percent (85%) and ninety percent (90%) of the joint Medicare and Medicaid payment to the ICDS Plan, ODM and CMS may require a corrective action plan.

4.2.6.1.2 For Demonstration Years 1 through 5, if an ICDS Plan has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment to the ICDS Plan, the ICDS Plan must remit the amount by which the eighty-five percent (85%) threshold exceeds the ICDS Plan's actual MLR multiplied by the total Capitation Rate revenue of the contract.

4.2.6.1.3. For Demonstration Years 6 through 9, in addition to remitting the amount by which the eighty-five percent (85%) threshold exceeds the ICDS Plan's MLR multiplied by the total Capitation Rate revenue, the ICDS Plan will also remit according to the following schedule:

4.2.6.1.3.1. In Demonstration Year 6, if the ICDS Plan's MLR is below eighty-six percent (86%) and above eighty-five percent (85%), the ICDS Plan would remit fifty percent (50%) of the difference between its MLR and eighty-five percent (85%) multiplied by the total Capitation Rate revenue;

4.2.6.1.3.2. In Demonstration Year 7, if the ICDS Plan's MLR is below eighty-seven percent (87%) and above eighty-five percent (85%), the ICDS Plan would also remit fifty percent (50%) of the difference between its MLR and eighty-five percent (85%) multiplied by the total Capitation Rate revenue; and

4.2.6.1.3.3. In Demonstration Years 8 and 9, if the ICDS Plan's MLR is below eighty-eight percent (88%) and above eighty-five percent (85%), the ICDS Plan would also remit fifty percent (50%) of the difference between its MLR and eighty-five percent (85%) multiplied by the total Capitation Rate revenue.

5. This Addendum deletes Subsections 4.3.9 and 4.3.10 and replaces it with the following Subsections 4.3.9 and 4.3.10:

4.3.9. Withhold Measures in Demonstration Years 2-9

4.3.9.1. The quality withhold will increase to two percent (2%) in Demonstration Year 2 and three percent (3%) in Demonstration Years 3-9.

4.3.9.1.1. CMS will apply an additional one percent (1%) quality withhold to the Medicare A/B rate component starting in Demonstration Year 6. See Section 4.3.10 of this Contract for more information.

4.3.9.2. Payments will be based on performance on the quality withhold measures listed in Table A-3. The ICDS Plan must report these measures according to the prevailing technical specifications for the applicable measurement year.

4.3.9.3 If the ICDS Plan is unable to report at least three of the quality withhold measures listed in Table A-3 for a given year due to low Enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes.

Table A-3 Quality Withhold Measures for Demonstration Years 2-9

Measure	Source	CMS Core Withhold Measure	State Withhold Measure
Encounter data	CMS/State defined measure	X	
Plan all-cause readmissions	NCQA/HEDIS	X	
Annual flu vaccine	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	NCQA/HEDIS	X	
Reducing the risk of falling	NCQA/HEDIS/HOS	X	
Controlling blood pressure	NCQA/HEDIS	X	
Part D medication adherence for diabetes medications	CMS	X	
Nursing facility diversion measure (Suspended as of DY 2)	State-defined measure		X
Long term care overall balance measure (Suspended as of DY 2)	State-defined measure		X
Minimizing Institutional Length of Stay (Starting DY 6)	CMS-defined measure		X

Measure	Source	CMS Core Withhold Measure	State Withhold Measure
Medication Reconciliation Post-Discharge (Starting DY 6)	NCQA/HEDIS		X

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

4.3.10. Additional CMS Withhold Measure in Demonstration Years 6-9

4.3.10.1. Starting in Demonstration Year 6, CMS will apply an additional one percent (1%) quality withhold to the Medicare A/B rate component only.

4.3.10.2. Payment will be based on performance on the quality withhold measure listed in Table A-4. The ICDS Plan must report this measure according to the prevailing technical specifications for the applicable measurement year.

4.3.10.3. If the ICDS Plan is unable to report the quality withhold measure listed in Table A-4 for a given year due to low Enrollment or inability to meet other reporting criteria, an alternative measure will be used in the quality withhold analysis. Additional information about this policy is available in the Ohio Quality Withhold Measure Technical Notes.

Table A-4 Additional CMS Quality Withhold Measure for Demonstration Years 6-9

Measure	Source
Diabetes Care: Blood Sugar Controlled	NCQA/HEDIS Reverse score of the reported HEDIS rate for HbA1c poor control (>9.0%)

6. This Addendum adds a new Section 4.5:

4.5 Incentive Payments

4.5.1. For Demonstration Years 7-8, the ICDS Plan must comply with the terms of the 2021 COVID-19 Vaccination Additional Incentive (DY 7) and the COVID-19 Vaccination Additional Incentive for January 2022 – June 2022 (DY 8) as described under paragraphs 3 and 4 of Appendix O of the MyCare Ohio Provider Agreement. Incentive arrangements must comply with the following:

4.5.1.1. May not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement. Capitation payments will be calculated as if the ICDS Plan received the full quality withhold for the applicable Demonstration Year.

4.5.1.2 Are for a fixed period of time and performance is measured during the rating period under the contract in which the incentive arrangement is applied.

4.5.1.3. May not be renewed automatically.

4.5.1.4. Made available to both public and private contractors under the same terms of performance.

4.5.1.5. Does not condition participation in the incentive arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.

4.5.1.6. Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy at § 438.340.

4.5.1.7 Such incentive payment, if applicable, will be excluded from revenue for the MLR calculations, as described at Section 4.2.6, and risk corridor calculations, as described at Section 4.2.

7. This Addendum adds a new Section 4.6:

4.6 Provider Relief Payments

4.6.1. In accordance with Amended Substitute House Bill 169 as passed by the 134th General Assembly, for providers of community-based DME, behavioral health services, hospice services, State Plan home health services, and HCBS waiver services, the ICDS Plan will pay a 10% increase to a provider's base rate for services provided to ICDS Plan enrollees during DY 8, or $100, whichever is greater. ODM will calculate the payment increase under Sections 4.6.1.1 and 4.6.1.2 and direct the ICDS Plan to pay the increase in the form of interim and reconciled lump-sum payments, as applicable. Interim payments will be calculated as partial payments of total amounts due to providers.

4.6.1.1. For providers of community-based DME, behavioral health services, hospice services and State Plan home health services, ODM will calculate the interim payment based upon the total value of claims for services provided to ICDS Plan enrollees during a proxy period of service dates of 7/1/2020 through 6/30/2021. The interim payment amount will be limited to 50% of the total payment increase. At the conclusion of DY 8, ODM will recalculate the increase against the total value of claims for services provided to ICDS Plan enrollees during DY 8 (i.e., for dates of service 1/1/2022 through 12/31/2022), and direct the ICDS Plan to pay any additional amount owed to the provider.

4.6.1.2. For providers of HCBS waiver services, ODM will calculate the interim payment based upon the total value of claims for services provided to ICDS Plan enrollees during a proxy period of service dates of 11/1/2020 through 10/31/2021. The interim payment amount will be limited to 50% of the total payment increase. At the conclusion of DY 8, ODM will recalculate the increase against the total value of claims for services provided to ICDS Plan enrollees during DY 8 (i.e., for dates

of service 1/1/2022 through 12/31/2022), and direct the ICDS Plan to pay any additional amount owed to the provider.

This Addendum deletes Subsection 5.7.1 and replaces it with the following Subsection 5.7.1:

5.7.1 This Contract shall be in effect starting on the date on which all Parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2023, so long as the ICDS Plan has not provided CMS and ODM with a notice of intention not to renew, pursuant to 42 C.F.R. §422.506 or Section 5.5, above.

Signatures

In Witness Whereof, CMS, ODM, and the ICDS Plan have caused this Agreement to be executed by their respective authorized officers:

_____ _____

[ICDS Plan Signatory Name] Date
[ICDS Plan Signatory Title]
[ICDS Plan]

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In Witness Whereof, CMS, ODM, and the ICDS Plan have caused this Agreement to be executed by their respective authorized officers:

_____ _____

Lindsay P. Barnette
Director
Models, Demonstrations & Analysis Group
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

Date

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In Witness Whereof, CMS, ODM, and the ICDS Plan have caused this Agreement to be executed by their respective authorized officers:

_____ _____

Kathryn Coleman
Director
Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

Date

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In Witness Whereof, CMS, ODM, and the ICDS Plan have caused this Agreement to be executed by their respective authorized officers:

_____ _____

Maureen M. Corcoran
Director
Ohio Department of Medicaid

Date

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