

Strategic Framework for Coordination and Alignment between Coordinated Care Organizations and Long Term Care

Oregon's proposed Medicaid transformation was initiated by HB 3650, which was passed by the legislature with broad bi-partisan support in June 2011. HB 3650 is the result of a recognition on the part of Oregon's governor and legislature that fundamental structural transformation in the way we deliver and pay for health care services is essential to not only preparing for the implementation of federal health reform in 2014, but to ultimately achieving the triple aim of better health, better health care and lower health care costs. Oregon's goal is to create a health care system that emphasizes prevention and where physical health care, behavioral health care and oral health care are financially integrated within Coordinated Care Organizations (CCOs) that are community-based and given the flexibility to achieve the greatest possible health within available resources. Each CCO will operate within a global budget where they will be held accountable and rewarded for improved quality and outcomes.

This paper presents the strategies for coordination and alignment between CCOs and the Long Term Care (LTC) system. Medicaid-funded LTC services are legislatively excluded from CCO budgets and will continue to be paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services. Approximately 24,000 dually eligible beneficiaries in Oregon (about 40 percent) receive Medicaid-funded LTC services. In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to coordinate care and share accountability, including financial accountability.

Oregon's Policy Goals for Health System Transformation:

Transform Oregon's Medicaid delivery system so that it focuses on prevention, integration and coordination of health care across the continuum of care to improve outcomes and to bend the cost curve.

- Promote the triple aim of better health, better health care, and lower costs.
- Establish supportive partnerships with CMS to implement innovative strategies that will result in higher quality, more cost effective health care under Medicaid and Medicare.

Oregon's Department of Human Services Policy Goals for Long Term Care Placement

Decisions:

LTC placement decisions should balance:

- The preferences and goals of the person;
- The right of the person to live as independently as possible, in the least restrictive setting; and
- The cost of the living arrangement.

System Coordination between CCO/LTC:

System and care coordination are key activities of health system transformation and are critical activities for a high performing healthcare system that coordinates services and activities of the Area Agency on Aging (AAA)/State's Aged and People with Disabilities (APD) system and their contractors with the CCOs and their delivery system network. Successful coordination will improve person-centered care, align care and service delivery and provide the right amount of care at the right time for beneficiaries across the LTC system. CCOs and the AAA/APD system will need to implement care coordination strategies tailored to the unique skills and service environments associated with home care, home and community based care, acute care, skilled nursing facility care and long term nursing care.

The CCO Implementation Proposal to the legislature includes several references to the expectations of the CCOs related to coordination and accountability for LTC:

“Since individuals receiving Medicaid-funded LTC services and supports represent a significant population served by CCOs, CCOs should include these individuals and the LTC delivery system in the community needs assessment processes and policy development structure.” (Pg. 37)

- “CCOs should demonstrate the following elements of care coordination in their applications for certification:
- How they will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member’s care, and, in the absence of full health information technology capabilities, how they will implement a standardized approach to patient follow-up.
- How they will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services.
- How they will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of each in the process of communication.
- How they will meet State goals and expectations for coordination of care for individuals receiving Medicaid-funded long term care services given the exclusion of Medicaid-funded long term services from CCO global budgets.” (Pg. 21)

“A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the CCO and/or to the LTC system. Other elements of shared accountability between CCOs and the LTC system will include: contractual elements, such as specific requirements for coordination between the two systems; requirements to clearly define roles and responsibilities between the two systems through a memorandum of understanding, a contract or other mechanism; and reporting of metrics related to better coordination between the two systems.” (Pg. 37)

Contracts/MOUs

To implement and formalize coordination and ensure relationships exist between CCOs and the local LTC offices, CCOs will be required to work with the local AAA or APD local office to develop a Memorandum of Understanding (MOU) or contract, detailing how they will coordinate and the roles and responsibilities of each side. This MOU or contract will be the mechanism for the two systems to operationalize the requirements for coordination in a way that works for both systems locally. An MOU could be used if the arrangement between the CCO and AAA is limited to an agreement about roles and processes. The CCO and AAA may also decide to have a formal financial arrangement (contract) with upfront CCO investment in local office activities and/or shared savings from the CCO to the local office based on improved health outcomes and reduced medical costs. Core requirements for care coordination between the LTC system and CCOs are represented in Appendix A.

OHA will oversee these contracts/MOUs by reviewing documentation (copies of the contract/MOU), using compliance oversight mechanisms and performance metrics to ensure that required activities are conducted and that individuals receiving Medicaid-funded LTC are jointly served by CCOs and APD/AAAs.

OHA and DHS will ensure that member/client complaints or grievances would follow the “no wrong door” policy and follow the standard complaints and grievance processes set forth by CCOs, AAA/APD, DHS, and DMAP. Thus, a complaint to an AAA/APD local office about a CCO would be properly routed through the CCO complaint process. The Oregon Health Policy Board has determined that individuals will receive plain language information on their member rights including complaints and grievances.

Division of Roles/Responsibility:

Due to the exclusion of the Medicaid-funded LTSS in HB 3650, clear delineation of roles and responsibilities are needed to reduce duplication, improve efficiency, and meet the goals of Health System Transformation (HST). The key roles and benefits of CCOs and LTC are listed below.

CCO:

- Role: Health care delivery including preventive, early intervention and acute health services, behavioral health services, health services coordination and information sharing, care team coordination, use of non-traditional health workers (health system navigators, peer wellness counselors, community health workers), Person-Centered Primary Care Homes, after hours medical consultation.
- Post Acute Skilled Care and Transitions to Medicaid-funded LTC: (see below)
- Benefits: Medical/primary care; hospital services; mental health/behavioral health; medical transportation; Medicare Skilled Nursing (including Medicaid cost sharing for Medicare Skilled Nursing benefit); Medicare and Medicaid home health; durable medical equipment; emergency transport (ambulance); home enteral/parenteral nutrition and IV services; rehabilitation services such as, physical, occupational, and behavioral/mental health therapies; medical-surgical

services; pharmaceutical services including Medicare Part D; speech-language pathology; audiology; and hearing aid services; transplant services; hospice services and other palliative care.

LTC:

- AAA/APD Role: Coordination and information sharing with CCO, LTC financial/service eligibility, LTSS authorization and placement (home and community based/Nursing Facility except when Medicare skilled), LTSS case management coordination and troubleshooting, Adult Protective Services, contracting for Medicaid LTC providers, Licensing and Quality Assurance, LTC Ombudsman. Eligibility and enrollment for Medicaid, Medicaid low-income co-pay.
- Post Acute Skilled Care and Transitions to Medicaid-funded LTC: (see below)
- Medicaid-funded LTC Benefits: In-home supports/services, Adult Foster Care, Residential Care Facilities, Assisted Living Facilities, LTC nursing facility state plan, State Plan Personal Care for APD, Adult Day Services, Contract Nursing Program, Home Delivered Meals, administrative examinations and reports, non-medical transportation (except in some regions where contracted to transportation brokerages), PACE state plan (including Medicare benefits).
- Other AAA/APD Supports and Services: As the Aging and Disability Resource Connection the following are provided: information and assistance, options counseling; care transitions coaching; nursing facility transition/diversion; connection to evidence based chronic disease self-management, Aging and health promotion; Supplemental Nutrition Assistance Program (SNAP), Older American's Act Services (information/Assistance/Outreach, In-home assistance, Family Caregiver Supports, Oregon Project Independence, respite, transportation, home and congregate meals, legal assistance, caregiver counseling/support, training).

Other Resources and Community Programs to Maintain Independence:

- Low-income housing, Low Income Energy Assistance Program, Department of Veteran's services, Parish Nursing, Food banks, community specific charities and non-profit organizations, volunteers.

Post Acute Skilled Care:

Oregon will explore with CMS the following federal Medicare flexibilities around post acute skilled care:

- Waiving requirements for an inpatient stay before allowing skilled benefit (currently a 3-day stay is required). Instead, individuals who meet skilled criteria from the emergency room or other settings could enter skilled care;
- Allowing skilled care to be provided in non-skilled settings (would need to ensure that individuals retain access to their full Medicare and Medicaid benefits).

Outstanding Issue: Roles related to Post Acute Skilled Care and Transitions to Medicaid-funded LTC

Stakeholders responded to initial drafts of this document with divergent perspectives on roles for CCOs and AAA/APD offices during the critical period after an acute care episode as well as transitions to Medicaid-funded LTC. Following is the original draft section shared with stakeholders.

Post Acute Skilled Care: CCO would have responsibility for payment and coordination for post acute care and placement decisions for up to the first 100 days after an individual leaves an acute care setting while the individual meets Medicare skilled criteria. This includes primary responsibility for placement in the least restrictive service setting (including consideration of Home and Community Based Services or HCBS) while ensuring health outcomes and value and considering the individual's desires and goals. CCOs also have the responsibility for payment and coordination for the home health benefit.

Transitions to Medicaid-funded LTC:

CCO would coordinate transitions to Medicaid-funded LTC by notifying AAA/APD within 3 days of post acute placement when post acute care is expected to last 30 days or less. CCOs would notify AAA/APD no later than the 15th day of post acute placement if post acute care is expected to last more than 30 days. CCO would also notify AAA/APD within 3 days of post acute placement for any individuals currently served by AAA/APD in Medicaid-funded LTC.

Key stakeholder perspectives:

- Limited resources require a close examination of areas with potential for duplication of effort, and in order to best manage transitions, CCOs should have primary responsibility for medically related post acute care placements, as the draft language above would allow.
- Ensuring communications and coordination between CCOs and AAA/APD is particularly critical during transitions, and stakeholders were concerned that this proposal would minimize the role of AAA/APD during this time and could lead to inappropriate placements.

Promising Models and Practices:

As part of their CCO certification application, entities will describe how they will coordinate care for individuals receiving Medicaid-funded LTC services, and may incorporate the promising models identified through planning work and stakeholder workgroups. Oregon has identified several models currently being tested or practiced to better coordinate care. These include co-location approaches, services in congregate settings, and clinician/home based programs. Co-location models consist of locating LTC staff in medical settings such as a hospital or the health plan locating a staff in the LTC office. Services in congregate settings bring services to natural communities or settings, such as low-income housing or PACE program settings where individuals congregate. Clinician/home-based programs use a variety of clinicians to assess and provide services in an individual's home or living setting.

Shared Accountability

In order to ensure that coordination between the two systems is occurring and to align incentives between the two systems to provide quality care and produce the best health and functional outcomes for individuals, there will be a system of shared accountability, including traditional accountability mechanisms, reporting of key metrics, and financial accountability.

Traditional Mechanisms for Shared Accountability

As a foundation, shared accountability will be created via the traditional accountability mechanisms the state has with each partner.

- The CCO criteria and contracts with OHA will include specific requirements for CCO coordination with AAA/APD and LTC providers.
- Similarly, DHS will hold LTC providers to requirements (via contracts with DHS, rules or other mechanisms such as provider enrollment agreements) to better coordinate with the medical system, appropriate to the provider type, and these provider agreements, contracts and rules will also be revised to change or remove any requirements that are contrary to the goals of CCO and LTC coordination.
- DHS Inter-governmental Agreements with AAAs and the state APD local office policies will also include requirements to coordinate with the CCO.
- All of these vehicles could also be used to put in place minimum requirements for performance on key metrics.
- OHA/DHS will monitor and enforce compliance for the above mechanisms via contract and rule compliance and oversight processes, work plans, and corrective action plans.

Metrics/Monitoring

Metrics for performance reporting will be selected related to high leverage areas where the activities of one system have significant impacts on the costs and outcomes realized in the other system, or where coordination between the two systems is key to reducing costs and improving outcomes. These high leverage areas will be used to identify process and structure measures and related outcome measures. The process and structure measures will be used to ensure that best practice approaches are being put in place to ensure coordination between the two systems, and the outcome measures will be used to assess whether those approaches have been successful.

In addition, there will be an overarching set of outcomes or goals related to the alignment between the two systems. The overarching goals will not only be linked to a subset of metrics, but also linked to quality assurance, quality improvement and evaluation processes. The overarching outcomes or goals for the two systems include:

- Delivery of Person-Centered Care
- Delivery of Care in Most Appropriate Setting
- Improved Quality of Life
- Reduced Avoidable ER or Inpatient Hospitalizations
- Support Highest Level of Functioning and Independence

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- Reduced Total Cost of Care
- Improved or Maintained Health Outcomes

The table below includes examples of high leverage areas, and a subset of potential or illustrative metrics associated with each high leverage area. The relative impact of each system will vary by measure, and therefore, the complete metric framework for shared accountability will specify how measures will apply to CCOs, AAA/APD local offices, and LTC providers – whether all metrics will apply to each entity or some subset of metrics will apply to specific entities.

SHARED ACCOUNTABILITY HIGH LEVERAGE AREA	SAMPLE OR ILLUSTRATIVE PROCESS/STRUCTURE MEASURES	SAMPLE OR ILLUSTRATIVE OUTCOME MEASURES
CCO Person Centered Care process linked with LTC care planning processes	% LTC members that have person centered care plan developed jointly by the member, LTC providers, PCPCH, AAA/APD case manager	Member experience of care overall: <ul style="list-style-type: none"> ○ Getting needed care & getting care quickly ○ Seamless experience of care across CCO and LTC providers ○ Consumer experience and satisfaction
Care Coordination	% LTC members medical records that integrate elements from, and share elements with, Patient Centered Primary Care Homes (PCPCH), specialty providers, AAA/APD local offices and other social service providers	% members with improved or maintained functional status in ambulation, ADLs, transfers, bathing, managing medications, pain etc.
Intensive Care Coordination for High Needs Members	% high needs members in LTC assigned to the CCO intensive care coordinator with preferred ratio of high need members	Readmission rates (30 day risk-adjusted for hospital and inpatient psychiatric)
Communication across CCO and LTC systems	% LTC providers for whom a strategy for Interoperability and health information exchange has been established	Provider experience and Satisfaction Ease of referral and authorizations
Integrated Behavioral Health and Substance Abuse Treatment	% LTC members with positive screening for mental illness or substance use disorder engaged in treatment 30 days from screening date	Rate of emergency department use for individuals with serious mental illness or substance use disorders

SHARED ACCOUNTABILITY HIGH LEVERAGE AREA	SAMPLE OR ILLUSTRATIVE PROCESS/STRUCTURE MEASURES	SAMPLE OR ILLUSTRATIVE OUTCOME MEASURES
Transitions of care for <ul style="list-style-type: none"> • LTC-LTC • LTC-Acute • Acute-Post Acute • Acute-LTC • Post-Acute - LTC 	% transitions where information transfer occurred same day (e.g. nurse to nurse consult or receipt of physician’s discharge)	Rate of emergency department use following transfer
End of Life Care Planning or Advanced Care Planning	% relevant subpopulation offered advanced planning or POLST	% members whose end-of-life care matches preferences in POLST registry

The overall approach is to develop a balanced set of metrics, so that utilization metrics are balanced with process metrics and health and functional outcomes, to ensure that the overall measurement approach is person-centered and avoids perverse incentives. The measurement and reporting of these metrics will be phased in, with a general approach of:

- First year: reporting process measures and feasible outcomes measures¹, while the full set of outcome measures are being developed. The development of final measures is also dependent on negotiation with, and requirements of, CMS related to the CMS Financial Alignment Demonstration for integrating care for individuals dually eligible for Medicare and Medicaid. These requirements and negotiations are expected to be completed by summer 2012.
- Second year or later: measurement and reporting of the full set of outcome measures begin.
- Measurement development and changes to measures for shared accountability for LTC will be defined through the same process used for overall CCO metric development.

The data that is reported will be closely monitored to track the impacts of CCO implementation and detect any unintended consequences in either system, which will be addressed through the traditional accountability mechanisms described above.

Financial Accountability

A selection of these metrics will also be used as the basis to hold CCOs and the LTC system financially accountable for their impact on and coordination with each other. As with the metrics, the development of final financial alignment requirements is also dependent on negotiation with, and requirements of, CMS related to the CMS Financial

¹ Note: some outcomes measures may not be feasible to collect in the first year for several reasons: outcomes reflect longer term impacts of changes, the measure is not yet clearly defined, the collection mechanism is not defined, etc.

Alignment Demonstration. There are several options for holding CCOs financially accountable:

- Making a portion of overall CCO quality incentive payments be related to metrics for shared accountability with LTC. Depending on available funding, OHA plans to offer incentives to reinforce these reporting and performance expectations, with the specific incentive design to be determined. CCOs who did not meet performance expectations related to shared accountability for LTC could be at risk for this payment.
- For LTC providers and AAAs/APD offices, financial incentives tied to performance metrics, depending on availability of funding. The development of these metrics would consider which metrics and incentives are appropriate for AAA/APD offices as well as different types and sizes of providers.
- Shared savings arrangement between CCOs and LTC partners (providers and AAAs/APD offices) around benchmarks such as reduced rehospitalization rates and ED utilization (and/or other health system costs). CCOs and LTC partners could elect to come to their own shared savings agreements. Absent those agreements, the state could coordinate shared savings arrangements, for example, adjusting a portion of CCO payments for sharing between CCOs and LTC partners if benchmarks were achieved.
- Exploring with CMS the use of other mechanisms, including tying a portion of demonstration quality payments to shared accountability. Under the Financial Alignment Demonstration a portion of participating CCOs' aggregate payment will be withheld until the end of the contract year to be evaluated against established quality standards, which could include standards related to shared accountability with LTC; if the CCO meets the quality standards for the given year they will be able to receive the portion of the payment withheld.

As with the measurement, financial accountability will be phased in, with a focus on process measures in the first year while work is underway to develop outcome and utilization/cost metrics and to find the best way to tie incentives to them. Some consideration will be given if one side of CCO-AAA/APD fails to participate.

Other Accountability Mechanisms

Other approaches that may be considered for sharing accountability with LTC providers would include potentially giving LTC providers preferred contracting status depending on their performance on metrics or in coordinating with CCOs, and potentially putting in place a public ratings or rankings system to publicize performance on quality measures similar to the CMS nursing home compare system.

APPENDIX A: Select CCO Criteria and Associated Expectations for CCOs and AAA/APD Related to LTC

Core requirements for coordination between AAA/APD and CCOs are represented below. Specific expectations for LTC providers are not included here, but would evolve from the expectations listed below. The first two columns are excerpts from the Health Policy Board's CCO Implementation Proposal (Appendix D) and the second two columns illustrate the expectations for CCOs and AAA/APD regarding coordination and accountability for individuals receiving Medicaid-funded LTC services and supports.

These requirements will be formalized in one or more of the following mechanisms:

- CCO expectations will be formalized in CCO criteria for CCO certification (in the Request for CCO Applications) and/or CCO contracts.
- APD expectations will be formalized in DHS policy and operations.
- For regions served by a contracted Area Agency on Aging (AAA), AAA expectations will be formalized in the Intergovernmental Agreements between DHS and the AAAs.
- For both CCOs and AAA/APD, expectations will be reflected in contracts or Memoranda of Understanding (MOUs) that are required between CCOs and their local AAA or APD office. DHS/OHA will provide further specificity in a template and instructions on the content expected in these contracts or MOUs. This MOU or contract will be the mechanism for the two systems to operationalize the contractual requirements for coordination in a way that works for both systems locally.

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Criteria From HB 3650	OHPB Baseline Expectations for CCOs	CCO Expectations Related to LTC	AAA/APD Expectations Related to CCO
<p><u>Partnerships:</u> CCOs shall have agreements in place with publicly funded providers to allow payment for point of contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Additionally, a CCO is required to have a written agreement with the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority.</p>	<ul style="list-style-type: none"> • OHA to review CCO applications to ensure that statutory requirements regarding county agreements are met. 	<ul style="list-style-type: none"> • CCOs will partner with AAA/APD local offices to develop written contracts or MOUs describing their system coordination agreements regarding CCO members receiving Medicaid-funded LTC services. These agreements will reflect care coordination strategies including but not limited to: <ul style="list-style-type: none"> ○ Prioritization of high needs members and development of individualized care plans ○ Establishing member care teams ○ Use of best practices ○ Transitional care practices ○ Use of health information technology ○ Member access and provider responsibilities ○ Role of primary care home ○ Safeguards for members ○ Patient engagement and patient preferences ○ Outcome and quality measures ○ Governance structure ○ Learning collaboratives 	<ul style="list-style-type: none"> • AAA/APD will partner with CCOs in their region to develop a contract or MOU describing their system coordination strategy for AAA/APD clients who are members of the CCO. • DHS/APD will provide support to and oversight of AAAs/APD local offices, including a contract/MOU template with the minimum information required.

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Criteria From HB 3650	OHPB Baseline Expectations for CCOs	CCO Expectations Related to LTC	AAA/APD Expectations Related to CCO
<p><u>High Need Members:</u> Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable ED visits and hospital admissions</p>	<ul style="list-style-type: none"> • CCO uses individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs. Plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction. 	<ul style="list-style-type: none"> • CCOs will define universal screening process that assesses individuals for critical risk factors that trigger intensive care coordination for high needs members receiving Medicaid funded LTC services. <ul style="list-style-type: none"> ○ CCO will factor in relevant referral, risk assessment and screening information from local AAA/APD offices and LTC providers. ○ CCOs will define how it will communicate and coordinate with AAA/APD when assessing members receiving Medicaid-funded LTC services. • CCOs’ individualized person-centered care plans will include information about the supportive and therapeutic needs of each member, including LTC services and supports needs. <ul style="list-style-type: none"> ○ Plans will reflect member or family/caregiver preferences and goals captured in AAA/APD service plans as appropriate. ○ Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from AAA/APD and with LTC providers. 	<ul style="list-style-type: none"> • AAA/APD will provide CCOs with access to information needed to identify members with high health care needs. • AAA/APD will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid AAA/APD offices into CCOs’ individualized care plans for members with intensive care coordination needs.

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Criteria From HB 3650	OHPB Baseline Expectations for CCOs	CCO Expectations Related to LTC	AAA/APD Expectations Related to CCO
<p><u>Member and Care Team:</u> Each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings.</p>	<ul style="list-style-type: none"> • CCO demonstrates how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member’s care, and use a standardized patient follow-up approach. 	<ul style="list-style-type: none"> • CCO will support the flow of information to AAA/APD. • The CCO-appointed lead provider or care team will confer with all providers responsible for a member’s care, including LTC providers and AAA/APD. • To support care teams, CCO will <ul style="list-style-type: none"> ○ Work with AAA/APD to ensure that it identifies members receiving LTC services. ○ Include LTC providers and AAA/APD case managers as part of the team based care approach. ○ Adapt team-based care approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services. 	<ul style="list-style-type: none"> • AAA/APD will define roles, responsibilities and process for assignment of and participation in the CCO care team, including coordination with CCO lead care coordinator, for members needing routine and intensive care coordination. • AAA/APD will ensure that CCO providers/care teams are notified of which CCO members are receiving LTC, the relevant local AAA/APD office contact, and contact for relevant LTC provider. • AAA/APD will have knowledge of and actively participate in CCO team based care processes when appropriate. • DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams.

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Criteria From HB 3650	OHPB Baseline Expectations for CCOs	CCO Expectations Related to LTC	AAA/APD Expectations Related to CCO
<p><u>Best Practices:</u> Each CCO uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.</p>	<ul style="list-style-type: none"> • CCO describes capacity and plans for ensuring best practices in areas identified by HB 3650. • CCO establishes a Clinical Advisory Panel (CAP) or uses other means to ensure clinical best practices. The CAP, if one is formed, should be represented on the CCO governing board, similar to the Community Advisory Council (CAC). • CCO describes plans for: an internal quality improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops; and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols/policies. 	<ul style="list-style-type: none"> • CCO will describe capacity and plans for ensuring that best practices are applied to individuals in LTC settings, including best practices related to care coordination and care transitions. 	<ul style="list-style-type: none"> • AAA/APD will support CCO efforts to implement best practices approaches, and will share best practices including care coordination, care transitions and evidence based healthy aging programs related to serving individuals in LTC settings with CCOs.

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Criteria From HB 3650	OHPB Baseline Expectations for CCOs	CCO Expectations Related to LTC	AAA/APD Expectations Related to CCO
<p><u>Transitional Care:</u> Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long term care setting</p>	<ul style="list-style-type: none"> • CCO demonstrates how it will incent and monitor improved transitions in care so that members receive comprehensive transitional care, as required by HB 3650 • Members’ experience of care and outcomes are improved through coordination. Coordinated care, particularly for transitions between hospitals and long-term care, is key to delivery system transformation. • CCOs should demonstrate how hospitals and specialty services would be accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes. 	<ul style="list-style-type: none"> • CCO will demonstrate how it will coordinate and communicate with AAA/APD to incent and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive comprehensive transitional care, as required by HB 3650. • Other expectations TBD, see discussion of outstanding issue on Page 5. 	<ul style="list-style-type: none"> • AAA/APD will demonstrate how it will coordinate and communicate with CCO to incent and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive comprehensive transitional care, as required by HB 3650. • Other expectations TBD, see discussion of outstanding issue on Page 5.

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Criteria From HB 3650	OHPB Baseline Expectations for CCOs	CCO Expectations Related to LTC	AAA/APD Expectations Related to CCO
<p><u>Health Information Technology:</u> Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable</p>	<ul style="list-style-type: none"> • CCO documents level of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically, and develops a HIT improvement plan for meeting transformation expectations. • CCO participates in a Health Information Organization (HIO) or is registered with a statewide or local Direct-enabled Health Information Service Provider 	<ul style="list-style-type: none"> • As part of the HIT improvement plan, CCO will identify a strategy to partner with the LTC system to improve upon any existing efforts to share information electronically. 	<ul style="list-style-type: none"> • AAA/APD will partner with CCO in developing electronic information sharing strategy. • DHS/APD will develop mechanisms to improve the sharing of relevant DHS Information with CCOs.
<p><u>Member Access and Provider Responsibilities:</u> Members have access to a choice of providers within the CCO's network and providers in the network:</p> <ul style="list-style-type: none"> • Work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of members 	<p>CCO describes how it will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services.</p>	<ul style="list-style-type: none"> • [OHPB Baseline Expectations] • Tools developed for members should be accessible to individuals receiving LTC services and supports and/or their family or representative. 	<ul style="list-style-type: none"> • AAA/APD will provide education materials to Medicaid clients, contracted providers, family caregivers and client-employed providers on member access to services through the CCO.

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Criteria From HB 3650	OHPB Baseline Expectations for CCOs	CCO Expectations Related to LTC	AAA/APD Expectations Related to CCO
<ul style="list-style-type: none"> • Members are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history • Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication • Are permitted to participate in networks of multiple CCOs • Include providers of specialty care • Are selected by CCOs using universal application and credentialing procedures, objective quality information and removed if providers fail to meet objective quality standards • Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members 	<ul style="list-style-type: none"> • How it will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication. • How members will be informed about access to non- traditional providers, if available through the CCO, including personal health navigators, peer wellness specialists where appropriate, and Home Care Workers. 	<p>(see prior page)</p>	<p>(see prior page)</p>

Strategic Framework for Coordination and Alignment between CCOs and Long Term Care

Criteria From HB 3650	OHPB Baseline Expectations for CCOs	CCO Expectations Related to LTC	AAA/APD Expectations Related to CCO
<p><u>Patient Centered Primary Care Homes (PCPCH):</u> Each CCO shall implement, to the maximum extent feasible, patient-centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology.</p>	<ul style="list-style-type: none"> • CCO adheres to HB 3650 requirements for patient-centered primary care homes. • CCO demonstrates how the patient-centered primary care home delivery system elements will ensure that members receive integrated, person-centered care and services, as described in the bill, and that members are fully informed partners in transitioning to this model of care. 	<ul style="list-style-type: none"> • CCO will partner with the local AAA/APD office to develop a method for coordinating services with PCPCH providers for members receiving LTC services. 	<ul style="list-style-type: none"> • AAA/APD will develop methods and protocols for supporting and coordinating with PCPCH providers. • AAA/APD will support coordination between LTC providers and PCPCH providers.

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<p><u>Safeguards for Members:</u> OHA shall adopt rules for member safeguards including: protections against underutilization of services and inappropriate denials; access to qualified advocates; education and engagement to help members be active partners in their own care.</p>	<ul style="list-style-type: none"> • CCO adheres to HB 3650 requirements regarding member safeguards, including access to qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers, and to applicable Medicare and Medicaid regulations not waived. • CCOs will describe planned or established mechanisms for a complaint/grievance and appeals resolution process, including how that process will be communicated to members and providers. 	<ul style="list-style-type: none"> • CCO will coordinate safeguards, including access to peer wellness specialists, personal health navigators, and community health workers where appropriate and develop processes ensuring these services are coordinated with LTC services to maximize efficiencies. • CCO will describe how planned or established mechanisms for managing member complaints and grievances will be linked to, coordinated with, and inform team-based care practices for members in LTC. 	<ul style="list-style-type: none"> • AAA/APD will ensure that choice counseling materials and processes reflect member rights, responsibilities, and understanding of benefits. • AAA/APD will ensure that staff understand and communicate safeguards, including use of peer wellness specialists, personal health navigators, and community health workers and ensure that these services are coordinated with LTC services to maximize efficiencies. • AAA/APD will coordinate with CCOs to manage member complaints and grievances for CCO members.
<p><u>Patient Engagement:</u> CCO will operate in a manner that encourages patient engagement, activation, and accountability for the member’s own health.</p>	<ul style="list-style-type: none"> • CCO actively engage members in the design and, where applicable, implementation of their treatment and care plans • CCO ensures that member choices are reflected in the development of treatment plans and member dignity is respected. 	<ul style="list-style-type: none"> • CCO will actively engage members in the design and, where applicable, implementation of their treatment and care plans, in coordination with AAA/APD where relevant to LTC service planning. 	<ul style="list-style-type: none"> • AAA/APD will actively engage individuals in the design, and where applicable, implementation of their LTC service plan, in coordination with CCO where relevant to health care treatment and care planning.

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<p><u>Outcome and Quality Measures:</u> Each CCO reports on outcome and quality measures identified by the Authority under Section 10 and participates in the All Payer All Claims data reporting system</p>	<ul style="list-style-type: none"> • CCO reports and demonstrates an acceptable level of performance with respect to OHA-identified metrics. • CCO submits APAC data in a timely manner according to program specifications. 	<ul style="list-style-type: none"> • CCO will demonstrate an acceptable level of performance related to shared accountability for individuals receiving LTC services and supports. 	<ul style="list-style-type: none"> • AAA/APD will demonstrate an acceptable level of performance related to shared accountability for individuals served by the CCO and receiving LTC services and supports.
<p><u>Governance Structure:</u> Each CCO has a governance structure that includes:</p> <ul style="list-style-type: none"> • A majority interest consisting of the persons that share the financial risk of the organization • The major components of the health care delivery system, and • The community at large, to ensure that the organization's decision-making is consistent with the values of the members of the community 	<p>CCO will clearly articulate:</p> <ul style="list-style-type: none"> • How it will meet governance structure criteria from HB 3650; • How the governing board makeup reflects community needs and supports the goals of health care transformation; • What criteria will be/were used to select for governing members; • How it will assure transparency in governance. 	<p>CCO will clearly articulate:</p> <ul style="list-style-type: none"> • How CCO governance structure will reflect the needs of members receiving LTC services and supports through representation on the governing board or community advisory council. 	<ul style="list-style-type: none"> • AAA/APD will participate at the community level in the board / Advisory panel for LTC perspective as needed. • AAA will articulate how the membership of the local governing boards, Advisory Councils, or governing structures will reflect the needs of clients served by the regional CCO(s). • DHS/APD will articulate how APD will include CCO participation in their policy development structures.

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<p><u>Learning Collaborative:</u> Each CCO participates in the learning collaborative described in ORS 442.210</p>	<p>CCO adheres to HB 3650 requirements for participation in learning collaborative.</p>	<ul style="list-style-type: none"> [OHPB Baseline Expectations] 	<ul style="list-style-type: none"> AAA/APD will participate in learning collaborative on relevant topics such as care coordination, LTC, best practices.