

Oregon Health Policy Board

AGENDA

February 14, 2012

Market Square Building

1515 SW 5th Avenue, 9th floor

1 pm to 3:30 pm

Live web streamed at: [OHPB Live Web Streaming](#)

#	Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll call Consent agenda: 1/24/12 minutes	Vice-Chair	X
2	1:05	Director's Report --Legislative update --CMS update	Bruce Goldberg	
3	1:20	Orientation to the Indian health system	Jim Roberts Northwest Portland Area Indian Health Board	
4	1:35	DHS Stakeholder Recommendations for Preserving and Enhancing Oregon's LTC System	Erinn Kelley-Siel	
5	1:50	CCO-Long Term Care Alignment Medicare 3-Way Contract	Susan Otter	
6	2:30	Final Report: Medicare-Medicaid Listening Groups	Brian Nieuburt	
7	2:40	Invited testimony	TBA	
8	3:05	Public testimony	Vice-Chair	
9	3:30	Adjourn	Chair	

Next Meeting:
March 13, 2012
Market Square Bldg.
8:30 am to noon

Oregon Health Policy Board
DRAFT Minutes
January 24, 2012
8:00am to 12:30pm
Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

Item
<p>Welcome and Call To Order Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present.</p> <p>Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).</p> <p>Consent Agenda: The minutes from the January 10, 2012 meeting were unanimously approved.</p> <p>A video entitled “Coordinated Care in Oregon: Ted Hanberg’s Story” was screened.</p> <p><i>Coordinated Care in Oregon: Ted Hanberg’s Story can be found here.</i></p>
<p>Director’s Report – Bruce Goldberg Bruce Goldberg spoke about his January trip alongside Governor Kitzhaber to speak with CMS and budget officials at the White House. He presented a series of graphs that summarized Health Management Associates’ Projected Savings attributable to Health System Transformation through Coordinated Care Organizations. Goldberg said the projections show that the nation can look at Health System Transformation as a way to simultaneously improve care and achieve its 10-year savings target.</p> <p><i>The Director’s Report can be found here, starting on page 7.</i></p>
<p>Medical Liability Report – Jeanene Smith, Bill Wright, Michelle Mello, Kate Baicker and Allen Kachalia Jeanene Smith, Bill Wright, Michelle Mello, Kate Baicker and Allen Kachalia presented an update on Medical Liability. Wright spoke about his work with Baicker, giving an overview of the studies and surveys that were conducted on defensive medicine as well as unnecessary care and overutilization. Wright said their key findings included the cost of defensive medicine in Oregon, and the prevalence and costs drivers of defensive medicine. Michelle Mello spoke about her work with Allen Kachalia on medical liability reform in Oregon, in which they explored caps on noneconomic damages, medical panels, OTCA coverage extension, modifications to Oregon’s JSL statute, and the administrative compensation system.</p> <p><i>The Medical Liability Report can be found here, starting on page 15.</i></p>
<p>Update on Integration of Medicare and Medicaid Services for Individuals Who are Dually Eligible – Susan Otter Susan Otter gave an update regarding the three-way contract with the State, CMS and the Health Plan to blend Medicaid and Medicare funding for individuals who are dually eligible. Otter said they are working with CMS to align Medicaid and Medicare administrative processes. They are working toward a deadline of releasing a draft of the Proposal to Integrate Care at the beginning of March for 30-day public comment period. Otter said she will return to the Board in February to present a more complete update, including more detail about the group’s strategies.</p> <p><i>The Update on Integration of Medicare and Medicaid Services for Individuals Who are Dually Eligible can be found here, starting on page 33.</i></p>
<p>PEBB/OEBB – Diane Lovell Diane Lovell spoke about the PEBB/OEBB transformation plan. She said PEBB/OEBB’s vision and strategies are anchored in a patient-centered, primary home care model. Lovell spoke about the plan’s key features, which include improvement of employee health, creativity and innovation, plan performance and information, flexibility in plan design and contracting, and choice among high quality plans. Lovell also said that PEBB will finalize its RFP structure in September and release the RFP in October; OEBB plans</p>

to release its RFP in October 2013.

The PEBB/OEBB Plan for Transformation can be found [here](#), starting on page 35.

Review of Public Comment – Tina Edlund

Tina Edlund spoke about public comments that have been submitted to the board regarding the CCO Implementation Proposal. Edlund said the largest number of comments came from alternative care providers regarding nondiscriminatory language and the second largest number of comments was made about the role of counties. Edlund also said the Northwest Indian Health Board asked the OHPB to pay particular attention to the special status of the Tribes.

The Summary of the Second Round of Public Comment can be found [here](#).

CCO Implementation Proposal Review– Diana Bianco

Diana Bianco reviewed the CCO Implementation Proposal and led a discussion about the issues that were raised at the last Board meeting. The topics reviewed included CCO certification, ADR, patient rights, payment methodologies that support the Triple Aim, financial transparency and the matrix.

The CCO Implementation Proposal can be found [here](#).

Review of HB 3650, Section 13 – Chair Eric Parsons

Chair Eric Parsons led the review of HB 3650, Section 13. The Board unanimously approved the CCO Implementation Proposal.

The CCO Implementation Proposal can be found [here](#).

Legislative Concept – Jeremy Vandehey

Jeremy Vandehey gave an overview of Legislative Concept 97 and summarized its five key elements.

Changes in LC 97 include:

- Language indicating the Legislature's approval of the Proposal
- Section 6 - Ensures DCBS and OHA can share information
- Section 8 - Nondiscrimination language
- Section 11 - Requires quarterly reports to the Legislature
- Technical corrections

LC 97 can be found [here](#), starting on page 45.

Public Testimony – Chair Eric Parsons

The board heard public testimony from six people:

Michele Stranger Hunter, Oregon Foundation of Reproductive Health, said preventive reproductive health measures should be included as core CCO performance measures. She said these preventive measures include tracking unintended pregnancies, contraceptive access, and pre-conception care. Hunter said basic screening can go a long way.

John Mullin, Oregon Law Center, offered thanks and recognition to the Board. Mullin said CCOs, if successful, will be the wave of the future. He also said that OHA needs to engage people on Medicaid now regarding future changes to their services.

Gail Bauhs, TriMet, spoke about Medicaid transportation brokerages. She said TriMet is interested to see if brokerages will be included in the budgets of CCOs. She asked if there are CCOs, will there still be a regional brokerage system?

Jennifer Pratt, Oregon Primary Care Association, said she is proud to be an Oregonian and to watch the Proposal process. Pratt said the Board will need to address undocumented residents and find time to speak to their needs.

Jim Massey, Naturopathic physician, said the CCO Implementation Proposal is a sign of how great Oregon is as a state. He said CCOs have opportunity to create health care that is integrated and if we

focus on prevention, we won't have to spend as many health care dollars.

Laura Farr, Oregon Association of Naturopathic Physicians, said that moving forward, the OHA needs to set the expectation that CCOs must allow access to all provider types, reflect a patient's right to choose with non-discrimination language, illuminate a solid dispute resolution process and have consistent definitions for "provider" and "primary care provider."

Written testimony that was handed out is available on the Policy Board meetings page:

<http://health.oregon.gov/OHA/OHPB/meetings/index.shtml>

Adjourn

Next meeting:

February 14, 2012

1:00 p.m. to 3:30 p.m.

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

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**Monthly Report to
Oregon Health Policy Board
February 14, 2012**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Program

- Through December 2011, **108,148** more children have been enrolled into Healthy Kids for a total child enrollment of **378,221**.
- **6,503** of these children are now enrolled in Healthy KidsConnect.
- This is 135% of our goal of 80,000 more children and a 40% increase in enrollment since June 2009 (baseline).
- *See the attached table for a more detailed look at Healthy Kids enrollment.*

OHP Standard

- The 2011/2013 biennial goal is to have an average monthly enrollment of 60,000 individuals enrolled in OHP Standard. This goal has been carried over from the 2009/2011 biennium.
- As of November 15, 2011, enrollment in OHP Standard is now **66,200**.
- There have now been twenty-three random drawings to date. The last drawing was on December 7, 2011 for 6,400 names.

Legislative Update

The CCO Proposal bill, SB 1580, has moved through the Senate Health and Human Services committee and through the Joint Ways and Means committee. We are expecting it to be heard on the Senate floor some time this week.

During Ways and Means, there was disagreement over a clause relating to medical liability reform, and the creating of a task force aimed at tackling that issue for the 2013 legislative session.

Centers for Medicare & Medicaid Services (CMS) Update

Positive discussions with CMS officials regarding waiver approvals continue. Staff from OHA and CMS are in constant contact. A further update will be provided at today's meeting.

Welcome Dr. Carla McKelvey

Please join me in welcoming Dr. Carla McKelvey to the board. She is currently a practicing physician at North Bend Medical Center in Coos Bay, as well as president of the Oregon Medical Association. She will be a valuable asset to the board.

Upcoming

Next OHPB meeting:

March 13, 2012

8:30 AM to 12:00 PM

Market Square Building

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Increase Over Baseline	Monthly net enrollment change	% of Goal Achieved
9-Jul	271,493	0	271,493	3,648	3,648	5%
9-Aug	276,712	0	276,712	8,867	5,219	11%
9-Sep	281,374	0	281,374	13,529	4,662	17%
9-Oct	289,015	0	289,015	21,170	7,641	26%
9-Nov	294,459	0	294,459	26,614	5,444	33%
9-Dec	298,600	0	298,600	30,755	4,141	38%
10-Jan	303,026	0	303,026	35,181	4,426	44%
10-Feb	305,785	205	305,990	38,145	2,964	48%
10-Mar	309,047	549	309,596	41,751	3,606	52%
10-Apr	312,191	923	313,114	45,269	3,518	57%
10-May	314,933	1,133	316,066	48,221	2,952	60%
10-Jun	316,891	1,338	318,229	50,384	2,163	63%
10-Jul	319,878	1,662	321,540	53,695	3,311	67%
10-Aug	322,694	1,948	324,642	56,797	3,102	71%
10-Sep	326,545	2,335	328,880	61,035	4,238	76%
10-Oct	331,837	2,700	334,537	66,692	5,657	83%
10-Nov	334,120	3,046	337,166	69,321	2,629	87%
10-Dec	337,498	3,441	340,939	73,094	3,773	91%
11-Jan	342,272	3,712	345,984	78,139	5,045	98%
11-Feb	348,660	4,081	352,741	84,896	6,757	106%
11-Mar	349,424	4,372	353,796	85,867	971	107%
11-Apr	353,526	4,732	358,258	90,329	4,462	113%
11-May	354,070	4,970	359,040	91,111	782	114%
11-June	356,645	5,196	361,841	93,892	2,781	117%
11-July	358,990	5,419	364,409	96,432	2,540	121%
11-Aug	360,644	5,626	366,270	98,300	1,868	123%
11-Sep	363,474	5,935	369,409	101,428	3,128	127%
11-Oct	366,811	6,140	372,951	104,890	3,462	131%
11-Nov	367,953	6,364	374,317	106,241	1,351	133%
11-Dec	369,723	6,503	376,226	108,148	1,907	135%

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**NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD**

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinalt Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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SENT VIA TELEFAX/EMAIL: (503) 947-2341 & ohpb.info@state.or.us

January 9, 2012

Oregon Health Policy Board
Eric Parsons, Chair
Lilian Shirley, Vice-Chair
500 Summer Street NE
Salem, OR 97301

Dear Mr. Parsons and Ms. Shirley:

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638¹ tribal organization that represents health care issues of forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. This includes all nine Tribes in the State of Oregon. We are writing to provide you with our comments and recommendations concerning the draft "CCO Implementation Proposal" to implement the requirements of HB 3650.

Our comments are intended for the second comment period that begins tomorrow, January 10, 2012, when the Oregon Health Fund Board convenes its meeting to begin consideration of an updated draft proposal to implement Coordinated Care Organizations (CCO). The recommendations included in the attached document represent the consensus views of all nine Oregon Tribes and the Native American Rehabilitation Association (NARA). These recommendations have been developed by Tribal leaders, health directors and NARA representatives in a series of meetings held over the past year.

We hope that you implement our recommendations as you finalize the CCO implementation plan and make recommendations to the Oregon Legislature. Our recommendations are included around five areas:

- Alternative Payment Methodologies and Global Budgets;
- Mandatory Enrollment;
- Indian Health Benefit Package;
- Options for providing specialty care, and;
- Tribal Consultation.

¹ A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

We believe that our recommendations will effectively integrate the Indian health system into the CCO process. Otherwise there will be complications that will need to be resolved, which will ultimately cost time and money and affect the quality of care that Indian people receive in the Medicaid program. We hope we can avoid these types of complications.

We welcome any questions you might have concerning our recommendations. We would also volunteer our organization to provide an overview to the OHFB on the Indian health system and its unique and complex set of federal laws that embody our recommendations. Please feel free to reach out to us if needed.

If you have any questions, feel free to contact Jim Roberts, Policy Analyst, at (503) 228-4185 or email at jroberts@npaihb.org. Thank you for your consideration!

Sincerely,

A handwritten signature in blue ink that reads "Joe Finkbonner". The signature is fluid and cursive, with the first name "Joe" and last name "Finkbonner" clearly legible.

Joe Finkbonner, RPH, MHA
Executive Director

cc: Bruce Goldberg, OHA Director
Judy Mohr Peterson, Medicaid Director
Jeanne Phillips, Deputy Director, Medical Assistance Programs
Nine Oregon Tribal Leaders & Health Directors
Jackie Mercer, Executive Director, NARA

Tribal Recommendations to Integrate the Indian Health Care Delivery System Into Oregon's Coordinated Care Organizations (H.B. 3650)

January 9, 2012

Executive Summary

House Bill 3650 establishes the Oregon Integrated and Coordinated Health Care Delivery system to replace managed care systems for Medicaid beneficiaries. The new system of Coordinated Care Organizations (CCOs) would be accountable for management of integrated and coordinated health care within a set global budget. The law requires the state to develop qualification criteria for CCOs, alternative payment methodologies, and to develop standards for patient centered primary care homes. The law also requires the state to adopt consumer and provider protections and to monitor and enforce these requirements.

CCO's may seem new to most, but not in the Indian health system. Since 1954 the Indian Health Service (IHS) has operated an integrated health care delivery model (primary care, behavioral health, and public health) that operates on a fixed (global) budget from Congress. Tribal health budgets are fixed funding that come via annual funding agreements with IHS that use a prioritized list of services to manage services to a population via the CHS program. CCO's service geography is similar to CHSDA health delivery regions. CCO reporting of quality and outcomes are comparable to IHS quality measures and reporting processes that are in place for Government Performance Results Act and Performance Assessment Rating Tool, which Tribes have utilized for years. Annual audits and accreditation also enhance quality outcomes. Thus, the objectives of CCOs are not new to the Indian health system. CCOs are delivery systems that Tribes will embrace if they effectively integrate our health care system.

On December 20th, Oregon Tribes and the NPAIHB met with State representatives to discuss the implementation of CCOs and how the changes might impact Tribal health programs. This dialogue allowed the opportunity to develop tribal recommendations for how CCOs can effectively integrate Indian health programs into the new CCO delivery system. The recommendations developed are around the following items:

- Alternative Payment Methodologies
- Mandatory Enrollment
- Indian Health Benefit Package
- Options for providing specialty care
- Global Budgets
- Tribal Consultation

The recommendations we provide are consistent with the Federal protections and requirements of IHS, Tribal and urban Indian operated health programs in Medicaid managed care organizations (MCOs). Medicaid MCOs refer to programs that coordinate, rationalize, and channel the delivery of care without being risk-based, and; also refers to care managed by organizations that assume full financial risk for the care managed. Medicaid MCOs in general are efforts to coordinate, rationalize, and channel the use of services to achieve desired access, service, and outcomes while controlling costs. These applications also

apply to Oregon’s new CCOs and meet the CMS definitions of being managed care organizations. Thus, CCOs are used interchangeably with MCOs in our recommendations.

Background

The provision of health services to AI/AN people stems from a unique trust relationship between the United States and Indian Tribes. The Federal government’s trust responsibility provides the legal justification and moral foundation for Indian specific health policymaking – with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this segment of the American population. It’s important to underscore that when Congress passed the Affordable Care Act¹, there were a number of Indian specific protections included to promote the health reform goals for AI/AN people. Similar protections were included in the Recovery Act² that exempted AI/ANs from cost sharing in Medicaid and CHIP, Medicaid estate recovery and provided rights of reimbursement for Indian health providers from Medicaid managed care entities. This serves as an example of the policy precedence for Indian specific health policy making. The existence of this truly unique obligation supplies the legal justification and moral foundation for health policy making specific to AI/ANs—with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of Indian people.

The Indian health system in Oregon is a unique and complex system comprised of ten ambulatory care clinics and one urban program that is governed by unique laws, regulations and policies. The Indian health system consists of services provided by the Indian Health Service (an agency in the U.S. Department of Health and Human Services); programs operated by Indian tribes and tribal organizations through Indian Self-Determination and Education Assistance (ISDEAA) agreements, and; by urban Indian organizations that receive grant funding from IHS under Title V of the Indian Health Care Improvement Act.

These programs serve some of the poorest and most isolated populations in the state. Due to the severe and chronic underfunding of Indian health system, AI/ANs have limited access to health care services and suffer some of the highest rates of health disparities when compared to other population groups. Many beneficiaries served by the Indian health system live in remote or sparsely-populated reservation areas. The Indian health system was designed to reach these beneficiaries in their communities which have little, if any, other health infrastructure presence. Even in more populated areas, the Indian health system provides the most meaningful access to health care due to challenges of low income and cultural differences that make other health services essentially inaccessible.

These characteristics are what make the Indian health system unique and requires it to have a comprehensive focus. The IHS delivery system strives to be an integrated, a community-based system that emphasizes prevention and public health, delivers and purchases health care services, and provides the infrastructure for health improvements by building health facilities and sanitation systems. It also provides work force improvement through training, recruitment and retention of health personnel. This system is the health care home for the AI/AN people that it serves. The tribal leaders who direct it, and, increasingly, its workforce, are its users, as are their grandparents and their grandchildren, and it

¹ Patient Protection and Affordable Care Act, (P.L. 111-148), commonly referred to as the “Affordable Care Act”.

² American Recovery and Reinvestment Act of 2009 (P.L. 111-5), commonly referred to as the “Recovery Act”.

will be the health care home for their grandchildren's grandchildren. The incentives in the Indian health system are not financial; its mission is the improvement of the health status of Indian people.

This is why it is important that the implementation of CCOs effectively integrate Indian health programs into their service model. The following recommendations can achieve this objective.

Measuring Health Quality and Reporting in the Indian Health System

The Indian health system strives to provide the best health care possible and is required by federal law to report annually on quality measures on its patients under the Government Performance and Results Act (GPRA). Other government health programs operated by the the Department of Veterans Affairs and the Department of Defense have to do the same. This means that all government health care programs are expected to improve the health of their patients with the money they get from Congress. Each year IHS includes its GPRA report card to Congress as part of the IHS budget submission. The GPRA report card tells Congress about the quality of care IHS is providing to its patients. The report card includes certain performance measures developed by IHS for the AI/AN patient population. For example, quality of care is measured by how well we are treating diabetes and heart disease. It also measures how well we are doing in preventing diseases like cancer, obesity, and HIV. Last year, IHS reported on 21 GPRA and three other clinical performance measures. The GPRA report is provided to the Office of Management and Budget (OMB) and Congress.

IHS programs also required to meet quality and accreditation standards for the purposes of participating in the Medicare, Medicaid and CHIP programs. To comply with this requirement IHS, Tribal and urban Indian programs are routinely accredited through such organizations as the Accreditation Association for Ambulatory Care or the Joint Commission Joint Commission on Accreditation of Health Care Organizations. This process requires Indian health programs to submit to a process in which their quality of care services and performance are measured against nationally-recognized standards. The accreditation process demonstrates that the Indian health system is committed to providing high-quality health care and that it has demonstrated that commitment by measuring up to the nationally-recognized standards.

IHS programs are required to comply with federal requirements for financial accountability. IHS programs must submit data for the purposes of the federal Program Assessment Rating Tool (PART), which measures budget and program performance so that the Federal government can achieve better results. A PART review helps identify a program's strengths and weaknesses to inform funding and management decisions aimed at making the program more effective. The PART therefore looks at all factors that affect and reflect program performance including program purpose and design; performance measurement, evaluations, and strategic planning; program management; and program results. This process includes a consistent series of analytical questions to measure programs over time it allows weakness to be identified so that improvements can be made to improve outcomes.

Tribes enter into legal binding contracts or compacts with the federal government under the Indian Self-Determination and Education Assistance Act (P.L. 93-638, "ISDEAA"), and; urban Indian programs enter into legal binding grant arrangements under Title V of the IHCA. In the course of carrying out these legally binding agreements with the Federal government, Tribes and urban programs must comply with the requirements of the Single Audit Act. Each IHS programs must complete the requirements of an OMB A-133 audit; which is a rigorous, organization-wide audit examination of funds that are received by

private, state and federal sources. Completion of this requirement demonstrates to the Federal government that the use of funds to provide health care is appropriately utilized. The audit is typically performed by an independent certified public accountant (CPA) and encompasses both financial and compliance components. Incomplete or irregular audits can jeopardize the funding that is received by IHS programs if corrective action is not taken and completed.

Recommendations:

1. Alternative payment methodologies and Global Budgets

H.B. 3650, Section 5, requires OHA to encourage CCOs to establish alternative payment methodologies that reward value and good health outcomes rather than volume and that limit increases in medical cost. CCOs shall also be encouraged to use payment structures other than fee-for-service that promote prevention, provide person-centered care and reward comprehensive care coordination. Providers and facilities may not charge, and CCOs may not reimburse for, services not covered by Medicare because they are related to health care acquired conditions.

This section also requires CCOs to reimburse Type A, Type B and rural critical access hospitals at cost until July 1, 2014. After July 1, 2014, OHA shall require CCOs to continue to reimburse specific hospitals at cost if the OHA determines that hospitals face sufficient financial risk. However, this section does not prohibit a CCO and a hospital from mutually agreeing to another method of reimbursement. The basis of this payment principle should be the same for the treatment of Indian health providers who serve similar populations and experience higher cost to provide care.

Tribal Recommendation:

HB 3650, Section 5 includes a requirement that CCOs must comply with federal requirements for payments to providers of the Indian health services, including but not limited to the payment protections of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C). Tribes recommend that the established Federal reimbursement process that uses the OMB encounter rate for IHS and Tribal programs and FQHC fee for service for urban health programs be maintained. IHS, Tribal and urban Indian health programs should not be subjected to any unnecessary certification or licensure requirements to participate in the CCO networks or as a condition of reimbursement.

In addition to the Section 5 exemption, there are federal requirements that protect the Indian health system for reimbursement and participation in the Medicaid program. The Indian Health Care Improvement Act (IHCIA or P.L. 94-437; amended as P.L. 111-148) contains such protections. The IHCIA at Section 206 stipulates that Indian health providers have a Federal right to receive reimbursement for the services they provide. Under Section 206, Indian health providers have the right to recover the "reasonable charges billed ... or, if higher, the highest amount any third party would pay for care and services furnished by providers other than governmental entities... "

The HHS Secretary has the responsibility under the Act to enforce this provision. If Indian health providers are not included in CCO plan networks, there may be more expensive transaction costs incurred by both the Indian providers and the CCO. Alternatively, if the requirement for Indian providers to be reimbursed by health plans is not effectively enforced, then the CCO may realize a potential windfall by collecting premiums or alternate resources for AI/AN enrollees – most likely

paid for with Federal dollars – and not making full payment for the health services their Indian enrollees receive from IHS and Tribal providers.

Additionally, the IHCIA at Section 408(a)(2), provides that Indian health programs are not required to obtain a license from the State as a condition of reimbursement by any Federal health care program so long as the Indian program meets “generally applicable State or other requirements for participation as a provider of health care services under the program.” A “Federal health care program” means “any plan or that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or in part, by the United States Government,” including health insurance programs under chapter 89 of title 5; and any State health care program, which includes Medicaid, and CHIP, as well as any program receiving funds under certain other provisions of Federal law. Thus, the State or CCOs cannot require licensing in the State as a condition for network provider status nor as a condition for payment for services. Section 408 is as follows:

[a]ny requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the [Indian Health] Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law.

IHCIA Section 408 further states that “IHS, tribal and urban Indian organization programs shall be eligible for participation in any Federal health care program to the same extent as any other provider.” Consequently, federal law requires that tribal and urban health programs be offered participation in CCOs. Although tribal and urban programs are not required to participate, Section 408 mandates that states and CCO must offer to include all tribal and urban health programs within their provider networks.

In order address issues that might arise concerning reimbursement or participation of Tribal and urban programs in the networks of CCOs, the State should require CCOs to contract with IHS, Tribal or urban Indian providers using a contract addendum that sets forth federal rights and responsibilities similar to that used in the Medicare Part D program. This is also important to ensure that CCOs meet network adequacy and cultural competency requirements that are essential to providing and managing the care of AI/AN people. Use of a standard contract addendum will reduce legal and administrative uncertainty as CCOs seek to maintain compliance with all applicable federal laws.

2. Mandatory Enrollment

H.B. 3650, Section 27 and 28, requires that persons eligible for health services, which do not include Medicaid-funded long-term care for the purposes of this section, must enroll in a CCO, with several exceptions including: non-citizens; American Indian or Alaska Native beneficiaries; and other groups that OHA may exempt by rule (e.g. pregnant women in the third trimester). Mandatory enrollment does not apply to a person living in an area not served by a CCO or where the CCO’s provider network is inadequate, or PACE enrollees. In any area not served by a CCO but covered by a prepaid

managed care organization, a person must enroll with the managed care organization to receive any of the health services it offers.

There are a variety of reasons why and AI/AN may choose to exercise their option to opt out of being enrolled in a CCO. AI/ANs may prefer to continue to see providers they have an established relationship and that understand their needs and concerns and provides culturally appropriate care. There may be transportation or other economic constraints that prohibit them from receiving care other than through Indian programs. Or they may have job or educational related circumstances that result in relocation between cities and the reservation. Whatever the reason, there must be options for AI/AN who opt in and out of CCOs and requirements for CCOs to coordinate with Indian health programs to manage AI/AN clients access to care and to ensure that Indian health programs are reimbursed in a timely manner. Unless this happens it limit access to specialty care for AIAN patients that will result in negative health outcomes and an unintended consequence that discriminates against AI/ANs from being able to access specialty care.

Regardless, whether an IHS, Tribal or urban Indian health program is a participating provider in a CCO, it should be a requirement that any covered service rendered to a Medicaid patient should be reimbursed at the FFS rate or comply with the established federal requirements for payments to providers of Indian health services under the OMB encounter rate. The State should also establish procedures to make prompt and timely payment consistent with the rule for prompt payment of providers under Section 1932(a) of the Social Security Act. These payment requirements should also apply to any wrap-around payments from the State in accordance with ARRA, Section 5006 (42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C)).

Tribal Recommendations:

Since H.B. 3650 includes an exemption for AI/AN from mandatory enrollment the CCO system should be able to identify AI/AN beneficiaries and provide them with the an open card option similar to what is used in the OHP and IHS, Tribal and urban health programs should be eligible to be reimbursed on a FFS basis. The patient population that is eligible for this option would be any individual that is eligible to receive services through the Indian health system. HB 3650 defines AI/AN beneficiary consistent with the definition adopted by the Centers for Medicare and Medicaid Services (CMS) definition of "Indian" in its implementation of the Medicaid cost sharing protections enacted in Sec. 5006 of the Recovery Act (codified at 42 U.S.C. § 1396o(j)). This regulation, 42 C.F.R. § 447.1 - 447.50, broadly defines the term "Indian" consistent with the Indian Health Service's ("IHS") regulations on eligibility for IHS services.

We recommend that the state develop requirements to address the issues related to the relationship of shared patients between the Indian health system and CCOs. These requirements should address coordination and access to care for AI/AN patients, and; compliance with Medicaid prompt payment requirements to Indian health providers. The development such requirements should not be placed on IHS programs or CCOs, but should be the responsibility of the Oregon as the single state Medicaid agency. At a minimum these requirements should address AI/ANs enrolled in CCOs, who receive services from IHS, Tribal and urban Indian health programs and specialty care access for those for AI/ANs not enrolled in MCOs.

The State should require CCOs that enroll AI/ANs to treat any referral made by an IHS, Tribal or urban Indian health program to be treated as a participating primary care provider for the purposes

of receiving services from the CCOs network and for reimbursement of services provided by the Indian health system. Without such a requirement Indian health referrals will likely be refused service by the CCO network providers.

3. Indian health benefit package

H.B. 3650, Section 39, makes a conforming amendment to ORS 414.428, which is the regulation that provides an individual who is eligible for or receiving medical assistance and who is an AI/AN beneficiary shall receive the benefit package of health services described in ORS 414.707 if: (a) The Oregon Health Authority receives 100 percent federal medical assistance percentage for payments made by the authority for the health services provided as part of the benefit package described in ORS 414.707, or; “(b) The authority receives funding from the Indian tribes for which federal financial participation is available.

Tribal Recommendation:

Tribes have requested that the state explore options to exempt AI/AN from benefit reductions or explore alternatives to be able to provide optional services that have already been reduced in the Oregon Health Plan. We recommend that the State continue to work with Tribes and CMS in the development of waiver or state plan amendment (whichever is necessary) to allow implementation of Section 29. The requirements of Section 39 would make such services completely budget neutral to the State and provided needed services to address the health disparities that persist in Oregon’s tribal population.

4. Global Budgets

HB 3650, Section 13 requires the OHA develop—and the legislature to approve—a meaningful public process for CCO qualification criteria and a global budgeting process. It is noted that the draft report “CCO Implementation Proposal” for HB 3650 mentions that “all Medicaid dollars are in the global budgets” with the exception of long-term and mental health drugs. It is important to recognize that Oregon provides Tribes funding under its Medicaid plan for targeted case management (TCM) and out-stationed eligibility workers. Oregon operates a Tribal TCM program that provides Medicaid case management services to AI/ANs to assist eligible beneficiaries in obtaining medical and other services necessary for their treatment.³ The target group consists of individuals served by tribal programs, or receiving services from a federally-recognized Indian tribal government located in the State, and not receiving services from other Title XIX programs. The OHA also provides IHS, Tribal and urban programs reasonable compensation for activities directly related to the receipt and initial processing of applications for individuals, including low-income pregnant women and children, to apply for Medicaid at outstation locations other than state offices.⁴ Both of these programs are very important in providing outreach, enrollment and linkage activities for Indian people.

³ ORS 410-138-0610, Targeted Group - Federally Recognized Tribal Governments in Oregon.

⁴ ORS 410-146-0460, Compensation for Out-stationed Outreach Workers.

Tribal Recommendation: TCM and out-stationed eligibility workers are services that in most instances could not be performed on reservations by CCOs. Thus the funds provided to Tribes for these programs should be exempt from CCO global budget and continue to be received by Tribes under the State Medicaid plan. CCOs will likely lack the presence in Tribal communities to perform these services. IHS, Tribal and urban programs also carry these services out within their existing health programs that give them a distinct advantage in conducting these services. They are in the clinics and conducted with members of the community who understand the needs of the patients they serve.

5. Tribal Consultation

In recognition of the special relationship with tribal governments, the United States government has recognized the importance of Tribal consultation by reaffirming Executive Order 13175 to ensure regular and meaningful consultation and collaboration with tribal officials in Federal policy decisions that have tribal implications. In 1975, Oregon established the Legislative Commission on Indian Services (CIS) to improve services to Indian people by improving communication and coordination with Tribes. Following establishment of the Commission, the legislature overwhelmingly supported passage of SB 770, a bill that acknowledges and promotes government-to-government relations with Oregon Tribes. This establishes a foundation that the State and the legislature consult with Oregon Tribes in developing policies and implementing programs that will affect their interests.

Section 5006(e) of the Recovery Act codifies in statute, at section 1902(a)(73), the requirement that States utilize a process to seek advice on a regular, ongoing basis from designees of the Indian Health Programs and Urban Indian Organizations concerning Medicaid and CHIP matters having a direct effect on Indians, Indian Health Programs or Urban Indian Organizations. The statute requires the solicitation of advice on an "on-going, regular basis". In order to assure the spirit of this obligation is fulfilled; CMS will require States to demonstrate that they have sought advice from designees of Indian Health Programs and Urban Indian Health Organizations throughout the process of developing state plan amendments, waiver requests, and demonstration projects. The "on-going, regular basis" requirement is intended to assure that the State has the benefit of substantive input and evaluation of impact from Indian Health Programs and Urban Indian Health Organizations during the proposal development process so that the State can meaningfully take this information into account.

Tribal Recommendation:

Tribes recommend that the State consult with Tribes over the final operational plan to implement CCOs where there are tribal implications that will affect the above recommendations and prior to the State's submission of the Medicaid State plan amendment or waiver request to implement CCOs. Tribes acknowledge that some of the State's Medicaid responsibilities could be subrogated to CCOs and that in these instances that State and CCOs must ensure that the tribal consultation process is adhered to when issues are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations.

6. Criteria for Coordinated Care Organizations

HB 3650, Section 5 sets forth the qualification criteria for CCOs including the governance structure, financial requirements, and components of health care delivery systems. Options to organize CCOs include community-based organizations, statewide organizations with community-based participation, a single corporate structure, or a network of providers organized through contractual relationships. In almost every instance the Oregon's Indian health care delivery system can meet all the requirements of these structures. Tribal and urban communities by their very nature are community based and their health clinics are their organizations that provide health care. Collectively they can coordinate to be statewide or become a single corporate structure and already include community participation. The Indian health system can also be formalized into a networked structure of providers through contractual relationships amongst itself or with other health system providers. While the benefits and challenges of becoming a CCO are not known by the Indian health system at this time, we would like to preserve the ability to become CCOs if it would be beneficial to our providers and patients.

Tribal Recommendations: We recommend that the qualification criteria to establish a CCO should not preclude the ability of IHS, Tribal and urban Indian health programs to become a CCO. We also recommend that the criteria for CCOs must require that they meet network adequacy requirements for providing care to AI/ANs located on Indian reservations and that there also be requirements for meeting cultural competency for providing care to all Oregonian populations.

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Aging and People with Disabilities

LTC Budget Note Report

Erinn Kelley-Siel, DHS Director

Trisha Baxter, COO for Aging and Disability Programs

Human Services Ways and Means
February 8, 2012



HB 5030 Budget Note

Department of Human Services and key stakeholders were directed to make recommendations to preserve and enhance Oregon's long term care system.

Recommendations to address:

- Best mix of services and supports, including support for caregivers, to maintain independence, health, safety;
- Best blend of federal, state and private resources; and
- Plans to better align state and local structures, identify cost efficiencies, and create incentives.

Stakeholder Groups

Group 1 focused on seniors and individuals with disabilities at high risk of Medicaid eligibility (with charge to i.d. services to prevent or delay entry into Medicaid **as appropriate*).

- Representatives from Governor's Commission on Senior Services, Oregon Disabilities Commission, State Independent Living Council and Area Agencies on Aging.

Group 2 used the health transformation opportunity to focus on the best blend of resources, alignment, and efficiencies for individuals eligible for Medicare, Medicaid, and Medicaid Long Term Services and Supports.

- Representatives selected from the Governor-appointed Medicare-Medicaid Integration of Care and Services Workgroup.

Group 1 Focus: “Pre-Medicaid”

An individual at high risk of Medicaid LTC Eligibility.

- 1) Financial Eligibility: A senior or person with a disability that met income eligibility for Medicaid LTC (currently \$2,022/mo) and who had under \$40,000 in liquid assets (equivalent to six months of the cost of a private-pay stay in a Nursing Facility).
- 2) Health and Behavioral Risks
- 3) Social and Environmental Risks

Group 1 Recommendations:

- Leverage Aging and Disability Resource Connection model as the statewide organizational structure for information, options counseling, preventative and support services (Virtual ADRC by 12/31/12; Full Implementation of Model by 12/31/13);
- Use Oregon Project Independence (as envisioned by HB 3037 (2009)) as part of a larger prevention and early intervention continuum (Assessment/Cost Benefit Analysis; Care Transition; and Inclusion of Persons with Disabilities); and
- Pursue new and enhance existing preventative programs to mitigate health and behavioral, social and environmental, and financial risks of Medicaid eligibility, for example: stronger employment support programs; expansion of EBP health promotion activities targeting at-risk older adults; and strategies to expand utilization of LTC Insurance (HIX & DCBS partnership) and financial counseling.

Group 2 Recommendations:

- Pursue flexibility in rules and resources to maximize availability of lower cost services and increase use of private contributions for federal match;
- Identify and develop promising models of service coordination between Coordinated Care Organizations and the Long Term Care System, for example;
 - Person-centered team approaches, such as Interdisciplinary Service Teams – Shared Assessments & Integrated Service Plans;
 - Delivering services in congregate settings (housing with services, Program for All-Inclusive Care for the Elderly (PACE));
 - Clinician/Home-Based Programs (NPs, PAs, RNs providing interventions to an individual in their home, CBC or NF).

Group 2 Recommendations (cont'd):

- Reduce risks of cost shifts between CCOs and the LTC system through shared accountability mechanisms. *see Appendix C*
- Some strategies recommended include:
 - Process Measures that ensure coordinated service planning and transitions of care;
 - Outcome Measures demonstrating that CCOs and the LTC system are jointly accountable to improve client health, functionality and well-being (*appropriate to goals of care);
 - Financial incentives and shared savings for coordination of services based on measures/performance;
 - Non-payment for duplicative services.

Related Activities in Process

- OHA has a design contract with CMS
 - \$1 million in funding over 12 months to develop a proposal to integrate care for dually eligible individuals
- CMS has also offered all states new opportunity for 3-way contracts between health plans, state and CMS for blending Medicare and Medicaid funding for dual eligible beneficiaries
 - Oregon indicated intent to include this model in design contract proposal
- Design contract may also be opportunity to pursue other promising coordinated service delivery models
 - Housing with services
 - More flexible Program of All-Inclusive Care for the Elderly (PACE)

Related Activities in Process

DHS Modernization Initiative:

Technology:

- Eligibility Automation
- Data Sharing and Interoperability
- Streamlined Data Reporting
- Aggregate and Real-Time Outcomes and Process Measures

Service Delivery:

- Self-service options for customers
- DHS and Partner case managers focus face-to-face time & energy on individuals with greatest needs
- DHS and service-delivery Partners have access to client-specific real time, integrated data
- Improved accountability for results and service equity, in partnership with clients and community partners

Conclusion

Opportunities Exist to:

- ✓ Improve services and supports to enhance the independence, health and safety of older Oregonians and Oregonians with disabilities;
- ✓ Better coordinate existing resources and services to ensure access and high quality care;
- ✓ Achieve alignment and coordination across systems and create incentives to assure consistent, efficient and effective service delivery; and
- ✓ Bend the Medicaid LTC cost-curve.

Full report available at: <http://www.oregon.gov/DHS/aboutdhs/budget/2011-2013/docs/ltc-budget-note-rpt.pdf>



Oregon

John A. Kitzhaber, MD, Governor

Department of Human Services

Office of the Director

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January 13, 2012

The Honorable Senate President Peter Courtney
The Honorable Co-Speaker of the House Bruce Hanna
The Honorable Co-Speaker of the House Arnie Roblan
900 Court Street, NE
Salem, OR 97301

RE: Report for the House Bill 5030 (2011) Budget Note on Oregon's Long Term
Care System

Dear Legislators:

House Bill 5030 (2011) directed the Governor to convene key stakeholders and Department of Human Services (DHS) staff to make recommendations in January 2012, preserving and enhancing Oregon's long term care system for seniors and individuals with disabilities.

The enclosed report is the result of two stakeholder workgroups convened by the Governor. The report is also posted on the DHS website at:

<http://www.oregon.gov/DHS/aboutdhs/budget/2011-2013/index.shtml>

Sincerely,

A handwritten signature in black ink, appearing to read "ELM", with a long horizontal flourish extending to the right.

Eric Luther Moore
Chief Financial Officer

Enclosure

The Honorable Senate President Peter Courtney
The Honorable Co-Speaker of the House Bruce Hanna
The Honorable Co-Speaker of the House Arnie Roblan
January 13, 2012
Page 2 of 2

cc: The Honorable Senator Alan C. Bates
The Honorable Representative Jean Cowan
The Honorable Representative Tim Freeman
The Honorable Representative Vic Gilliam
The Honorable Representative Carolyn Tomei
The Honorable Senator Laurie Monnes Anderson
The Honorable Senator Jeff Kruse

George Naughton
Ken Rocco
Gina Rumbaugh
Sheila Baker
Kate Nass
Sandy Thiele-Cirka

Report for the House Bill 5030 (2011) Budget Note on Oregon's Long Term Care System

January 2012

Executive Summary

House Bill 5030 (2011) directed the Governor to convene key stakeholders and Department of Human Services (DHS) staff to make recommendations preserving and enhancing Oregon's long term care system for seniors and individuals with disabilities.

The Governor assigned two groups to work on specific subsections of this budget note. Representatives of the Oregon Disabilities Commission, Governor's Commission on Senior Services, State Independent Living Council and Area Agencies on Aging focused on the best mix of services and supports to prevent or delay Medicaid eligibility. A subgroup of the Governor-appointed Medicare-Medicaid Integration of Care and Services Workgroup focused on the best blend of resources, alignment, and cost efficiencies and incentives for services to individuals with triple eligibility: Medicare, Medicaid, and Medicaid-funded long term services and supports. Much of the work of the second group focused on the relationship between the long term care system and the changes to health care delivery through the development of Coordinated Care Organizations (CCOs).

Common themes emerged among the recommendations of each group. Themes include directing more resources to preventative, low cost, and least intrusive services and supports, better communication and coordination among service providers, and education and empowerment of individuals receiving services and supports.

Recommendations for the best mix of services and supports for individuals at high risk of Medicaid eligibility:

- Strengthen and enhance the Aging and Disability Resource Connection (ADRC) as the organizational structure to provide information, referral, preventative and support services to individuals statewide;
- Recognize OPI as only part of a larger prevention and early intervention continuum. Strengthen OPI through a more rigorous assessment of the program and expand on the supports for individuals and caregivers before they qualify for more costly Medicaid Long Term Care programs;
- Mitigate health and behavioral risks of Medicaid eligibility through health promotion and preventative programs, transition programs, employment programs, and community health improvement assessment programs;

- Mitigate social and environmental risks of Medicaid eligibility through volunteer and peer mentoring programs, family caregiver programs, and housing and employment programs; and
- Mitigate financial risks of Medicaid eligibility through strengthened awareness and training to prevent financial fraud, abuse and exploitation, promotion of long term care insurance and other money management programs.

Recommendations for the best blend of resources, alignment, and cost efficiencies and incentives of services for individuals who are eligible for Medicare, Medicaid, and Medicaid long term services and supports:

- Pursue flexibility of resources (such as purchasing Durable Medical Equipment) to maximize appropriate, lower cost services and supports and opportunities to use private contributions for federal match;
- Pursue promising models of service and care coordination (e.g., Co-Location, Services in Congregate Settings, Clinician/Home-Based Programs) for better alignment of services provided by CCOs and the long term care system;
- Enhance service coordination between the long term care system and CCOs through memoranda of understanding, robust information sharing and coordination with interdisciplinary teams, transition planning, reduced duplicative practices, and education and engagement of individuals receiving the service; and
- Reduce the risk of cost shifts between CCOs and the long term care system through shared accountability mechanisms, such as appropriate outcome and process metrics, financial incentives and shared savings for coordination of services, and possibly penalties where appropriate (e.g., not paying for duplicative services when providers do not follow the service plan).

DHS is actively looking for ways to realign existing resources and system supports with the recommended actions. Generally speaking, however, both workgroups agreed that some additional, upfront investment in these strategies would yield a return on that investment, i.e., better outcomes for individuals and their caregivers, and more cost-effective use of federal, state and local resources.

DHS and its external stakeholders look forward to further direction from the Legislature regarding its priorities for next steps.

Subsection (1) Group:

- Ann Balzell, Oregon Disabilities Commission (ODC)
- Jonathan Bartholomew, Governor's Commission on Senior Services (GCSS)
- Peggie Beck, GCSS
- Brenda Durbin, Area Agencies on Aging and Disabilities (O4AD)
- Ryan Green, ODC
- Ruth A. McEwen, ODC
- Barry Fox-Quamme, State Independent Living Council (SILC)
- Charles Richards, GCSS
- Rodney Schroeder, O4AD
- Catherine Skiens, GCSS
- Sherry Stock, ODC
- Sheila Thomas, SILC
- Tina M. Treasure, ODC
- Kenneth Viegas, GCSS

Staff:

- Erinn Kelley-Siel, DHS Director (Sponsor)
- Bill Lynch, Meeting Outcomes (Facilitator)
- Patricia Baxter, Aging and Physical Disabilities Chief Operating Officer
- Elaine Young, State Unit on Aging
- Linda Dreyer, State Unit on Aging
- Lori Watt, State Unit on Aging
- Kelsi Eisele, DHS
- Max Brown, DHS

Subsection (2) Group:

- Rhonda Busek, BS, MBA, PacificSource Health Plans
- Jim Carlson, Oregon Health Care Association
- Ellen Garcia, MPH, Providence ElderPlace
- Ruth Gulyas, Oregon Alliance of Senior and Health Services
- Jennifer Hahn, GNP-BC, Peace Health Medical Group
- Mary Rita Hurley, RN, MPA, Oregon Center of Nursing
- David Komeiji, BA, PT, MMSC, Retired
- Kay Metzger, Lane Council of Governments Senior and Disability Services
- Veronica Sheffield, MS, BS, BSN, RN, Willamette Valley Providers Health Authority

Staff:

- Erinn Kelley-Siel, DHS Director (Sponsor)
- Patricia Baxter, Aging and Physical Disabilities (APD) Chief Operating Officer (Co-Chair)
- Susan Otter, Office of Health Policy and Research (OHPR) (Co-Chair)
- Selina Hickman, APD Services
- Megan Hornby, APD Services
- Kate Sharaf, OHPR
- Bob Weir, OHPR
- Matt Bartolotti, OHPR
- Kelsi Eisele, DHS
- Max Brown, DHS

Introduction

House Bill 5030 (2011) directed the Governor to convene key stakeholders, including representatives from the Department of Human Services (DHS), to develop recommendations for enhancing and preserving Oregon's long term care (LTC) system¹ for seniors and individuals with disabilities. This budget note requested recommendations regarding:

- (1) The best mix of services and supports, including supports to caregivers, to be available in every Oregon community that will keep seniors and people with disabilities as independent as possible, healthy and safe.
- (2) Specific plans and recommended steps to best blend state and federal resources with private pay to assure access to high quality care and supports for individuals, families and caregivers.
- (3) Plans and recommended steps to better align state and local administrative structures, identify cost efficiencies and create incentives to assure consistent, efficient and effective service delivery and high quality service outcomes.

In convening key stakeholders and DHS representatives, the Governor tasked two groups to work on the budget note subsections by taking them in specific directions. For subsection (1), the Governor asked the group to focus on “non-Medicaid” programs and systems design that prevent or delay entry into Medicaid programs, while supporting the financial independence of seniors and individuals with disabilities as long as possible. For subsections (2) and (3), the Governor asked a separate group to focus on individuals with “triple eligibility”: seniors and individuals with disabilities who receive Medicare, Medicaid and Medicaid-funded long term services and supports (LTSS).

The group working on subsection (1) included five representatives from the Oregon Disabilities Commission (ODC), five representatives from the Governor's Commission on Senior Services (GCSS), two representatives from the State Independent Living Council (SILC), and two representatives from the Area Agencies on Aging (AAA). The group working on subsections (2) and (3) was

¹ For purposes of this report, “long term care” (LTC) refers to the system of long term services and supports, including nursing facilities, community based care, and in-home services. “Long term services and supports” (LTSS) refers specifically to these services.

convened as a subgroup of the Governor-appointed Medicare-Medicaid Integration of Care and Services Workgroup.

The need to plan for the future of LTC in Oregon is compelling. One reason is that over the next twenty years, Oregon's aging demographic will change significantly. In 2009, slightly more than one in every eight people was age 65 or older; by 2030, nearly one in five will be 65 or older. Additionally, there will be a significant increase in individuals 85 or older. In 2010, about 76,000 reached age 85; by 2030, this group is projected to be over 120,000, an increase of almost 60 percent. In addition to the growing senior population, an increasing population of younger individuals with disabilities constitutes a significant portion – nearly 40 percent – of people receiving long term services and supports.

Oregon's Medicaid program provides LTSS as a safety net for seniors and individuals with disabilities who have exhausted all other resources available to them and meet the Medicaid criteria for assistance with activities of daily living (ADLs). Most individuals with Medicaid LTSS also qualify for Medicare, and are therefore are individuals with "triple eligibility": they receive Medicare, Medicaid, and Medicaid LTSS.

At this time, the future growth of Oregon's Medicaid LTC system is unsustainable. Since the start of the recession in 2008, Oregon's General Fund (which provides the required state match used to draw down federal Medicaid funds) has fallen and, according to most projections, will not keep up with the growing need for Medicaid-funded LTSS over the next decade. The federal government provided a boost to the Medicaid program with an enhanced match under the American Recovery and Reinvestment Act (ARRA) of 2009, but that supplemental funding ended on July 1, 2011. With no other supplemental funding in the offing, Oregon faces both a short and long term budget deficit in the future. Medicaid continues to be the fastest growing expense in state budgets. As such, it is imperative that Medicaid, including the Medicaid LTC system, can continue to provide for those who need it, even under current and future fiscal realities.

In 2011, new state legislation and federal policy changes provides some new opportunities to rethink the future of LTC in Oregon – both Medicaid LTC and beyond. On the state level, the 2011 Legislature passed House Bill 3650, which creates a new form of delivering many Medicaid services through Coordinated Care Organizations (CCOs). Under this legislation, CCOs, once fully implemented, will be responsible to integrate and provide Medicaid-funded physical, behavioral, and oral health services for the individuals enrolled. Entities seeking to become

CCOs will demonstrate that they meet specific criteria and be certified as CCOs by the state, and then will be given global budgets to cover services for Medicaid enrollees in a particular geographic area, while being held accountable to performance measures designed to ensure that quality care is delivered, health outcomes improve, and costs are reduced.

On the federal level, the Centers for Medicare and Medicaid Services (CMS) offered all states the opportunity to pursue three-way contracts among health plans, the state, and CMS for blended Medicare and Medicaid payment to plans, set at a level to target savings that can be shared. This opportunity is available for plans that fully integrate Medicare and Medicaid services, including LTSS in addition to physical and behavioral health services. The Oregon Health Authority is working with DHS to prepare a formal proposal to integrate care for dually eligible beneficiaries under a CMS initiative—called the “design contract.” Oregon has submitted a Letter of Intent indicating that it will be including this blended capitation approach in its design contract proposal to CMS. The work under subsections (2) and (3) of this report will support the development efforts of Oregon’s proposal to CMS.

HB 3650 and new policies of CMS create new opportunities for more efficient health care delivery and savings for Medicaid, yet HB 3650 explicitly excluded the LTC system from the purview of CCOs. The opportunity for making Medicaid LTC sustainable, then, lies in the possibility that its system can coordinate with the other Medicaid-provided services under the CCOs. This type of coordination and alignment will also be required in order to meet CMS expectations for integration of LTSS in order to bring in the Medicare funding. If LTSS can work in concert with better care coordination of physical, mental, behavior and oral services, then both the CCOs and the Medicaid LTC system may mutually benefit by slowing the growth of costs and serving a growing need with fewer available resources in the future.

But given the sheer gravity of the growing disparity between available revenue and the demographic changes coming to Oregon, it is imperative to devote as much – if not more – thinking to long term services and supports outside Medicaid’s LTC system. In this vein, the Governor requested that the group working on subsection (1) make recommendations for the best mix of services and supports to keep seniors and individuals with disabilities as financially independent as possible so as to prevent or delay their entry into Medicaid LTC. What follows is a list of recommendations created and agreed to by the group listed above for subsection (1). This report then provides recommendations from group addressing Medicaid

LTC – subsection (2) and (3) of the budget note, and concludes with next steps for Oregon’s system of LTC – both in Medicaid’s system and beyond.

Subsection (1): Recommendations on the best mix of services and supports to keep seniors and individuals with disabilities as financially independent as possible so as to prevent or delay their entry into Medicaid LTC.

In meeting Oregon’s LTC challenge, much work remains to be done for those who need long term services and supports, but who are not yet eligible for Medicaid LTC. As cited in the department’s “A Report on: Long-Term Care in Oregon” (September 2010), national studies indicate that 80 percent of LTSS is provided and paid for by the individual, family members, and friends and close to 30 percent of all households are involved in some kind of caregiving for seniors and individuals with disabilities. This assistance poses challenges for caregivers, often leaving family members and friends overwhelmed. Moreover, most seniors and individuals with disabilities lack the financial resources to afford to pay for private LTSS for more than a few weeks or months.

This picture grows worse by current financial conditions of most households. Personal savings and retirement savings of the cohort over age 50 are insufficient for the long term supports and services they will need as the population becomes older. Private long term care insurance plans usually only cover limited periods for home health care and nursing facility care for those recovering from a serious illness or injury, and only a small percentage of Oregonians hold these insurance policies. Meanwhile, according to 2010 figures, nursing facilities in Eugene cost \$85,000 a year, while home care services in Portland, for private pay individuals, costs \$22,000 a year if care is provided four hours a day, five days per week.² As the aforementioned 2010 report notes:

When people begin to look for help for themselves, their spouses, an aging parent, or for a person with disabilities, they often do not have the information, skills or supports to make informed decisions. As a result, they often end up using more intense and expensive levels of care than are necessary. This is ironic since, over the course of the last two decades, there has been a dramatic increase in the amount of information, products, and options available to assist older people, people with disabilities, and their families to manage their needs.

² MetLife Mature Market Institute, “Market Survey of Long-Term Care Costs,” October 2010.

In facing the challenge to future LTSS needs in Oregon, then, the group examining subsection (1) considered many previous recommendations for the “non-Medicaid” population. In so doing, the group found many recommendations to implement, as well as some gaps that began to address shortcomings in previous recommendations.

In making recommendations for the non-Medicaid population, the group came to a consensus on who was at high risk for Medicaid eligibility. One indicator is financial eligibility – a senior or individual with disability that met income eligibility for Medicaid LTC (currently \$2,022 a month, or 300 percent of Supplemental Security Income eligibility), and who had under \$40,000 in liquid assets (equivalent to six months of the cost for a private-pay stay in a nursing facility). Beyond the basic financial criteria and risks for Medicaid eligibility, the group also considered two other major risk categories for Medicaid eligibility: health and behavioral risks and social and environmental risks.

The recommendations are also informed by certain principles. First, these recommendations are made in the context of changes occurring to Medicaid-covered health and behavioral services under House Bill 3650. This transformation does not always affect the non-Medicaid population directly, but many social systems and supports for the non-Medicaid population can benefit from closer collaboration with the Coordinated Care Organizations (CCOs) established under HB 3650. In so doing, this group believes that this collaboration can create the conditions under which the social model of social services may positively transform the medical model of health and behavioral services, instead of bringing the medical model to social services and supports.

Secondly, in keeping with the principles of individual independence, choice, and dignity, these recommendations reflect a commitment to culturally competent services that empower the individual regardless of his or her race, gender, ethnicity, religion, native language, sexual orientation, or geographic area.

Recommendations begin with a more robust development of Oregon’s Aging and Disability Resource Connections (ADRC) program, as well as strengthening its system of long term supports, including Oregon Project Independence, for the non-Medicaid population at risk for Medicaid covered LTC for health and behavioral risks, social and environmental risks, and financial risks.

Aging and Disability Resource Connection (ADRC)

As an organizing and foundational principle, the Aging and Disability Resource Connection (ADRC) is a critical structure to provide public education in addition to the four core services of:

1. Information and Assistance,
2. Options Counseling,
3. Person-Centered Transition Support, and
4. Evidence-Based Health Promotion.

The ADRC provides an organizational structure for coordination and collaboration between the Area Agencies on Aging (AAAs),³ Centers for Independent Living (CILs)⁴ and other key community partners to lessen duplication of services and to assure the most comprehensive information possible is provided in an efficient and effective manner.

Evidence in other states that have developed and implemented ADRCs has shown their benefit to bend the escalating cost curve for long term care and health care downward. A specific example is Wisconsin where they began ADRC implementation in the late 1990s and a recent status report indicates a significant benefit to local economies with more efficient information and access to various programs, a reduction in falls and medical costs through the use/implementation of evidence-based health promotion programs and high marks for consumer satisfaction. Additionally, data compiled by the Lewin Group for a study called “Project 2020” clearly shows the cost benefit, cost offsets and potential cost

³ AAAs were established under the Older Americans Act (OAA) in 1973 to respond to the needs of Americans 60 and over in every local community. By providing a range of options that allow older adults to choose the home and community-based services and living arrangements that suit them best, AAAs make it possible for older adults to remain in their homes and communities as long as possible. AAAs leverage federal OAA funds with local community resources to provide support services, including specialized information and assistance, transportation, in-home care; nutrition services through congregate and home-delivered meals; preventative health services through medication and chronic disease self-management; family caregiver supports and elder rights protections. AAAs, which are also local government entities, also have the option to deliver services under the Medicaid Home and Community-Based Services waiver for older adults and adults with physical disabilities. AAAs operate in all Oregon counties and are guided by consumer-directed advisory councils.

⁴ CILs provide specialized information and resources for people with all types of disabilities and regardless of age, all provided through a system which is governed and operated by people with disabilities themselves. Their expertise comes directly from peers who understand disability and the realities of living with such, as well as utilizing support services. The philosophy of Independent Living at its core, is based on self-sufficiency and self-determination. CILs currently provide general Information/Referral, skills training, peer counseling and advocacy to promote independence in all but 14 counties of the State of Oregon, with specialized, contracted services provided statewide.

avoidance of providing the services and core functions of the ADRC related to nursing facility diversion and preventing/delaying spend-down to Medicaid. The ADRC Advisory Council has also adopted, and will be reporting on, several performance targets related to consumer satisfaction and outcome measures.

Over the last three years with the support of federal grants, Oregon has started ADRC implementation. To date the following has been accomplished:

- Procurement and launch of a public website that supports a searchable resource database.
- Procurement of a contact system that captures consumer information such as demographics, service needs, information/referral provided, need for follow-up. This information produces management and data reports to track ADRC performance.
- Adoption of continuous quality improvement plan and consumer-based standards for Information and Assistance and Options Counseling.
- Contract with Portland State University Institute on Aging to develop and conduct a consumer satisfaction survey of ADRC services that will inform the setting of metric thresholds for the ADRC standards.
- Professional, Supervisor, Service delivery standards developed for Options Counseling.
- Staff training curriculum and train-the-trainer curriculum developed for Options Counseling. (80 staff and 30 supervisors have completed the training to date)
- One statewide brand to facilitate ease of access for consumers.
- Support to AAAs for national certification of Information and Assistance staff (43 staff to date are certified).
- Adoption of a 5-year strategic plan for statewide implementation of the ADRC.

Additionally, Oregon has completed or will soon complete grant-funded projects that have identified promising practices in the areas of care transitions, options counseling, and evidence-based health promotion and caregiver supports. These projects also produced important insights about consumers who have high healthcare utilization, a risk factor for Medicaid spend-down.

Once further developed and implemented, the ADRC will provide more Oregonians the necessary information and resources to make informed decisions, which will enhance people's ability to live as independent, healthy and safe as possible. This is good for the individual, the family and Oregon. People are

happier when they are able to make decisions about their own lives, and this depth of information and resources provided through a collaborative and inclusive process is both efficient (minimize costs) and effective (deliver high quality services to individuals). Unlike other information and referral services (such as 211), ADRCs specialize in targeted information and resources affecting seniors, individuals with disabilities, and their families, friends, neighbors, medical professionals and advocates.

ADRC implementation statewide should be a two part process to maximize our ability to quickly provide information and resources to Oregonians in the near term by utilizing existing structures, resources and recently developed technology; which can be expanded and enhanced as time progresses by broadening collaboration, training and the depth of ability across the state. The group recommends the following:

Recommendations – ADRC

- Phase I: By December 31, 2012 all areas of the state will be covered by a virtual ADRC which will provide all Oregonians with an initial set of functions.
 - Toll free (1-800 number) access to information and assistance specialists providing resources, programs and services available in their local communities for seniors and people with disabilities, as well as their family members and friends, neighbors and health professionals. This function will include a referral to an appropriate entity to meet the needs of the caller as available.
 - Enhancement and continued support of the website and on-line resource database which includes public and private resources available for seniors and people with disabilities. This searchable database will be available to information and assistance specialists as well as the general public who have Internet access.
 - Statewide use of the on-line contact and database system by AAAs and CILs (with feasibility for CIL use having been conducted/determined) by their information and assistance staff to document calls, requested information and provide a management tool to identify the prominent needs and requests for specific areas.
 - Training of ADRC staff, and their community partners, as appropriate, to use a validated risk tool to identify consumers at-risk of Medicaid spend-down and assure the reliability of data to measure the effectiveness of services to prevent or delay entry in to Medicaid.

- Training provided AAA and CIL staff, as appropriate, for national certification of Information and Assistance staff.
 - Medicaid screening and referral as appropriate to the local Medicaid agency for stream-lined access to public benefits and support the matching of federal funds.
- Phase II: By December 31, 2013 additional functions/resources will be available statewide through all ADRCs provided either directly by the ADRC or through developed partnerships with other local providers/partners. These additional functions include:
 - The remaining ADRC core services of Options Counseling, Person-Centered Transition Support and Evidence-Based Health Promotion programs.
 - Financial planning information and referral to services including:
 - Benefits of long term care insurance
 - Pros and cons of reverse mortgages
 - Screening tools/surveys to assist individuals and families determine risks, strategies and methods to manage income, assets, savings and prevention
 - Enhance and expand local resources to promote and assist self-advocacy, self-direction and additional resources/information to help individuals remain in their communities.
 - Provide services and information to assist family caregivers, which will strengthen the natural support system, through information and assistance, training, support groups, counseling and respite.

Oregon Project Independence (OPI)

Created in 1975, OPI serves individuals who are 60 years of age or older, or who have been diagnosed with Alzheimer’s disease or a related disorder. The program offers many services, most notably in-home supports, for those meeting certain service eligibility requirements.

Although OPI is thought of as an in-home services and supports program for the non-Medicaid population, House Bill 3037 (2011) expanded other possible services that could be included in the program, such as information and referral services, health promotion services, options counseling, and transportation options to assist individuals to stay in their own homes. Since 2005, the program has a provision to expand eligibility to younger adults with disabilities if there is adequate funding (ORS 410.435).

As a program paid for by General Funds and by many participants who pay for a portion or all of their services, OPI is vulnerable to fluctuations in the state budget. Recently, the program closed to new enrollees. Realizing these factors, the group recommended that the future thinking about OPI should consider it on a “continuum of strategies of care, supports and services” rather than a “stand-alone” program. OPI can play an important role in preventing or delaying Medicaid eligibility as a service of the ADRC discussed above, as well as with the CCO infrastructure established by HB 3037. This important shift in thinking about OPI may provide opportunities to leverage these state funds with federal funds.

Recommendations – OPI

Short term recommendations include:

- Create a report that includes the following information:
 - For individuals with a Service Priority Level (SPL) of 10, compare the average Medicaid cost per case (regardless of setting) with the average OPI cost per case. The report will include the cost of the Oregon Health Plan for individuals on Medicaid, and only includes a comparison of General Fund costs.
 - Identifies the aspects of the OPI program that contribute to the social factors of health, such as nutrition, cleanliness of the personal environment, and socialization.

Longer term recommendations include:

- OPI funded to a level that allows for the participation of younger persons with disabilities and fulfills the requirements of ORS 410.435.
- As Care Transition programs are established in the state, use OPI an integral component of all Care Transitions programs in the state. This is one area in which OPI can coordinate with the transition programs established under the CCOs.
- Fund a study that will show the effectiveness of OPI and other non-Medicaid programs as resources to divert people from Medicaid. Minnesota’s Alternative Care program is similar in structure (and larger in scope) to OPI, and may provide a methodology through which to analyze effectiveness of Medicaid diversion.

Risks for Medicaid Eligibility

In addition to the role of the ADRC as a structure to access important services such as OPI by the non-Medicaid population, the group had other recommendations to

mitigate health and behavioral, social and environmental, and financial risks that contribute to individuals spending down to Medicaid eligibility.

Recommendations – Health and Behavioral Risks

Intermediate Outcomes (1-2 years)

By 2014, a targeted number of seniors and people with disabilities defined as “non-Medicaid,” and who have accessed the ADRC, have reduced the health and behavioral risks that would have contributed to their entering the Medicaid program.

Goal:

Seniors and people with disabilities, family members and family caregivers are receiving the information and support they need from an ADRC to make informed decisions about decreasing their health risks for entering the Medicaid program

Recommendations to achieve this goal:

- Ensure that ADRC staff use a validated screening tool over the phone or in person to identify the target population and their risks for out of home placement and Medicaid eligibility.
- Ensure that ADRC staff demonstrate the knowledge, skills and abilities to guide at-risk individuals through a risk management and planning process that helps them address areas of risk and links them directly to risk improvement interventions (e.g., Family Memory Care, falls prevention programs, Living Well with Chronic Conditions, caregiver assessment and consultation) and other community resources and supports such as Peer Mentoring Services and/or mental health and addictions services.
- The ADRC will have at least one Participation Agreement in place with a local health care provider (Primary Care Practice, hospital, skilled nursing facility) that establishes a referral pathway to the ADRC for patients who meet the target population definition.

Other ADRC recommendations with a longer time frame for completion:

- Implement evidence-based care transition programs coordinated between ADRCs and hospitals or Skilled Nursing Facilities, and, in concert with

CCOs, to help older adults and people with disabilities avoid an unplanned re-admission or Emergency Department (ED) visit during a 30-day recovery period.

- Pending legislative approval of Coordinated Care Organizations, pursue Participation Agreements between the ADRCs and local CCO entities to support meeting selected standards for Patient Centered Primary Care Homes (see especially Care Coordination and Education and Self Management Support).

Recommendations at the state level:

- Strengthen employment programs and employment supports for individuals with disabilities and seniors who want or need to work, given the positive correlation with employment and health outcomes and the resources that can avoid or delay Medicaid covered services. Employment delays Medicaid eligibility because of access to health care and resources. This support includes assistive technology, workplace accommodations, and personal care assistance.
- For those who need personal care assistance that private insurance does not cover, Oregon's Medicaid Buy-In program, the Employed Persons with Disabilities program, can keep individuals with disabilities competitively employed while they pay a portion of their Medicaid services, as well as taxes and a lower need for subsidies such as housing, transportation, food, and other needs.
- Prioritize Title IIID and IIIE Older Americans Act (OAA) funds to support evidence-based health promotion programs that reach a wider population of at-risk older adults (falls prevention, nutrition counseling, physical activity, medication management, family caregiver support), and pursue strategies to extend these programs to younger adults with disabilities.
- As the development and implementation of CCOs unfolds, the department should work with Addictions and Mental Health and stakeholders on possible models for mental health and addictions services for seniors and individuals with disabilities who are not eligible for Medicaid.
- Develop an agreement between the Conference of Local Health Officials (CLHO), the Oregon Association for Area Agencies on Aging and Disabilities (O4AD), and CILs that incentivizes ADRCs to partner with their local public health department to field community health improvement assessments. (Local public health departments must produce an assessment as part of the process of obtaining accreditation.) These assessments will

survey representative consumers to collect data that measures factors such as:

- Barriers to physical activity
- Access to healthy food
- Access to adequate health and mental health services
- Access to adequate transportation, including transportation during evenings and weekends.
- And other topical areas that the partners wish to measure.

Recommendations – Social and Environmental Risks

Intermediate Outcomes (1-2 years)

By 2014, a targeted number of seniors and people with disabilities defined as “high-risk” for Medicaid and who have accessed the ADRC, have reduced the social and environmental risks that may have contributed to their entering the Medicaid program.

Goal:

Seniors, people with disabilities, family, friends, and caregivers are getting information and support from the ADRC to decrease their risks of isolation and lack of natural supports.

Recommendations that will achieve this goal:

- Complete a review of existing programs in Oregon staffed by volunteers (e.g., RSVP, Project Reach, etc.) that documents the following:
 - Services provided, including gate-keeping to community-based programs;
 - Volume of services provided;
 - Service outcomes;
 - Best practices used to recruit, develop and support volunteer staff; and
 - Recommendations for expanding programs with known outcomes.
- Fund a comprehensive study of the Family Caregiver Support Program begun in 2006 by Older Americans Act funds. In so doing:
 - Examine programs for evidence based and best practices both in Oregon and in other states.

- Explore current and potential programs that can also serve younger individuals with disabilities, including peer support programs.
- Convene a group of senior and disability advocates to develop a statewide plan for respite programs.
- Promote the work of the Oregon Real Choice Systems Change Grant – Building Sustainable Partnerships for Housing with the overall goal of eliminating barriers to accessing housing for individuals with disabilities.
- Pursue employment programs for seniors and individuals with disabilities who want or need to work, and strengthen volunteer programs for those who wish to volunteer. Employment and volunteering are key to those who are at risk of social isolation.

Other recommendations with a longer timeframe for completion:

- ADRCs should continue to explore opportunities for coordinated social and medical services that, to the greatest extent possible, can be provided to seniors and individuals with disabilities locally and, if necessary, where consumers live.
- ADRCs should strengthen peer mentoring (whether provided by the CILs or the CILs in concert with ADRCs) in resources for Independent Living, such as skills training, and knowledge of and access to assistive technology and adaptive equipment.

Recommendations – Financial Risks

Intermediate Outcomes (1-2 years)

By 2014, a targeted number of seniors and people with disabilities defined as “pre-Medicaid,” and who have accessed the ADRC, have reduced financial risks that may have contributed to their entering the Medicaid program.

Recommendations to achieve this outcome:

- Ensure that ADRC staff and volunteers will be trained to identify individuals possibly at risk for financial fraud, abuse, or exploitation and refer to the appropriate agency.
- Pursue the inclusion of long term care insurance as part of the health insurance exchange that will be created by 2014 in Oregon.
- Partner in publicizing long term insurance policies with employers who offer it, as well as the state’s Long Term Care Partnership program.

- Include the Department of Consumer and Business Services in exploring initiatives to expand money management education programs to the non-Medicaid population.
- Explore initiatives to expand the use of cash and counseling (self-direction) for services to the non-Medicaid population, such as those supported by OAA, OPI and Veterans-Directed Home and Community-Based Services (VDHCBS). VDHCBS was recently implemented by the AAAs serving Multnomah and Washington counties.
- Pursue advocacy at the federal level for reinstating the implementation of the Community Living and Assistance Services and Supports (CLASS) Act. Also pursue a possible CLASS Act program at the state level.

Subsections (2) and (3): Recommendations for Individuals who are Eligible for Medicare, Medicaid, and Medicaid LTC

As stated in the introduction, the new state statute in HB 3650 and the possibility of blending Medicare and Medicaid funding provides opportunities for coordinating the physical, behavioral, and oral health care of individuals dually eligible for Medicaid and Medicare. Also noted was that HB 3650 excluded Medicaid funded LTC from the purview of Coordinated Care Organizations (CCOs).⁵

Parallel medical and LTC systems: The medical system and LTC system have parallel service delivery systems, leading to fragmented care for beneficiaries. Without coordination and alignment between the two systems, some services are duplicated or denied in one system even if they may provide savings and improved coordination with the other system.

It is possible that the maintenance of two separate systems will continue to produce misaligned incentives, cost-shifting between the CCOs and the LTC system, and poor outcomes for beneficiaries. Both systems are also informed by different models regarding aging and disability, the medical model and the social model, with their differing conceptions of the role of professionals, individual and consumer choices, and risk.

⁵ Despite this exclusion, it is important to note here that HB 3650 provides for CCO criteria regarding transitional care for individuals who enter or leave acute care facilities of a long term care setting, and for CCOs to use health information technology to link services and care providers across the continuum to the greatest extent practicable.

Given the exclusion in HB 3650 of Medicaid-funded LTC from the CCOs, the question facing the group for subsection (2) and (3) is: How can we strengthen the relationship, and create mutual accountability, between services provided under the CCOs and LTC services provided by the Department of Human Services, Aging and People with Disabilities programs?

In addressing these issues of coordination and accountability, the group looked at:

- (2) Best blend of resources to ensure access: Specific plans and recommended steps to best blend state and federal resources with private pay to assure access to high quality care and supports for individuals, families and caregivers.

- (3) Alignment, efficiencies, and incentives to ensure outcomes: Plans and recommended steps to better align state and local administrative structures, identify cost efficiencies and create incentives to assure consistent, efficient and effective service delivery and high quality service outcomes.

Best Blend of Resources to Ensure Access

The group tackled this topic in several ways. First, the group identified alternative resources that could be used with more flexibility, and made recommendations for better leveraging private contributions. In addition, the group considered the specific blend of resources provided by the CCOs and LTC systems, however, those findings and recommendations also relate to the groups charge to identify efficiencies and incentives to ensure outcomes, and are captured toward the end of that section.

Recommendations – Flexible Use of Resources:

The group considered the full array of resources available to support individuals eligible for Medicare, Medicaid, and LTSS, by first identifying the federal, state, community, and private resources and services available to support these individuals. See Appendix B for an inventory of these resources. The group noted that some of these resources had a large positive impact on outcomes for individuals and savings to the system, yet were not used as effectively as they could be:

- Seek changes for more flexibility in purchasing and procurement of Durable Medical Equipment (DME). Flexibility in purchasing DME could improve independence and health outcomes. Explore the ability to reclaim and reuse DME while ensuring safety and liability protections.

- The non-emergent medical transportation system in many communities is not designed to meet urgent, unscheduled care needs. Opportunities to provide access to early intervention and prevention services are lost, resulting in increases use of ambulance and emergency room use.
- Adult day centers are an underutilized alternative LTSS that could reduce Home Care Worker hours, provide socialization and respite, improve nutrition, and allow earlier identification of potential health and functional issues.
- Increase the capacity of LTC system to provide placements, services, and supports for individuals with severe behavioral service needs.

In addition to identifying opportunities related to these resources, the group highlighted some specific recommendations around leveraging private contributions more effectively.

Leveraging Private Contributions:

Regarding the best blend of private resources, the group first identified changes in Medicaid that could create either new opportunities for federal Medicaid match or new savings, for example, by incentivizing individuals to purchase long term care insurance.

Recommendations – Leveraging Private Contributions:

- Explore flexibilities to use private contributions as match for federal funds, by increasing the individual’s contribution to services, and lowering their contribution toward room and board in community based care settings. The individual’s contribution to services is eligible for federal match, whereas their contribution to room and board is not.
- Pursue flexibilities with CMS to allow the use of supplemental payments without jeopardizing Medicaid payment for LTC and while ensuring consumers are protected. In several states, it is possible for family members to contribute supplemental service payments for a private room in a community based setting, for example. Oregon currently does not allow supplemental payments.
- Leverage Long Term Care Insurance via flexibilities with CMS. DHS and OHA should work to expand and improve on the existing Long Term Care Partnership Program.

Alignment, Efficiencies, and Incentives to Ensure Outcomes

The group developed recommendations for better aligning and coordinating between the Coordinated Care Organizations (CCOs) and Long Term Care (LTC) systems. Recommendations identifying efficiencies and incentives needed to ensure outcomes are addressed on pages 27-29.

Alignment and Coordination between CCOs and LTC Systems:

To begin, the group discussed promising models and pilot projects in Oregon for better service coordination⁶ between the medical and LTC systems. These practices are not exclusive and can be combined.

Promising service coordination models between CCO and LTC:

- Co-Location or Team Approaches – Some examples include:
 - Lane County pilot program where the Medicaid managed care plan has a psychiatric nurse practitioner located in the local AAA office, who consults with providers, individuals and case managers.
 - LTC case managers in medical settings (hospitals or primary care),
 - Service coordination positions jointly funded by the LTC and medical systems, or
 - Team approaches such as an interdisciplinary care team including LTC representation.
- Services in Congregate Settings - Includes models where a range of LTSS and medical services are provided in congregate settings to a group of common beneficiaries. In these models, services can be:
 - Limited to one type of service such as 'in home' personal care services provided in a congregate setting or
 - A comprehensive model such as the Program for All Inclusive Care for the Elderly (PACE) program where all LTSS and medical services are capitated and delivered by an eight-member interdisciplinary team.
- Clinician/Home-Based Programs - These include increased use of Nurse Practitioners, Physician Assistants, Registered Nurses and/or Geriatricians who perform assessments, plan treatments, and provide interventions to the person in their home, community-based, or nursing facility setting. PACE includes clinician home based programs for individuals receiving care in the home.

⁶ For purposes of this report, “service coordination” is defined as an inclusive category of social and medical services; “care coordination” is a subset of service coordination.

- Service Coordination- This is an essential component in all of the above projects but can be a stand-alone model. While the actual practices vary, care coordination models use defined protocols and reexamination of staff roles to promote person-centered care, improve sharing of information and alignment of critical assessment, service planning and interventions.

On the latter point of service coordination, the group discussed extensively the problems of cost shifting (see pages 45-46), as well as very practical considerations of implementing and codifying best practices of coordination between the medical and LTC systems.

Key Recommendations for Service Coordination:

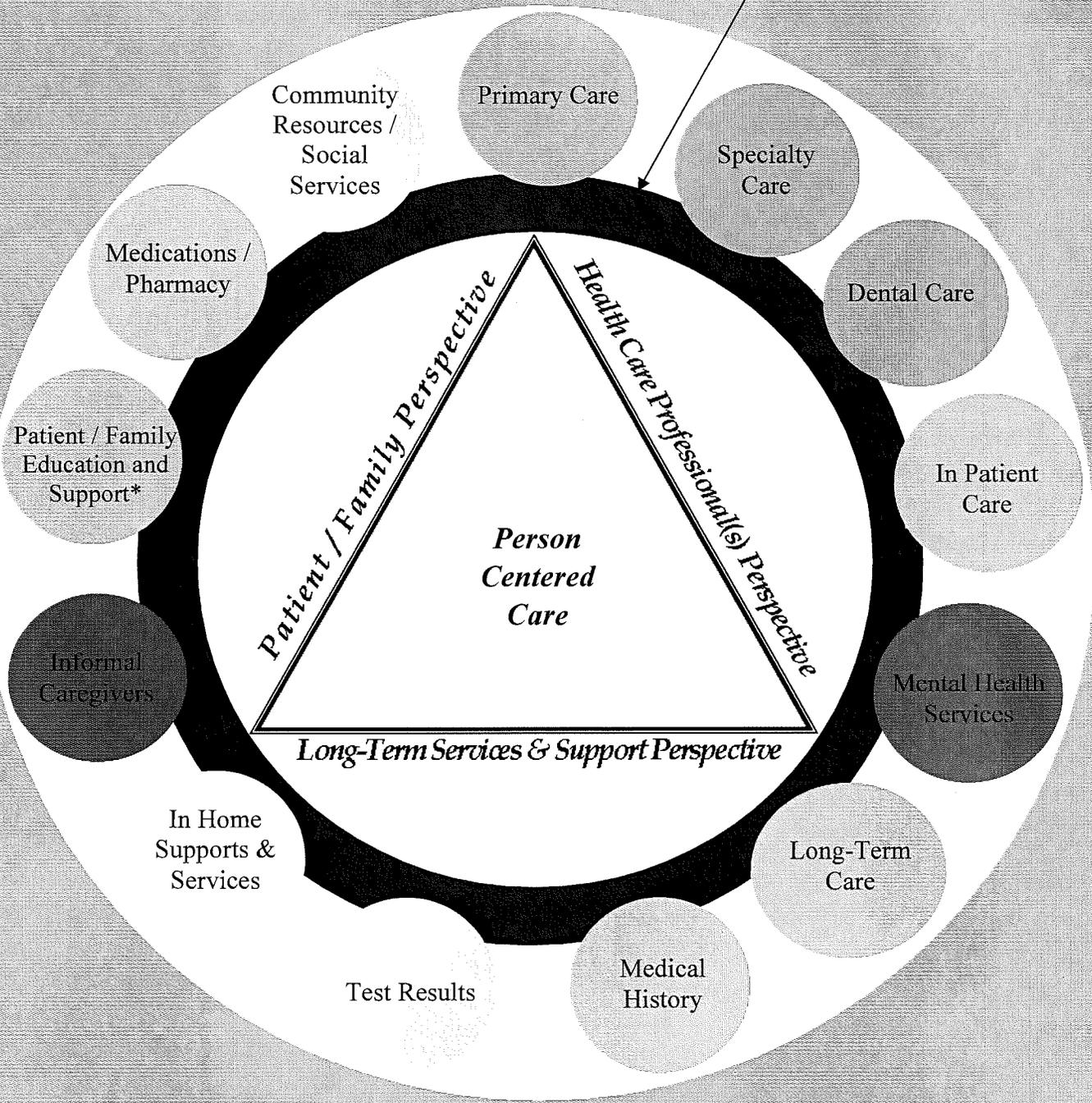
1. Expectations for coordination are formalized through state level CCO contracts, Area Agencies on Aging (AAA) Intergovernmental Agreements (IGA) as well as memoranda of understanding/contracts between the CCO and LTSS partners.
2. Communication practices are essential to successful care coordination practices. These include immediate information sharing protocols as well as the long-range goal of statewide electronic record sharing systems.
3. The state should provide guidelines and expectations for the effective education of individuals, providers and systems to facilitate better coordination and service delivery and informed engagement of individuals in their care.
4. Reduce duplicative practices in assessments, service planning and medical procedures in addition to emphasizing service coordination at transition points between long term and acute care, and for all high needs individuals.
5. Make available an Interdisciplinary Team approach (see illustration on the following page) that includes LTSS and CCO representation particularly for individuals who are most at risk and those in transition. This process must be person centered.
6. Ensure that reimbursement and regulatory mechanisms are provided as a framework to support participation in service coordination.
7. Include, and engage individuals so that they can be responsible for their choices and the goals of their care.
8. Transitions should be effectively managed between different levels and systems of care (acute, nursing facility, mental health and home and community) using best practices as well as innovative approaches.

9. Ensure that CCOs and the LTC system have coordinated after-hours access to advice, services and appropriate medical care. Use contracts to specify how this will be accomplished.
10. Explore and pursue models that integrate service provision and coordination. These may be new models or existing models with new flexibility: examples include Co-Location, Services in Congregate Settings (including PACE), and Clinician-Home Based Programs (see page 20). Provide additional flexibilities to existing LTSS providers that allow them to creatively test new models of care.

The following visual, based on a model published by the federal Agency for Healthcare Research and Quality (AHRQ), illustrates the model recommended by this report for services coordination. The person in the center reflects the person-centered approach the group recommends. According to AHRQ, “the *central goal* of care coordination is shown in the middle of the diagram. The *colored circles* represent some of the possible participants, settings, and information important to the care pathway and workflow. The *blue ring* connecting the *colored circles* is CARE COORDINATION—namely, anything that bridges gaps (white spaces) along the care pathway (i.e., care coordination activities or broad approaches hypothesized to improve coordination of care.”

Person-Centered Service Coordination Model⁷

CARE COORDINATION RING



*Includes new roles for non-traditional workers identified in HB 3650, including peer wellness specialists, personal health navigators and community health workers.

⁷ This visual is a modification of the Agency for Healthcare Research and Quality (AHRQ), "Care Coordination Measures Atlas" (<http://www.ahrq.gov/qual/careatlas/careatlas.pdf>)

Key Elements of Service Coordination:

The group explored key elements in service coordination in order to recommend best practices in its implementation. These elements included assessments, integrated service plans, interdisciplinary service teams, and communication.

Assessments:

An assessment is a process where a particular professional gathers clinical, regulatory or payment related information on a specific individual. In an integrated assessment process, information is shared across disciplines or settings for use in a common service plan. This requires formal information sharing agreements.

Recommendations - Assessments:

- Assessments must be person centered and address the whole person. Information gathered in assessments needs to:
 - Identify each individual's strengths, needs and goals.
 - Support and improve an individual's engagement and personal responsibility.
 - Identify social determinants of health, including caregiver and family supports, home environment, individual lifestyles, community inclusion, and access to transportation.
- Assessment data should be comprehensive enough to allow for prioritization of services, support service coordination and provide information needed by all members of the interdisciplinary team.
- Create a screening or risk assessment system to identify and assign high-risk, vulnerable enrollees to intensive service coordination and to differentiate service needs among beneficiaries.
- DHS and OHA need to explore ways, including waivers, to minimize the state and federal requirements that result in duplicative assessment processes with the goal of creating a standardized process across the CCO and LTC systems. Such exploration should include looking at the pilot projects/challenge grants being funded by the federal Department of Health and Human Services to improve the sharing of assessment data across acute and LTC settings electronically.

Integrated service plans:

An integrated service plan provides the framework for effective service coordination implementation. These plans are developed to meet the needs of the individual identified in the shared assessment process.

Recommendations – Integrated Service Plans:

- The integrated service plan should be person centered and identify supports needed to ensure that the individual is activated and empowered to engage in health promotion, prevention and disease self management.
 - The integrated service plan must build on information gathered in assessments including individual strengths, goals and needs, including community participation.
 - The plan should include an individual's preferences for care, including identification of an individual's desire for palliative interventions.
- Integrated service plans should combine information from LTSS with information from any provider within the CCO's delivery system network. The plan must follow the individual receiving care and be updated over time.
- The integrated service plan should include robust crisis service planning. It should contain information necessary to support behavioral health related emergencies even with diagnoses such as Traumatic Brain Injury or dementia.
- The plan should ensure that supports are identified to provide culturally appropriate interventions and communication.

Interdisciplinary Service Teams:

Integrated service plans are developed and carried out by an interdisciplinary team (IDT). Membership is determined by the individual needs, services and goals defined in the service plan.

Recommendations – Interdisciplinary Service Teams (IDT):

- IDTs must be supported by aligned incentives, contract requirements with CCOs and LTSS providers and Intergovernmental Agreements (IGAs) with Area Agencies on Aging.
- A method for adjudication of disagreement is needed within the IDT. This should occur locally at the lowest possible level.
- The IDT must be culturally appropriate and person centered

IDT Roles and responsibility:

- IDTs are responsible for coordinating all aspects of an individual's care with an emphasis on transitional care. IDTs must assess the full care spectrum, including medical, long term care, behavioral, and dental health, in part to ensure treatments and services are not duplicative or in conflict.

- Members of the IDT must communicate regularly (at least every 6 months) or when there is a change in condition, either virtually or in person, for the purpose of coordinating care.
- IDT must be able to authorize both LTC and CCO resources to align with population needs.
- IDT accountability for outcomes, risk or cost needs to be defined and understood by all members.

IDT Membership:

- Procedures and protocols are needed to assign individuals to teams with appropriate levels of membership and intensity of oversight. These should be based on risk, vulnerability, or service needs.
- Members of the IDT should include:
 - A care coordinator lead with responsibility for critical service coordination activities. There must be allowance for individual choice and accommodation of preference when designating the service coordinator lead.
 - Providers of health care and LTSS.
 - Members of the non-traditional workforce such as peer wellness specialists, health system navigators and community health workers.
 - The individual and their family or caregivers.

Recommendations – Education

- Both CCO and LTSS staff and providers will need education to support person centered care, a shared mission, establishment of shared goals and promotion of a culture of understanding and respect across disciplines.
- Education and information should be consistent and non-duplicative between the CCO and the LTC system. The goal is a seamless experience for the consumer.
- Individuals and family members or representatives may need education and support to:
 - Understand their role and the implications and outcomes of the decisions that they make around their care.
 - Promote personal responsibility and active participation in personal health care goals.
 - Understand service planning and care coordination processes.

Communication:

Recommendations in Assessment and Interdisciplinary sections will support improved communication practices between individuals, providers, IDT members

as well as LTC and CCO system level partners. The following recommendations were also identified.

Recommendations – Communication:

- Communication processes need to be established for sharing information including: Medicaid authorizations, LTC eligibility assessments and individualized service plans generated by LTC providers, the CCO and other delivery system network providers (e.g. mental health treatment plans).
 - CCOs need to know when members are receiving LTC services and have triggers in place to set up service coordination activities.
 - The LTC system needs to know when the CCO has identified a person who is in need of LTSS. The CCO must have documented processes for identification of those individuals and processes for timely referral to the LTC system for assessment and LTSS interventions.
- Communication practices and systems can and need to be developed independent of electronic records systems so that privacy barriers don't prevent care coordination.
- Continue efforts to develop Health Information Exchange systems, but we should not wait to improve sharing of information.
- Need to create a common language and understanding of terminology between systems.

Other Alignment and Coordination Recommendations

The group included some additional recommendations on alignment and coordination.

Recommendations- Other Alignment and Coordination

- CCOs must demonstrate that, in concert with the LTSS providers, they have a plan and an adequate system of monitoring the health status of individuals being served. This includes a systematic approach to surveillance, early detection and early intervention to prevent further functional decline and costly care.
 - Establish a process for monitoring service coordination successes and failures and ensuring accountability across the CCO and LTC system.
- Service coordination activities should be expanded to Patient Centered Primary Service Home (PCPCH) models as they are established.
- Create a pool of resources that can be used when the IDT agrees that purchase of equipment or other services is necessary but does not fall under Medicare or Medicaid payment guidelines would be beneficial.

- Standardize requirements in contracts and intergovernmental agreements to provide a minimal set of requirements to meet the needs of individuals who receive LTC but flexible enough to support models in rural areas or other community specific needs and partnerships.

Efficiencies and Incentives to Ensure Outcomes between CCOs and LTC

Systems:

In addition to the recommendations on coordination, the group considered efficiencies and incentives to ensure outcomes. The group considered first the problems of cost shifts between the LTC system and the medical services provided under CCOs. Then the group identified outcomes metrics and mechanisms for shared financial accountability to create efficiencies and incentives to ensure outcomes.

Potential Cost shifts between CCOs and LTC systems:

Appendix C includes an inventory of potential cost shifts between the LTC and CCO systems that were discussed by the group. Some of these cost shifts and other inefficiencies are illustrated below:

Cost shifts from LTC system to CCOs:

- Lack of communication from the LTC system to the health plan about changes in individuals' status limits the ability of plans to effectively manage medical care for those individuals.
- CCO may not control the types of setting individuals discharge to; PAS screenings⁸ and individual choice may result in individuals placing into lower levels of care than medically appropriate leading to failure of the LTC placement and possible readmission to the hospital.
- Lack of community support and respite care for family members, particularly related to behavioral health needs, leading to increased emergency room utilization.

Cost shifts from the CCO to LTC system:

- Durable Medical Equipment can be important to ensuring that individual is able to live independently and lack of access to this equipment can increase LTC system costs such as increased need for assistance with activities of daily living.

⁸ The Pre-Admission Screen (PAS) generally refers to the process that DHS uses to determine an individual's eligibility for Medicaid-funded LTC services.

Other related drivers of increased costs and inappropriate emergency room utilization and hospitalizations include:

- Physicians and other health care providers, especially psychiatric providers, are not paid to deliver services in LTC facilities resulting in lack of access, lack of treatment or under treatment which results in increased use and more expensive services such as acute inpatient services.
- Lack of 24-hour services and lack of transportation services are additional factors driving Emergency Room usage by individuals receiving LTC.
- Poor post acute care coordination results in individuals not receiving the appropriate intensity and amount of care, and services not being coordinated, leading to worse outcomes and potential avoidable readmissions.
- In addition to readmissions to the hospital, failed LTC placements may be associated with a range of costs such as DME purchases and personnel costs.

Metrics and outcomes:

The group was asked to consider how metrics should be used in supporting the goal of system accountability between the Long Term Care System and CCOs.

Recommendations – Metrics:

- Both outcome and process measures should be developed and used to support system accountability.
- Process measures should ensure coordinated service planning and transitions of care. Suggested process measures include:
 - Completion rates for person-centered service plans, and evidence that the individual to be served was engaged in service-planning,
 - Evidence that the service plan was followed across system partners,
 - Evidence that education was provided to the individual,
 - Evidence that individuals were offered advanced care planning, including of Physicians Orders for Life Sustaining Treatment (POLST), or Advanced Directives, and
 - Evidence that transitions of care were effectively managed including timely and accurate, transfer of clinical information and status changes between the LTC system, the CCO and providers within the CCO's delivery system network.
- Outcome measures should demonstrate that CCOs and the LTC system had been effective in working together to ensure that an individual's health, functionality, and well-being are maximized, understanding that some individuals would be expected to improve, while for others, a positive

outcome would be maintaining function and health or reducing the rate of decline. Suggested outcome measures include:

- A healthy days measure,
 - Rate of return to home, as defined by the beneficiary,
 - Rate of inappropriate emergency room utilization, hospitalizations, or readmissions – or, ideally, a holistic measure looking at utilization patterns to support the triple aim,
 - Rate of medication adherence,
 - Improvement or maintenance in Activities of Daily Living or level of functioning, and
 - Satisfaction of individuals served.
- Measures should be appropriate to the population and the goals of care. The metrics that are most appropriate in one population may not be appropriate for another population, based on differences in the health status and expected trajectory of each group, as well as the goals of care for that population. For instance, while improving or maintaining function is an important goal for a major part of the population, it may not be appropriate for those with severe chronic and/or health conditions, and particularly for those in or nearing end-of-life.
 - Measures may need to be risk-adjusted to avoid creating disincentives to serve high needs individuals. At the same time, this risk adjustment must be implemented in a way that is mindful of the need to also create incentives to improve the health of the population rather than accepting the status quo.

Sharing financial accountability:

Given these potential cost shifts, the group was presented with financial models that might mitigate them. Members of the subgroup supported the idea that there needed to be financial models to support coordination between CCOs and LTC, with more support for incentives or shared savings than for penalties or shared risk. In particular, concerns were raised about sharing risk with providers for costs that they might not be able to control, or for which they were not solely responsible.

Recommendations – Sharing Financial Accountability:

- Positive financial incentives should be put in place, particularly shared savings and incentive payments tied to desired outcomes.
- There should be incentives to encourage process/structure of coordination across the two systems, such as participation in integrated service teams.

- To the extent feasible, shared savings and incentives should be locally determined, possibly through a negotiation between the CCO and the LTC providers/system in the area.
- Some types of penalties may be appropriate, such as not paying for duplicative services when providers are not following the care plan.
- Individual smaller providers including home care workers and adult foster homes are not appropriate for penalties/sharing risk.
- Consider how to address issues of individual responsibility and particularly individuals that refuse reasonable care in putting in place shared accountability for performance.

Other Recommendations for Efficiencies:

- OHA and the CCOs should work with CMS to waive the 3-day prior hospital stay requirement for skilled nursing facility services under Medicare.
- Encourage CCOs to explore ways to be more flexible in allowing services to be provided in alternative settings, breaking down barriers to person-centered care.

Conclusion

The department and its external stakeholders appreciate the opportunity the 2011 Legislative Assembly gave to plan for the future of the long term services and supports in Oregon. In light of the changes inherent in Health System Transformation, the relationship between the Long Term Care system and the establishment of Coordinated Care Organizations is paramount in providing effective and efficient services and supports to seniors and individuals with disabilities. These recommendations are intended to orient the department and its stakeholders to planning this future under the circumstances of limited resources. We will use these recommendations to keep our planning process accountable to the Legislature, and the department appreciates any feedback the Legislature may have.

Appendices:

- A. Inventory of Long Term Care and Community Resources
- B. Areas of Misalignment & Risk that May Invite Cost-Shifting

Inventory of Long Term Care (LTC) and Community Services

The purpose of this listing is to provide a beginning overview of the services and supports that are needed and or utilized by seniors or persons with physical disabilities.

(**Funding Sources**)

	State	Federal	Private Pay	Other (local, non-profit)	Notes
LTC Placement/Services and Supports					
Medicaid Financial/Service Screening	General Fund (GF)	Medicaid			
Older American Act (OAA)* Information/Assistance/Outreach	GF	OAA/Medicaid			In AAA/Medicaid offices funding is blended for Medicaid screening and referral and information and assistance
Veterans Affairs (VA)– Aid & Attendance (payment to help cover home and community based services) VA Nursing Home.		Veteran’s Affairs (VA)			May provide offset or supplemental services to triples who have service related disabilities.
Case Management (CM)- Authorization of Services HCBS, OHP, Service Rates, In Home Hours, Durable Medical Equipment, Transportation, Special Needs, Nursing, all settings	GF	Medicaid/OAA			
CM -Monitoring, Assistance with residential placements or in home supports. Problem Resolution, Crisis Response, all settings	GF	Medicaid/OAA			
CM- Coordination with families, in home care, medical, residential and nursing providers, all settings	GF	Medicaid/OAA			This function is not provided consistently throughout state and may be provided by nurses or licensed residential provider.

	State	Federal	Private Pay	Other (local, non-profit)	Notes
Contract Nursing –Assessment, Service Plan, Teaching Delegation, Coordination	GF	Medicaid			
Medicaid In Home Services – Spousal Pay, Independent Choices, Client Employed Providers, Agency	GF	Medicaid			
Specialized Living Apt	GF	Medicaid			Population specific
Oregon Project Independence (OPI)– In-Home Services/Day Care	GF		Individual pays on a sliding scale		
OAA Personal Care, Homemaker and Chore services (typically augments OPI funding)		OAA			
Personal Care 20 hours (PC20)	GF	Medicaid			Individuals not eligible for LTC full benefits may be eligible for 20 hours of assistance. Available through SPD/AAA and County Mental Health
24 hour Residential Services - Adult Foster Home, Residential Care and Assisted Living Services, Alzheimer’s, Special Needs/Pop Contracts.	GF	Medicaid			
Nursing Facility- long term	GF	Medicaid			
Adult Day Care	GF	Medicaid			
OAA Adult Day Care		OAA			
OAA Respite services		OAA			
Program of All Inclusive Care for the Elderly (PACE)	GF	Medicaid/ Medicare			
	State	Federal	Private Pay	Other (local, non-profit)	Notes

Long Term Care Insurance – covers home and community based care and/or Nursing Facility			Personal Income/ Resources		See note below chart under innovations
State Independent Living Council – consumer-directed model of peer support, information and referral, skills training, and advocacy	GF	Title VII			Some services may not be available in all areas.
Medical Services and Supports					
Oregon Health Plan	GF	Medicaid			
Veterans Affairs Medical Services		VA			
Parish Nursing				Volunteer ministry	Usually delivered through churches.
Senior Health Insurance Benefits Assistance (SHIBA)- Medicare enrollment		Medicare		Volunteer	May be provided through partnerships with AAA or not for profit agencies.
Oregon Prescription Drug Program					Group purchasing discount program.
Medication Assistance				Pharmaceutical Companies/ non-profits	
Medicare-Medicaid Package**					
Durable Medical Equipment, prosthetics, orthotics, and Supplies	GF	Medicaid/ Medicare			Where Medicare is listed under the DMAP services Medicare is primary payer/Medicaid secondary payer.
Nursing Facility – Post Acute	GF	Medicare/ Medicare			
Administrative Examinations and Reports	GF	Medicaid			
	State	Federal	Private Pay	Other (local, non-profit)	Notes
Ambulance Services	GF	Medicaid/ Medicare			
Dental services	GF	Medicaid			

Federally Qualified Health Centers	GF	Medicaid/ Medicare			
Home Enteral/parenteral nutrition and IV services	GF	Medicaid/ Medicare			
Home Health services	GF	Medicaid/ Medicare			
Hospice services	GF	Medicaid/ Medicare			
Hospital services	GF	Medicaid/ Medicare			
Rehabilitations Services, such as Physical, Occupational, and Behavioral/Mental Health Therapies	GF	Medicaid/ Medicare			
Medical Transportation services	GF	Medicaid			
Medical-Surgical services	GF	Medicaid/ Medicare			
Pharmaceutical services	GF	Medicaid/ Medicare			
Physician Services	GF	Medicaid/ Medicare			
Private Duty Nursing services	GF	Medicaid			
Renal Services	GF	Medicaid			
Speech-Language Pathology, Audiology and hearing Aid services	GF	Medicaid/ Medicare			
Transplant services	GF	Medicaid/ Medicare			
Vision services	GF	Medicaid			

	State	Federal	Private Pay	Other (local, non-profit)	Notes
Transportation					
Private vehicle			Individuals funds		Vehicle is allowable asset under Medicaid for medical transportation.
Public transportation	GF	Medicaid		Local funds	
Medical and Non Medical Transportation	GF	Medicaid			
OAA Transportation		OAA			
Behavioral Services and Supports					
Residential Services such as, Enhanced Care, and Enhanced Care Outreach Services (ECOS)	GF	Medicaid			Combined Mental Health/SPD.
Clinic based or outpatient mental health services	GF	Medicaid			Combined Mental Health/SPD.
Substance Abuse services – inpatient and clinic	GF	Medicaid			
Mental Health screening and evaluation provided through Pre-Admission Screening and Resident Review (PASRR)	GF	Medicaid			
Nutritional Services and Supports					
Supplemental Nutrition Assistance		USDA			
Home Delivered Meals (Medicaid)	GF	Medicaid			
OAA Home Delivered and Congregate Meals		OAA	Donation		
Food Banks				Donations	

	State	Federal	Private Pay	Other (local, non-profit)	Notes
Housing Services					
Low Income Housing Assistance		HUD		County	State and County based programs not in DHS/OHA.
Retirement Housing- Apt models, non licensed w. meals, housekeeping included)			Personal income/ resources		Medicaid in home services may be provided in these settings.
Elderly Rental Assistance Program					Renters 58 years old or older, household income \$10,000 or less.
Other Services and Supports					
Protective Services	GF	Medicaid			Available without regard to income.
OAA Legal Assistance		OAA			
OAA Caregiver Counseling/Support		OAA			
OAA Education		OAA			
LTC Ombudsman	GF	Medicaid			Advocacy and monitoring for persons in licensed settings.
Low Income Home Energy Assistance Program (LIHEAP)		LIHEAP			
Acute care medical team and supports		Medicare			
Volunteer programs					Volunteer usage could lower costs.

***State Older American Act Programs:** These federally funded services are provided to Oregonians aged 60 years or older regardless of income levels. Contributions/fees/donations can be requested for OAA services.

- Older American Act Services are provided by the Area Agencies on Aging (AAA). Some AAAs also operate the Medicaid program. When the local AAA does not operate the Medicaid program then the local SPD office manages the program.
- Aging and Disability Resource Centers (ADRC) are currently being piloted in the AAAs as an expanded service to include the population that does not receive Medicaid. The current pilots have involved, for example, additional education and

certification of Information and Assistance workers, increased options counseling on LTC choices for the non-Medicaid population, increased use of evidenced based education to improve health, prevent losses, and increase independence, and partnerships using evidenced-based approaches to improve hospital transitions and reduce hospital readmissions.

****Medicare – Medicaid Package** is edited and limited list of the most common services utilized by Medicaid-Medicare eligible population.

Areas of misalignment & risk that may invite cost shifting

This inventory attempts to capture major areas and sources of cost shifting. This is not an exhaustive inventory and some areas of cost shift may be intertwined in multiple ways. Some causes for cost shift can be attributed to:

- Misaligned financial incentives such that health plans or long term care (LTC) systems do not have financial incentives to reduce cost shifts and invest in appropriate infrastructure, etc.
- Lack of understanding between the social and medical models of care.
- Lack of shared information about an individual receiving care and services between social and medical model providers.
- Misaligned administrative policies and rules that exacerbate these issues.

L= cost shift from LTC **C**= cost shift from Coordinated Care Organization (CCO)

I. Cost shift due to lack of care/prevention:

L- Unnecessary emergency room visits and hospitalization due to:

- LTC placement failure (see below).
- Inadequate care plan.
- Inability to address medical needs in LTC setting.
- LTC providers seeking to avoid liability for failing to address medical needs.
- Lack of 24-hour medical service supports available to individuals in HCBS settings.

C- Poor access to primary care in LTC settings due to lack of reimbursement to primary care providers. This results in increased acuity and intensity of care.

L/C- Lack integrated care planning between LTC and CCO:

- Inadequate supports to ensure person-centered decision-making for individuals that lack the decisional capacity to participate.

L /C – Change of condition leading to premature entry into LTC due to:

- Lack of access to existing community resources.
- Lack of access to behavioral health, addictions treatment, psychiatric evaluations and psychiatric medication review.
- Lack of alternative resources and high LTC eligibility limits.
- Barriers to getting independence enhancing devices (Durable Medical Equipment (DME), adaptive equipment).

L /C - LTC placement failure due to:

- Lack knowledge/education and capacity to care for individuals with mental/behavioral health needs in the LTC system including positive behavioral supports and other environmental interventions.

- Lack of access to behavioral health, mental health, medications, and psychiatric evaluations for people coping primarily with disorders such as dementia and Traumatic Brain Injury (TBI). Due to misaligned financial incentives.
- Lack of clarity when Mental Health Crisis services can or should be used for severe behavioral health disturbances for individuals living in Home and Community Based Services (HCBS) or LTC.
- Evictions from LTC or HCBS following a behavioral health or mental health disturbance while the individual is hospitalized. This typically results in extended acute care stays.
- Lack of specialized services/resources in LTC for complex conditions such as: bariatric care, TBI, dementia, severe behaviors, etc.

II. Discharge from acute care setting:

C- Inappropriate NF utilization due to accelerated discharge planning.

C- Poor hospital discharge planning, post acute care coordination and implementation resulting in:

- Failure of HCBS placement and/or deterioration in condition.
- Increase in Medicaid exceptional payments to HCBS due to:
 - Lack of medical wrap-around services.
 - Lack of behavioral wrap-around services.
- Increase in NF staffing costs due to untreated or undertreated medical conditions and unclearly defined behavioral treatment needs (e.g. delirium).

C- Increase in Medicaid special needs payments for home adaptations and DME due to higher acuity discharge into community.

III. Overlapping Services:

C- Increase in contract registered nursing costs due to decrease or denial of Medicare home health services.

C- Increase in staffing in HCBS due to:

- Denial of DME.
- Lack of behavioral health services.

L/C- Fragmented care coordination and poor transitions due to lack of role clarity, including lack of medication management leading to poly-pharmacy for people with multiple conditions and multiple prescribers.

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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

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

- 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	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
	from screening date	
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 Alignment Demonstration. There are several options for holding CCOs financially accountable:

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.

- 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.

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>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.

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>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.

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>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.

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>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.

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>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.

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>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.

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
<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.

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>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.

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>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.

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>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.

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DATE: January 25, 2012

TO: Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in Interested States

FROM: Melanie Bella
Director, Medicare-Medicaid Coordination Office

Jonathan Blum
Director, Center for Medicare

SUBJECT: Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans

I. Background

Since its creation in 2010, the Medicare-Medicaid Coordination Office (MMCO) has been working to improve the quality of care that individuals dually eligible for Medicare and Medicaid (Medicare-Medicaid enrollees) receive by expanding access to seamless, integrated programs. In July 2011, the MMCO announced a new opportunity for States to participate in demonstration projects to align financing between Medicare and Medicaid to support improvements in the quality and cost of care for Medicare-Medicaid enrollees (please refer to our July 8, 2011 State Medicaid Director (SMD) letter at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf for more information). Through the Center for Medicare & Medicaid Innovation (the Innovation Center), CMS will test two financial alignment models with States across the country – a capitated approach and a managed fee-for-service approach. The capitated model that will use health plans or other qualified entities¹ for delivery of medical, behavioral health, and long-term services and supports is the subject of the information in this guidance.

Under the capitated financial alignment demonstrations, CMS will work with interested States to combine Medicare and Medicaid authorities to test a new payment and service delivery model to reduce program expenditures under Medicare and Medicaid, while enhancing the quality of care furnished to Medicare-Medicaid enrollees. Demonstrations under this program will last three years, and our goal is to approve demonstration proposals and finalize demonstration plan selection in order to effectuate enrollments in 2013. All demonstrations will include a rigorous evaluation, the results of which will help inform the potential for future program changes.

Under these demonstrations, CMS, the State, and health plans or other qualified entities will enter into a three-way contract. The finalization of each contract will follow a joint plan selection process by CMS and each participating State. The three-way contracts will test administrative, benefit and enrollment

¹ Health plans or other qualified entities are referred to as “interested organizations” throughout this document.

flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees by utilizing a simplified and unified set of rules and an integrated payment model.

This guidance document includes more information about the demonstration, including:

- Payment Principles. Section II summarizes key information about how prospective capitated payment rates for health plans will be developed for the provision of an integrated benefit package for the full continuum of Medicare and Medicaid benefits to Medicare-Medicaid enrollees. It also outlines how savings will be achieved for both the Medicare and Medicaid programs.
- Standards in Key Programmatic Areas. Section III and Appendix 1 of this document summarize information about key programmatic areas under the demonstration in the context of current Medicare and Medicaid requirements in those areas. We note, in particular, that Medicare prescription drug (Part D) requirements will be applicable under the demonstration.
- State Demonstration Approval Process Key Dates. Section IV summarizes the key steps in the submission, review, and approval of State demonstration proposals, a process that will overlap with – but proceed separately from – the joint plan selection process. Given our goal of effectuating enrollments in demonstration plans in 2013, we note that the steps associated with State demonstration approvals will, in many cases, occur concurrently with the demonstration plan selection process, which is described in more detail in Section V of this guidance.
- Plan Selection Process Key Dates. Section V details key dates for interested organizations to provide the necessary context to inform their decisions about participation in this initiative. Interested organizations must be prepared to meet the timelines articulated in Section V in order to be selected as plans under demonstrations with effective enrollment dates of January 1, 2013.

Because this demonstration is combining Medicare and Medicaid authorities to provide integrated delivery of benefits, the joint plan selection will require that such organizations meet State-specific requirements, including a combination of Medicare, Medicaid and integrated requirements (some of which are described in this guidance). To be selected to participate in the demonstration, interested organizations will need to demonstrate their capacity to meet all requirements.

CMS is committed to providing the necessary information and training to States and all interested organizations, regardless of their previous level of experience in contracting with Medicare. Included in this guidance is background information on contracting and application timelines in the underlying Medicare program to provide context for certain timing and other flexibilities that will be available to plans interested in participating in the demonstration.

We also emphasize that organizations that are currently offering or intend to offer non-demonstration Medicare Advantage (MA) or Prescription Drug Plan (PDP) products in 2013 will need to proceed with application and plan approval processes for those products separately from the process for plan selection under the demonstrations.

- Instructions for Submitting a Notice of Intent to Participate as a Demonstration Plan. Section VI contains technical instructions for interested organizations. This notice of intent to apply (NOIA) process is non-binding, but it is a necessary step for any interested organization. Therefore, we encourage any interested organization to participate in this process consistent with demonstration planning underway in each State. While interested organizations may submit a NOIA earlier, an interested organization that does not meet the **April 2, 2012** NOIA submission deadline will not be permitted to operate a demonstration plan in 2013.
- Network Adequacy Determinations. Section VII introduces the process whereby interested organizations will demonstrate network adequacy under the demonstration, including the Medicare network adequacy requirements. We also outline the process whereby interested organizations may seek exceptions from Medicare network adequacy standards for non-drug medical services.

Interested organizations will be required to follow the instructions provided in this guidance in order to effectuate enrollments in 2013. We note that, in addition to the requirements described in this guidance, plans must also qualify for participation based on each State's specific plan selection process, which will be developed based in part on feedback received through various State stakeholder outreach processes currently underway.

CMS will provide more detailed guidance both to States and interested organizations between February and early April 2012. Any questions related to demonstration timelines and requirements should be sent to CMS MMCOcapsmodel@cms.hhs.gov.

II. Payment Principles

Under the capitated financial alignment demonstration, CMS and a participating State will enter into a three-way contract with selected health plans to provide the full range of Medicare and Medicaid benefits to Medicare-Medicaid enrollees in the demonstration areas. Participating plans will receive a capitation rate that will reflect the integrated delivery of the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees. This new payment model will:

- Align incentives;
- Provide plans with flexibility; and
- Improve quality of and access to health care services for enrollees.

Rates for participating organizations will be developed by CMS in partnership with each State based on baseline spending in both programs and anticipated savings that will result from integration and improved care management. The Part D portion of the capitation rate will be based on the standardized national average bid amount that will be risk adjusted in accordance with the rules that apply to all other Part D plans.

The rate will provide upfront savings to both CMS and the State. Absent savings for both payers, the demonstration will not go forward. CMS and its Office of the Actuary (OACT) will work together with the State and its actuaries to determine the portion of the capitated payment paid by CMS (for Medicare) and the State (for Medicaid).

III. Standards in Key Programmatic Areas

A. General Information

Over the last several months, MMCO has been working closely with the Center for Medicare, the Center for Medicaid and CHIP Services, and the Innovation Center to develop additional policy and operational detail for the capitated financial alignment demonstrations. In mid-December, we provided additional detail to States interested in pursuing the capitated financial alignment model. Appendix 1 includes summaries of key programmatic areas for the demonstration that will be further defined in the Memorandum of Understanding (MOU) negotiated between States and CMS (a draft template of which was provided in our July 8, 2011 SMD letter) and the three-way contract, and that will serve as a tool that we will use to work with States to build out State-specific details associated with their individual demonstrations. The chart in Appendix 1 summarizes Medicare and Medicaid requirements in these key programmatic areas and the pre-established parameter and/or preferred requirement standard in each area. Pre-established parameters are those demonstration parameters that have been determined and were announced in the MOU template that was released in the July 8, 2011 SMD letter. Preferred standards are CMS' starting point for the framework to be utilized under the State demonstrations and will be discussed in more detail with States as part of their demonstration and MOU development and approval processes.

B. Part D Requirements

As detailed in Appendix 1, Medicare Part D requirements – including with respect to specific benefits and cost-sharing, network adequacy, formularies, and submission of prescription drug event data – will be applicable to demonstration plans. Interested organizations should therefore begin to prepare for the submission (either by themselves or in partnership with a Pharmacy Benefit Manager, or PBM) of critical Part D requirements, including a formulary, a Medication Therapy Management Program (MTMP), a Part D pharmacy network, and a plan benefit package. We provide additional resources for information about Part D requirements in Appendix 1 and intend to provide training on these and other Medicare requirements to interested organizations to ensure they have the tools they need to successfully navigate the plan selection process.

IV. State Demonstration Approval Process Key Dates

Following is a summary of the steps associated with submission, approval, and review of State demonstration proposals. State-specific timelines will be developed for each demonstration proposal; the dates below identify the general sequencing of the demonstration development and approval processes. Given our goal of effectuating enrollment in demonstration plans in 2013, we note that these steps will in many cases occur concurrently with the demonstration plan selection process, which is described in more detail in Section V of this guidance.

1. **State Letter of Intent (October 2011):** States interested in pursuing either of the two financial alignment models were required to submit Letters of Intent (LOIs) to CMS by October 1, 2011. Thirty-eight States and the District of Columbia submitted LOIs. Currently, we estimate that approximately 26 States are still exploring a capitated demonstration; for more information about this subset of States, please refer to the Notice of Intent to Apply questions in Appendix 2. For State-specific information, please refer to information shared by individual States about their demonstration plans.

2. **State Planning & Design Process (October 2011 – ongoing)**: For those States that determine they would like to pursue a demonstration, the LOI and initial dialogue with CMS initiate a comprehensive planning and design process. States are required to work with stakeholders during both the design process and implementation (for those States that ultimately implement).
3. **Demonstration Proposal (Spring – Summer 2012)**: The design process will culminate in a State demonstration proposal to CMS. Upon submission (following a 30-day public notice period), CMS will evaluate each proposal to determine whether it has met the CMS established standards and conditions before the State can enter into negotiation of a formal Memorandum of Understanding (MOU) with CMS.
4. **Memorandum of Understanding (Summer - Fall 2012)**: Once it has been determined that a proposal has met the standards and conditions, CMS will notify the State and then work with States to develop a State-specific MOU based on the templates provided as part of the July 8, 2011 SMD letter.
5. **Three-Way Contract (by mid-September 2012)**: Following approval of the MOU, States pursuing the capitated model would undergo a process with CMS to select qualified health plans that will result in a three-way contract among CMS, the State, and health plans or other qualified entities.

V. Plan Selection Process Key Dates

Demonstration plans will ultimately be selected through a joint CMS-State plan selection process that will utilize state-based plan selection vehicles. While the Medicare plan requirements described in guidance are necessary for interested plans to establish readiness for participation in the demonstration, plans will ultimately have to qualify for participation through each State's specific plan selection process. In other words, while interested organizations will be required to follow the instructions provided in this guidance, these instructions are merely part of the process of establishing qualification for the demonstrations and should not be seen as conflicting with or undermining State-specific requirements that are currently being established.

This section details key dates for organizations interested in participating in the demonstration, as well as background on the standard Medicare Advantage (MA) and Prescription Drug Plan (PDP) application processes and timelines in order to provide the necessary context to inform interested organizations' decisions about participation in this initiative. We also describe the flexibilities that will be provided to interested organizations vis-à-vis the standard Medicare timelines. In order to ensure a seamless transition and minimize disruption and confusion for Medicare-Medicaid enrollees enrolling in demonstration plans, CMS will leverage Medicare processes and related timelines in the plan selection process under the demonstrations. Use of these timelines and processes will also be important for creating operational efficiencies for effectuating enrollments in 2013. Interested organizations should understand that we have already created flexibilities where possible, and demonstration applicants must meet the established deadlines in order to participate as a demonstration plan in 2013.

CMS and States expect to work in partnership with interested organizations that have experience in coordinating and delivering care to Medicare-Medicaid enrollees, including current Medicare contractors offering Special Needs Plans (SNPs), State Medicaid managed care contractors, and other qualified organizations. We recognize the need for extensive technical assistance on Medicare-related

requirements and processes, particularly for interested organizations with no previous contracting experience with the Medicare program, and we are committed to partnering with States and providing this assistance to interested organizations following the release of this guidance.

A. Background on Standard Medicare Advantage (MA) and Prescription Drug Plan (PDP) Application and Contracting Cycles

This demonstration will test an integrated program that will have its own unique requirements, while using many pre-established State and CMS processes and requirements as a starting point. Although we will provide some flexibility, as described in Section V.B., for plans selected to participate in this demonstration, it is essential that interested organizations understand the standard MA and PDP application and contracting cycles. It is worth noting that organizations interested in offering non-demonstration plans in the 2013 contract year must continue to follow the standard MA and PDP timeline described below. Major payment, policy, and operational guidance necessary for interested organization to successfully bid for the upcoming contract year is generally provided through the advance and final payment notices and the Parts C and D Call Letter process (please refer to <http://www.cms.gov/MedicareAdvtgSpecRateStats/AD/list.asp>, <http://www.cms.gov/PrescriptionDrugCovContra/>, and <http://www.cms.gov/HealthPlansGenInfo/> for previous advance and final rate notices, as well as draft and final Call Letters). Each year, the advance payment notice and draft call letter are released for public comment in mid-February, and the final payment notice and final call letter are released in early April. Key milestones in the standard annual MA and PDP application and plan approval process are detailed below:

- November: Organizations interested offering new MA or PDP products, or expanding current MA and PDP service area(s), are required to express their intent to submit an application through a non-binding Notice of Intent to Apply (NOIA). Submission of a NOIA enables CMS to provide applicants with a provisional contract number, as well as the necessary access to CMS systems for purposes of submitting applications, bids, plan benefit packages, formularies, models of care, etc.
- Early January: MA and PDP applications for the following contract year are made available. Please note that MA plans offering prescription drug coverage (MA-PD plans) must submit both an MA and Part D application.
- Late February: Applications are due. Applications include submissions of network adequacy, State licensure, and – for special needs plans (SNPs) – models of care for review and approval by the National Committee for Quality Assurance (NCQA). Applications are reviewed between late February and mid-May.
- April: For organizations offering Part D benefits, Medication Therapy Management Program (MTMP) submissions and formularies are due. Formularies and MTMPs are reviewed between mid-April and July.^{2 3}

² As provided under 42 CFR 423.120(b) and in Chapter 6 of the Prescription Drug Benefit Manual (refer to <http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf>), a Part D sponsor that uses a formulary under its qualified prescription drug coverage must meet requirements for the following:

- First Monday in June: Plans prepare their bids and plan benefit package submissions for CMS review. These submissions are reviewed in June and July.
- Mid-September: All contracts are finalized and signed.
- Mid-September to early October: Roll-out of information about all available Medicare health plans, including via the *Medicare & You* handbook and the Medicare Plan Finder tool on www.medicare.gov.
- October 1 – Plans may begin marketing plan benefits and information for the upcoming contract year.
- October 15 – December 7 – Annual Coordinated Election Period.
- January 1 – Beneficiary elections made during the Annual Coordinated Election Period are effective.

B. Calendar of Key Dates for Medicare Requirements Portion of the Demonstration Plan Selection Process

Summarized below are the key dates for demonstration plan approval for the 2013 contract year. Our primary focus in this section is on the Medicare-specific requirements that interested organizations will need to satisfy to operate as demonstration plans; however, we remind interested organizations that there will also be State-specific requirements that must be satisfied as part of the joint plan selection process. Those requirements will be further detailed in State demonstration proposals and in the MOU negotiations.

This timeline details the timing and other flexibilities interested organizations will have relative to the standard MA and Part D application and contracting cycles. Such flexibility includes the deadline for submitting the non-binding plan Notice of Intent to Apply (NOIA) and plan formularies. We also expect to provide flexibility in the timelines for submitting information about State licensure, network adequacy, and plan models of care. Other submission deadlines will be the same for interested organizations as they are for organizations offering non-demonstration MA plans and PDPs – specifically,

Pharmacy and Therapeutics committee; provision of an adequate formulary; a transition process; limitation on changes in therapeutic classification; provision of notice regarding formulary changes; limitation of formulary changes prior to beginning of contract year; provider and patient education; and formulary changes during the contract year.

³ As provided under 42 CFR 423.153(d) and in Chapter 7 of the Prescription Drug Benefit Manual (refer to <http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter7.pdf>), a Part D sponsor must establish an MTMP that is designed to ensure that covered Part D drugs prescribed to targeted beneficiaries (those that have multiple chronic conditions, are taking multiple Part D drugs, and are likely to incur annual drug costs above a certain threshold) are appropriately used to optimize therapeutic outcomes through improved medication use; is designed to reduce the risk of adverse events, including adverse drug interactions, for targeted beneficiaries; may be furnished by a pharmacist or other qualified provider; and may distinguish between services in ambulatory and institutional settings. While services and interventions may vary across setting, the criteria for identifying targeted beneficiaries eligible for MTMP cannot.

those associated with submission of Medication Therapy Management Programs (MTMPs) and the plan benefit package detailing all the benefits offered under the plan. **Organizations must be prepared to meet the timelines specified in this section in order to be qualified for plan selection under demonstrations with effective enrollment dates of January 1, 2013.**

Although we expect that most demonstration proposals will be made public by early April, portions of the plan selection process will occur concurrently with the State demonstration approval process, which is described in more detail in Section IV of this guidance. As a result, interested organizations will need to notify CMS of their intent to apply through a non-binding NOIA (please refer to Section VI of this document for detailed instructions on that process), as well as develop and submit a formulary, MTMP, and plan benefit package, before all State demonstration proposals are approved and MOU negotiations are complete.

We recognize that interested plans will need additional detail beyond that provided in the calendar below. We expect to issue additional information about key operational timeframes as well as additional details on future plan selection criteria in partnership with respective State agencies pursuing demonstrations. This guidance will be issued in CMS sub-regulatory vehicles, including the CY 2013 Draft and Final Call Letters.

Key Date	Required Action
December 2011 –Summer 2012	States submit demonstration proposals that are evaluated against Standards and Conditions. States and CMS negotiate MOU for proposals that meet the Standards and Conditions. The MOU will outline specific programmatic design elements, technical parameters, and approval package for necessary Medicare and Medicaid authorities and payment/financial models.
January 2012	CMS and States provide information to interested plans on standards in key programmatic areas, as well as key operational dates and timelines to interested plans.
Early 2012	CMS to provide interested plans with training on demonstration requirements.
February 17, 2012	Release for public comment of the Contract Year (CY) 2013 Draft Call Letter.
March – July 2012	Health plans or other qualified entities are selected through a CMS-State joint selection process. Interested organizations submit required information regarding demonstration requirements, including licensure, network adequacy, and plan model of care. CMS and States review and select participating plans and begin contract negotiations with selected plans.

Key Date	Required Action
March 26, 2012	Release of HPMS Part D formulary submission module for CY 2013.* <i>*Applies to organizations offering demonstration and non-demonstration plans</i>
April 2, 2012	Release of CY 2013 Final Call Letter. Additional information on demonstration requirements and timelines provided to interested plans.
April 2, 2012	Latest date for Interested plans to submit their Notice of Intent to Apply (NOIA) to offer demonstration plans electronically to CMS through an online Web tool.
April 9, 2012	CMS User ID connectivity form submissions must be received <u>no later than this date</u> to ensure user access to the CMS Health Plan Management System (HPMS) ⁴ for purposes of submission of formulary and plan benefit package information.
April 23, 2012	Release of the CY 2013 Medication Therapy Management Program (MTMP) submission module in HPMS.* <i>*Applies to organizations offering demonstration and non-demonstration plans</i>
April 30, 2012	Part D formulary submissions due to CMS <u>for interested organizations that are submitting a new formulary (e.g., those that have not submitted a formulary for CY 2013 for non-demonstration plans).</u>
May 7, 2012	MTMP submission deadline. <i>*Applies to organizations offering demonstration and non-demonstration plans</i>
May 14, 2012	Part D formulary submissions due to CMS <u>for interested organizations that have already submitted a non-demonstration plan formulary for CY 2013 and intend to utilize that previously submitted formulary for their demonstration plans.</u> ⁵

⁴ HPMS is a system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about provider networks, plan benefit packages, formularies, and other information via HPMS.

⁵ Note that organizations offering non-demonstration plans must submit their CY 2013 formularies by April 16, 2013.

Key Date	Required Action
June 4, 2012	<p>Submission of proposed plan benefit packages (including all Medicare and Medicaid benefits for demonstration plans) to CMS by interested organizations.*</p> <p><i>*Applies to organizations offering demonstration and non-demonstration plans</i></p>
June – July 2012	<p>CMS reviews submitted plan benefit packages.*</p> <p><i>*Applies to organizations offering demonstration and non-demonstration plans</i></p>
June 8, 2012	<p>Deadline for submitting Supplemental Formulary files, Free First Fill file, Partial Gap Coverage file, Excluded Drug File, Over-the-Counter Drug File, and Home Infusion File through HPMS.</p> <p><i>*Applies to organizations offering demonstration and non-demonstration plans</i></p>
July 30, 2012	<p>MTMP reviews completed.</p> <p><i>*Applies to organizations offering demonstration and non-demonstration plans</i></p>
July 30, 2012 (target date)	<p>Demonstration plan selection completed.</p>
Late July - September 2012	<p>CMS and State conduct readiness reviews for selected plans. CMS and States make final preparations for implementation, test all operational systems, and perform reviews to assure optimal preparation and adherence to contract requirements prior to implementation. CMS and States jointly confirm readiness requirements have been met.</p>
September 17, 2012 (target date)	<p>Roll-out of MA and Part D plan landscape documents, which include details (including high-level information about benefits and cost-sharing) about all available Medicare health and prescription drug plans for CY 2013.*</p> <p><i>*Applies to organizations offering demonstration and non-demonstration plans</i></p>
September 20, 2012 (target date)	<p>Three-way contracts between selected plans, States, and CMS must be finalized and signed <u>no later than this date</u>.</p>

Key Date	Required Action
Mid- to late September 2012	<p>CMS mails the CY 2013 <i>Medicare & You</i> handbook. The handbook includes high-level information – including basic cost-sharing and premium information – about available health plan options in a beneficiary’s specific geographic location.*</p> <p><i>*Applies to organizations offering demonstration and non-demonstration plans</i></p>
October 1, 2012	<p>For selected plans receiving passive enrollments of Medicare-Medicaid enrollees, notification of such enrollment and information about opt-out procedures must be sent to affected beneficiaries.</p>
October 1, 2012	<p>CY 2013 marketing activity begins.*</p> <p><i>*Applies to organizations offering demonstration and non-demonstration plans</i></p>
October 1, 2012	<p>Medicare Plan Finder on www.medicare.gov goes live for CY 2013.*</p> <p><i>*Applies to organizations offering demonstration and non-demonstration plans</i></p>
October 15 – December 7, 2012	<p>MA and Part D Annual Coordinated Election Period.*</p> <p><i>*Applies to organizations offering demonstration and non-demonstration plans</i></p>
January 1, 2013	<p>Enrollment effective date.*</p> <p><i>*Applies to organizations offering demonstration and non-demonstration plans</i></p>

C. Information for Organizations Offering Demonstration and Non-Demonstration Medicare Plans

Organizations that are currently offering or intend to offer non-demonstration MA or PDP products in 2013 will need to proceed with application and plan approval processes for those products separately from the process for plan selection under the demonstrations. We note that the NOIA deadline to offer non-demonstration MA plans and PDPs for contract year 2013 was in November 2011. Organizations that offer both demonstration and non-demonstration plans will be issued separate contract numbers for their proposed demonstration plans.

VI. Instructions for Submitting a Notice of Intent to Participate as a Demonstration Plan

CMS is pleased to announce the release of the Capitated Financial Alignment Demonstration Notice of Intent to Apply (NOIA) Web tool. Completion of this tool is required in order for interested organizations to obtain the necessary system access to meet the key deadlines articulated in the calendar in Section V of this guidance document. Since many of the State demonstration approval and demonstration plan selection processes will occur concurrently, any organization that is interested in working with a State to deliver the integrated benefits under these demonstrations must participate in this non-binding process and begin to prepare for the submission (either by itself or in partnership with a Pharmacy Benefit Manager, or PBM) of critical Part D requirements, including a formulary, Medication Therapy Management Program (MTMP), a pharmacy network, and a Part D benefit package). If an interested organization does not submit a NOIA by **April 2, 2012**, it will not be eligible to offer demonstration plans in 2013. We encourage interested organizations to submit a NOIA well before April 2, 2012 in order to ensure timely access to the Health Plan Management System (HPMS).

This NOIA process is separate from the process used for non-demonstration MA and PDP contracts. Organizations that are currently offering non-demonstration MA or PDP products will still need to submit a Capitated Financial Alignment Demonstration NOIA. Organizations with existing Medicare contracts will be issued a separate contract number specifically for their proposed demonstration plan(s).

The key dates related to this process are summarized below:

CY 2013 Application Activity	Date
Notice of Intent to Apply (NOIA) deadline* <i>*Organizations may submit a NOIA earlier, but must submit it <u>no later than</u> April 2, 2012.</i>	April 2, 2012
CMS User ID connectivity form submissions <u>must</u> be received by this date to ensure user access to HPMS.* <i>*Organizations that submit their NOIAs earlier should submit their CMS User ID connectivity forms as soon as possible following CMS' request to ensure access to HPMS as quickly as possible.</i>	April 9, 2012

A. Notice of Intent to Apply Requirements

CMS expects to provide interested organizations with additional instructions and key dates for submitting plan selection requirements, including licensure, network adequacy, and plan model of care information, in the CY 2013 Final Call Letter or other subregulatory vehicles no later than early April 2012. Given that some of the plan selection processes and requirements (e.g., submission of formularies, medication therapy management programs, and plan benefit packages) will be completed through the CMS Health Plan Management System (HPMS), demonstration applicants must have access

to HPMS. Timely completion of a NOIA and the CMS User ID connectivity form⁶ is necessary for ensuring HPMS access. Submitting a NOIA does not bind that organization to submit a formulary, MTMP, plan benefit package, or other required information. However, without a pending contract number and completed CMS User ID connectivity form, an interested organization will not be able to access the appropriate modules in HPMS to complete some of the requirements for participation in the demonstration. As a result, interested organizations that do not already have access to HPMS are encouraged to submit their NOIA as soon as possible in order to guarantee access in time to complete required modules by the dates detailed in Section V. Interested organizations that do not complete their NOIA submissions by **April 2, 2012** will not be eligible to offer demonstration plans in 2013.

B. Notice of Intent to Apply Submission Process

We encourage early submissions of Capitated Financial Alignment Demonstration NOIAs and will begin to accept NOIAs following the release of this guidance. The earlier interested organizations submit this information, the sooner they will have access to HPMS (note, for example, that the HPMS formulary submission module first becomes available March 26, 2012, but that an interested organization will not be able to access it until it has completed the NOIA process, meaning that it has both submitted the NOIA, as outlined in this section, and been assigned a CMS user ID, as specified below in section VI.C.) However, all NOIAs must be submitted by **5 p.m. Eastern Time on April 2, 2012**. CMS will not continue to process NOIAs for demonstration applicants after **April 2, 2012**. CMS will send confirmation emails to interested organizations once the Capitated Financial Alignment Demonstration NOIAs are processed and a contract number is assigned.

CMS will accept only NOIAs submitted electronically through its online Web tool. Organizations must use the following link to access and complete the NOIA Web tool:

<http://vovici.com/wsb.dll/s/11dc4g4ddb7>

A hard copy of the Web tool form is attached to this guidance as a reference for interested organizations (see Appendix 2). Appendix 2 identifies the questions an interested organization must complete to correctly request a pending contract number for an initial Capitated Financial Alignment Demonstration application. The assignment of contract numbers is done according to CMS rules. Interested organizations that already have existing Medicare Advantage or Prescription Drug Plan contracts will be assigned a separate contract number for the demonstration plan.

An interested organization must complete a separate NOIA for each State in which it intends to operate a demonstration plan. Please also note that P.O. boxes will not be accepted as a valid address for application purposes. Processing will be delayed for all NOIAs that contain a P.O. Box for the mailing address of the legal entity while CMS attempts to collect the street address for the legal entity.

C. CMS User IDs

All interested organizations submitting a NOIA will need CMS User IDs and passwords to access HPMS. After the NOIA is submitted, interested organizations will receive a confirmation email with the new

⁶ Note that only those organizations that are not currently Medicare contractors will need to complete a CMS User ID connectivity form.

contract ID and instructions for applying for a CMS User ID if they are not currently Medicare contractors.

Completed CMS User ID forms should be returned to CMS no later than **April 9, 2012**. We recommend that interested organizations use a traceable carrier to send the forms, and that they ensure they are submitting original forms with wet signatures (not copies). Organizations must identify where indicated all contract numbers that must be affiliated with the CMS User ID. Note that interested organizations will not be able to submit this form until CMS provides a pending contract number. Organizations must return the completed CMS User ID form to:

CMS
7500 Security Blvd
Mailstop C4-18-13
Baltimore, MD 21244
Attn: Lori Robinson

Existing Medicare contractor/HPMS users that would like to connect a pending contract number to current CMS User IDs must include the following information in an email to hpms_access@cms.hhs.gov:

1. User Name(s)
2. CMS User ID(s)
3. Current Contract Number(s)
4. Pending Contract Number(s)

Please refer technical questions about the Capitated Financial Alignment Demonstration NOIA process to Linda Anders at 410-786-0459 or Linda.Anders@cms.hhs.gov.

For questions related to HPMS user access, please send an email to hpms_access@cms.hhs.gov.

Any other questions about the demonstration timelines and requirements should be sent to CMS MMCOcapsmodel@cms.hhs.gov.

VII. Network Adequacy Determinations

As detailed in Appendix 1, CMS' preferred requirement standard for demonstrating network adequacy under the capitated financial alignment demonstration is to use Medicare standards for medical services and prescription drugs.^{7 8} For long-term care supports and services (LTSS), demonstration plans will use

⁷ Medicare Advantage requires that plans maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers. Also, plans must provide or arrange for necessary specialty care. The MA organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs. 42 CFR 422.112.

⁸ Part D plans must have a contracted pharmacy network that assures convenient access to network pharmacies, including retail, home infusion, long-term care, and I/T/U pharmacies. 42 CFR 423.120

State Medicaid network adequacy standards.⁹ For areas of overlap where services are covered under both Medicaid and Medicare (e.g., home health), the appropriate network adequacy standard will be determined via the CMS-State MOU negotiation and memorialized in the three-way contract with health plans, so long as such requirements result in a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Demonstration plan applicants will work directly with States during the joint plan selection process to satisfy State-specific network adequacy requirements for LTSS and any Medicare/Medicaid overlapping services for which, under the MOU, the Medicaid standard has been agreed to by CMS and the State. In addition, interested organizations will work with CMS to submit the necessary documentation to be evaluated against Medicare network standards for Part D and medical services. Demonstration plan network adequacy will be subject to confirmation through readiness reviews.

Demonstration plans will be able to utilize an exceptions process in areas where Medicare's medical service network adequacy standards may not reflect the number of dual eligible beneficiaries. As part of the joint selection process for demonstration plans, we will establish a joint State/CMS exceptions review team to evaluate exceptions requests for portions of demonstration plan service areas where the Medicare medical service standard cannot be met or where an alternate standard has been negotiated in the MOU. The State/CMS exceptions review team will review all submitted exceptions requests and make determinations about the adequacy of plans' network in areas where exceptions have been requested.

We expect to provide more information in the Final Call Letter about timelines associated with submission and evaluation of network adequacy information.

⁹ Medicaid managed care contracts must require the plan give assurances to the State and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. Among other requirements, plans must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. 42 CFR 438.207

Appendix 1: Comparison of Existing Managed Care Plan Requirements and Preferred Requirement Standards for Financial Alignment Demonstration Plans (as of 1.20.11)

The following chart summarizes Medicare and Medicaid requirements in these key programmatic areas and the pre-established parameter and/or preferred requirement standard in each area. Pre-established parameters are those demonstration parameters that have been determined and were announced in the MOU template that was released in the July 8, 2011 SMD letter. Preferred standards are CMS' starting point for the framework to be utilized under the State demonstrations and will be discussed in more detail with States as part of their demonstration and MOU development and approval processes. The MOU will ultimately be the basis of each three-way contract.

Issue	Federal Medicaid Requirements	Medicare Requirements	Pre-Established Parameter and/or Preferred Requirement Standard
1. Payment to Health Plans	States must pay rates that meet CMS actuarial soundness requirements. States may also establish additional requirements, e.g. risk adjustment, quality incentives, and risk corridors. States have flexibility in their rate-setting methodology; most set rates, but some do require plans to submit bids. 42 CFR 436.6 Plans may cover services above those required in the contract, but the cost of these may not be included in the payment rate. 42 CFR 438.6	Plans must submit Part C bid for monthly aggregate amount (Part C covered services and supplemental benefits) that meet CMS actuarial guidelines. Part C payments are linked to benchmarks connected to FFS experience and the plan's quality rating (see "Prescription Drug" row for Part D payment). Plans must share Part C rebates (a portion of savings for bids below the benchmark) with beneficiaries via premium reduction or supplemental benefits. CMS risk adjusts the bid and rebate payments for each plan. Plans are fully at risk and are not subject to risk sharing. 42 CFR 422 Subparts F and G.	Pre-Established Parameter: Plans will be paid on a capitated basis for the full continuum of Medicaid and Medicare Part C benefits provided to Medicare-Medicaid enrollees. No Part C or D premiums will be charged to beneficiaries. Rates for participating plans will be developed based on baseline spending in both programs and anticipated savings that will result from integrated managed care (SMD MOU template sec. III.I). As designed, aggregate savings compared to baseline costs will be "shared" proportionally by both States and CMS. Rates will be subject to OACT review. [Please see #3 below for additional payment information on Part D benefit]
2. Plan Selection	There is no Federal requirement that States accept all qualified plans, which means that States may limit the number of plans that can participate (though if there is mandatory enrollment they must generally assure a choice of at least two managed care entities). They may identify when new plans may seek to participate (e.g., may choose how often procurement happens). 42 CFR 438.52	Medicare has an annual contracting process, in which MA plans that apply and meet specified requirements may participate. Medicare generally cannot limit the number of plans an MA organization may offer, but does require that plans of the same type (e.g., HMO, PPO, PFFS) submitted by a given MA organization have "meaningful differences," as well as minimum enrollment levels to renew. 42 CFR 422 Subpart K	Pre-Established Parameter: Utilize joint plan selection process, either procurement or certification process (where approved) to select limited number of qualified plans. (SMD MOU template sec. III.2) Preferred Requirement Standard: The joint selection process will take into account previous performance in Medicare and Medicaid.

<p>3. Prescription Drugs</p>	<p>For non-Medicare-Medicaid enrollees, States may provide prescription drug coverage through FFS or managed care. States may use utilization management tools such as prior authorization or formularies.</p> <p>There is no Federal financial participation for prescription drug coverage for Medicare-Medicaid enrollees who are eligible to enroll in a Medicare Part D plan (even if they are not actually enrolled).</p> <p>States may provide coverage of Part D excluded drugs for Medicare-Medicaid enrollees using State-only funds.</p>	<p>Plans are paid four types of Part D subsidies: a direct subsidy, a reinsurance subsidy and two subsidies to cover premium and cost-sharing expenses for low-income beneficiaries. Plans submit bids for the direct subsidy, which are risk adjusted and subject to risk sharing. The reinsurance and low-income cost-sharing subsidies are 100% cost reconciled. Details on the Part D benefit may be found in:</p> <p>Prescription Drug Benefit Manual: https://www.cms.gov/PrescriptionDrugCovContra/12_PartDManuals.asp</p> <p>Part D Applications: https://www.cms.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp</p> <p>Part C Applications: http://www.cms.gov/MedicareAdvantageApps/</p> <p>Part D Regulations 42 CFR 423 Subparts F, G, and P: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=a2918a376335d69090f142a9da45e81f&rgn=div5&view=text&node=42:3.0.1.1.10&idno=42</p>	<p>Preferred Requirement Standard: Participating health plans will be paid according to the regular Part D payment rules, with the exception that the direct subsidy will be based not on a bid submitted by each plan, but on the standardized national Part D average bid amount. This national average bid amount will be risk adjusted according to the same rules that apply for all other Part D plans.</p> <p>Plans participating in the demonstration would be required to meet all other Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data. However, they would not be required to submit a bid. Beneficiaries in the demonstration would not be subject to any Part D premiums, but would continue to be subject to standard LIS copayment levels.</p> <p>Part D requirements can be located at the following links:</p> <p>Prescription Drug Benefit Manual: https://www.cms.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage</p> <p>Part D Applications: https://www.cms.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage</p> <p>Part D Regulations: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=a2918a376335d69090f142a9da45e81f&rgn=div5&view=text&node=42:3.0.1.1.10&idno=42</p>
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<p>4. Enrollment -- General</p>	<p>Permits voluntary or mandatory enrollment into health plans, with CMS approval. States that mandate enrollment into managed care entities must permit one chance to change plans within first 90 days of enrollment; an annual opportunity to change plans; and disenrollment for cause at any time (but these changes are usually limited to changing among plans rather than back to FFS). States vary in entities they permit to accept enrollment (for example, enrollment brokers). 42 CFR 438.56</p>	<p>Permits voluntary, beneficiary-initiated enrollment into MA and Part D plans, generally with lock-in through the end of the year thereafter, and with an annual coordinated election period each fall during which plans may be changed effective January 1. There are Special Election Periods that permit individuals to change plans outside that timeframe, including a continuous SEP that permits Medicare-Medicaid beneficiaries to change MA or PDP plans or disenroll back to Original Medicare at any time. Permits CMS to conduct passive enrollment into Part C and D plans in specific, limited circumstances (e.g., to prevent beneficiary harm or as a result of immediate plan termination), as provided under 42 CFR 422.60(g). Requires auto-enrollment of new Medicare-Medicaid enrollees into zero-premium Part D plans on a random basis (though they may disenroll at any time). 42 CFR 422 and 423 Subpart B</p>	<p>Pre-Established Parameter: For Medicare, States participating in the demonstration may request CMS approval for a passive enrollment process to enroll Medicare-Medicaid beneficiaries into participating health plans. Passive enrollment will require advance notice and an option upfront for beneficiary to opt out (or switch health plans) as well as an opportunity for the beneficiary to disenroll after enrollment is effective (SMD MOU template sec. III.C.2). Existing Medicaid authorities and protections will be maintained. This includes the option to submit waiver requests and/or plan amendments, requiring CMS review and prior-approval. Eligible population is full duals (SMD MOU template sec. III.C.1).</p> <p>Preferred Requirement Standard: All enrollments must ultimately be operationalized in CMS' systems to ensure that there is no duplication of coverage or payment.</p>
<p>5. Enrollment Effective Date</p>	<p>There are no federal requirements on when a contract year must start, so it varies by State. States with enrollee lock-in must offer an annual chance to change plans.</p>	<p>The contract year starts January 1. For individuals subject to lock-in, there is an "open enrollment" period October 15-December 7 in which they can change plans, for an effective date of January 1 of the following year.</p> <p>Medicare-Medicaid enrollees' Special Enrollment Period permits them to change up to monthly, with an effective date of the first of the following month.</p>	<p>Preferred Requirement Standard: For purposes of minimizing beneficiary disruption and confusion, ensure that passive enrollment process coincides with the underlying MA and Part C/D timeline such that beneficiary notice of demonstration options occurs prior to the annual coordinated election period (October 15 – December 7) in 2012.</p>

<p>6. Medical Loss Ratio (MLR)</p>	<p>There is no federal Medicaid requirement for MLR.</p>	<p>Beginning in 2014 contract year MA plans will be required to maintain an MLR of at least 85%.</p>	<p>Pre-Established Parameter: There will not be a minimum MLR requirement in the demonstration. However, participating plans will be required to report on costs to ensure transparency and facilitate evaluation, so we expect to have MLR information to determine what portion of premium participating health plans are spending on medical costs.</p>
<p>7. Solvency</p>	<p>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. Several types of entities are not subject to this requirement, including Federally qualified HMOs, as defined in section 1310 of the Public Health Service Act, public entities, entities whose solvency are guaranteed by the State, Federally qualified Health Centers or Rural Health Centers receiving grants from HRSA (or entities controlled by these centers) or entities who had prepaid risk contracts with States prior to 1970.</p> <p>Except as noted above, entities must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity. 1903(m)(1)(A) and (B); 42 CFR 438.116</p>	<p>Defers to State licensure requirement (i.e., requires the MA plans to meet State solvency and licensure standards). Each MA organization must be licensed under State law, or otherwise authorized to operate under State law, as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers one or more MA plans. If not commercially licensed, it must obtain certification from the State that the organization meets a level of financial solvency and such other standards as the State may require for it to operate as an MA organization. 42 CFR 422.400</p>	<p>Preferred Requirement Standard: Medicaid, as Medicare requirements already cede to State licensure and solvency requirements. However, in other areas related to the operation of an MA plan, federal law preempts state law (42 CFR 422.402)</p>

<p>8. Network adequacy</p>	<p>Medicaid managed care contracts require the plan to give assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care.</p> <p>Among other requirements, plans must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. 42 CFR 438.207</p>	<p>Medicare Advantage requires that plans must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.</p> <p>Also, plans must provide or arrange for necessary specialty care. The MA organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs. 42 CFR 422.112</p> <p>Exceptions to the Criteria CMS recognizes that in certain cases, an applicant's contracted network may not meet the provider network adequacy criteria. In such cases, the applicant may request an exception, from a pre-defined list created by CMS, for a specific provider/facility type in a specific county. These exceptions are detailed in the CMS Health Services Delivery Tables Exceptions Guidance. Plans must have a contracted pharmacy network that assures convenient access to network pharmacies, including retail, home infusion, long-term care, and I/T/U pharmacies. 42 CFR 423.120</p>	<p>Preferred Requirement Standard: Use State Medicaid standards for long term care networks and use Medicare standards for medical services and prescription drugs. Demonstration plans will be able to utilize an exceptions process in areas where Medicare network standards may not reflect the number of Medicare-Medicaid beneficiaries. Plans will be required to use Medicare network adequacy standards and review processes during plan selection process and network adequacy will be subject to confirmation through readiness reviews.</p> <p>For areas of overlap where services are covered under both Medicaid and Medicare, the appropriate network adequacy standard will be determined via MOU negotiation and memorialized in three-way contracts with health plans, so long as such requirements result in a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. Note: Part D requirements will continue to be applied; see #3 for details.</p>
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9. Out of Network Reimbursement	<p>With the exception of emergency services, for which hospitals are required to accept the Medicaid state plan rate, Medicaid does not impose requirements on plans related to out-of-network payment levels, which sometimes results in plans being at risk for high payments, e.g. if imposed by highly specialized providers.</p>	<p>Medicare requires out of network coverage for urgent/emergent services. 42 CFR 422.113(b)(2). For those services, plans must pay non-contract providers (and those providers must accept payment) at Medicare FFS level. 42 CFR 422.214</p>	<p>Preferred Requirement Standard: FFS payment rate is required to be paid by plan and accepted by provider, as provided for in federal regulation and applicable State law and regulations.</p> <p>Note: Part D requirements will continue to be applied; see #3 for details.</p>
<p>Appeals:</p> <p>Pre-Established Parameter: the demonstration will include a uniform appeals process. We recognize that in some States this may require regulatory changes or legislative approval, which could take some time; all contracts will require changes to be undertaken as expeditiously as possible. We also recognize that there are other circumstances (e.g. court orders) that may make certain aspects of a uniform appeals process a challenge.</p> <p>Note: Unless indicated otherwise, Part D appeal standards will remain unchanged.</p>			
10. Appeals – Timeframes for filing an appeal related to benefits	<p>Appeals may be filed with the plan anywhere between 20 and 90 days (varies by States). States are permitted to give enrollees direct access to State fair hearing process rather than exhausting plan appeals. 42 CFR 438.408.</p>	<p>Part C: Appeals must be filed within 60 days. 42 CFR 422.582 (reconsideration) 42 CFR 422.592 (IRE), 42 CFR 422.602 (ALJ).</p>	<p>Preferred Requirement Standard: Medicare – 60 days to file an appeal. If it is not possible for State to change Medicaid time frames currently in State regulation by 2013, use Medicare standard unless State Medicaid standard is more generous (i.e. allowable timeframe is greater than 60 days).</p>
11. Appeals – Access to State level or external review	<p>All States must provide access to a State Fair Hearing, either directly or (if the State requires exhaustion of the health plan level of appeal) after an initial appeal to the health plan. 42 CFR 431.205 and §438.408; and section 1902(a)(3) of the Act. Some States provide access to Ombudsman or Independent Review Entities for those enrolled in managed care.</p>	<p>Part C and D: Medicare allows beneficiaries in private health plans to access Independent Review Entities, but only after the filing of an initial appeal to a plan. 42 CFR 422.578, 422.592 for Part C; 42 CFR 423,580, 423, 600 for Part D.</p>	<p>Preferred Requirement Standard: Medicare – internal appeals should ideally go through the plan first, and then external appeals should go through the Medicare qualified independent contractor. However, some States enable beneficiaries to bypass plan internal appeal processes and seek out external appeals immediately. Absent regulatory change– the MMCO will not have the authority to prevent beneficiaries from seeking out external appeals through these channels prior to internal appeals processes in such States. Accordingly, States will be encouraged to provide—via contract, regulation or both—for initial appeals to be made via the plan first.</p>

<p>12. Appeals – Continuation of benefits pending appeal</p>	<p>Medicaid benefits generally continue and are paid for pending a timely appeal (FFP is available for these costs), when the appeal is requested within a certain timeframe. Note: this standard applies to reduction or termination of items or services. States also may reinstate benefits if requested within 10 days of the date of action (States vary). 42 CFR 431.231. Section 1902(a)(3) of the Act; 42 CFR 431.205; §438.420 (managed care). The State may seek recovery against the beneficiary if he or she loses the appeal.</p>	<p>Other than terminations of inpatient hospital care or other services by a “provider of services” (such as a nursing home or home health agency, which are covered regardless of the outcome of the initial level of appeal), benefits do not continue during the pendency of a Medicare appeal involving reduction or termination of items or services.</p>	<p>Preferred Requirement Standard: Hybrid – during internal plan review, benefits should be continued (per Medicaid standard), however once appeals reach external Medicare level, benefits not continued (per Medicare standard). Medicaid-only benefits would continue, per current standards. Note: only benefits that are initially provided and subsequently reduced or terminated may continue pending an initial appeal.</p>
<p>13. Appeals – Document notifying beneficiaries of appeal rights</p>	<p>Various documents may be used to notify beneficiaries of their appeal rights depending upon the State. Regulations require that information about appeals be included at the time of application, with a notice of adverse action on a claim, at the time of transfer or discharge from a SNF. 42 CFR 431.206. Also there are requirements of providing notice to beneficiaries enrolled in managed care organizations during terminations, suspensions, reductions in service, denial of payment, among others. 42 CFR 438.404.</p>	<p>Medicare Part C: Various denial notices are sent for specific coverage denials, and the Evidence of Coverage contains specific enrollee guidance regarding appeal rights. Medicare Part D: Various denial notices are sent for specific coverage denials, and the Evidence of Coverage contains specific enrollee guidance regarding appeal rights.</p>	<p>Preferred Requirement Standard: Hybrid – one document that explains integrated appeals process.</p>
<p>14. Appeals – Timeframes for resolution of an appeal related to benefits</p>	<p>Standard appeals must generally be handled within 45 days, with extensions available in certain circumstances. Expedited appeals are to be handled within 3 working days, with extensions up to 14 calendar days in certain circumstances. 42 CFR 438.402, and §438.408.</p>	<p>Part C and D: Standard plan reconsiderations must be resolved within 7 days (Part D) or 30 days (Part C). Expedited reviews are to be conducted within 72 hours.</p>	<p>Preferred Requirement Standard: Medicare -- 30 days for standard appeals per the Medicare Part C standard, and 72 hours for expedited appeals per the Medicare standard.</p>

<p>15. Benefits/ Medical Necessity</p>	<p>Each State must ensure that all services covered under the State plan and are included in the plan contract are available and accessible to enrollees to the extent they are in FFS, and using a medical necessity definition that is no more restrictive than that used in the State's Medicaid program. 42 CFR 438.210(a)(4)</p>	<p>Medicare covers medically necessary Part A and B services, i.e., those that are necessary for the diagnosis or treatment of illness or injury or to improve the functioning of malformed body members. If there is a question about new services, CMS will issue a national coverage determination or local decisions will be articulated in Local Medical Review policies. MA plans may also offer supplemental benefits beyond those required under Medicare Parts A and B (e.g., dental care and vision benefits). Section 1862(a)(1)(A) of the Act. 42 CFR §422.101 and §422.102.</p>	<p>Pre-Established Parameter: CMS and State may choose to allow for greater flexibility in supplemental benefits than currently permitted under either program, provided that they are in the blended rate. (SMD MOU template sec III.D.1).</p> <p>Preferred Requirement Standard: Medicare standards for acute services and prescription drugs and Medicaid standards for long term care services and supports, where there is overlap coverage will be determined by contract.</p>
<p>16. Marketing/ Beneficiary Information</p>	<p>Medicaid defines marketing as communication to non-enrollees with intent to persuade them to enroll. Cold calls are prohibited. Marketing materials must be prior approved by State. States may prohibit plan marketing altogether. 42 CFR 438.104 Plans must also provide specified information to potential enrollees as well as to enrollees (these are not considered "marketing."). The State must specify language and readability thresholds. 42 CFR 438.10</p>	<p>Medicare defines marketing as communications to potential enrollees as well as enrollees (certain ad hoc communications to enrollees are exempted). MA organizations and Part D sponsors must meet certain minimum requirements with respect to disclosure of plan information and marketing limitations. CMS must prior approve certain marketing materials (not that there is a "file and use" process for plans that does not require prospective CMS review of certain marketing materials). CMS requires plans to use certain standardized model marketing materials and notices. Plans must translate certain materials if a language is spoken by 5% of enrollees at plan benefit package level. 42 CFR 422.111, §423.128, Subpart V of Part 422, Subpart V of Part 423.</p> <p>As specified in subregulatory guidance, there are a broad range of standardized and model documents under the MA and Part D programs, some of which apply generally to all MA plans, but some of which were designed specifically for SNPs.</p>	<p>Pre-Established Parameter: Flexibilities include unified marketing requirements/review process. Enrollee materials shall be integrated to the extent possible, and must be accessible and understandable to beneficiaries, including those with disabilities and limited English proficiency. CMS and State will prior approve all outreach and marketing materials, subject to single set of rules (SMD MOU template sec. I; III.C.4; III.E.2). Note: Part D requirements will continue to be applied; see #3 for details.</p> <p>Preferred Requirement Standard: A flexible approach to both minimum marketing requirements and review processes. Consistent set of required beneficiary information. For readability and translation standards, defer to whichever standard is more beneficiary-friendly.</p>

<p>17. Quality -- Reporting measures</p>	<p>Federal Medicaid regulations require States to have plans report performance measures (with State specifying the measures). States may require measures to be reported on State contracting cycles (which may differ from Federal cycles). 42 CFR 438.240(d)</p>	<p>MA plans must “measure performance under the plan, using the measurement tools required by CMS, and report its performance to CMS. The standard measures may be specified in uniform data collection and reporting instruments required by CMS.” 42 CFR 422.152</p> <p>Reporting requirements also detailed here:</p> <p>http://www.cms.gov/HealthPlansGenInfo/Downloads/PartCTechSpecs_Oct11.pdf</p> <p>http://www.cms.gov/PrescriptionDrugCovContra/08_RxContracting_ReportingOversight.asp</p> <p>SNPs have additional requirements to measure performance under the plan, using the measurement tools required by CMS, and report performance to CMS. They must also provide outcome measures that are reported as part of materials beneficiaries use to select plans. 42 CFR 422.152(b)(3).</p> <p>SNP HEDIS measure requirements, as of 2009, are available here:</p> <p>http://www.cms.gov/SpecialNeedsPlans/Downloads/2009_SNP_HEDIS_Reporting_Regts.pdf</p> <p>CMS, together with the NCQA, has also developed six structure and process measures for SNPs.</p>	<p>Pre-Established Parameter: CMS and State shall determine applicable standards, and jointly conduct a single comprehensive quality management process and consolidated reporting process.(SMD MOU template sec. III.G.3, III.H.1 -3)</p> <p>Preferred Requirement Standard: Require strong, consistent quality oversight and monitoring requirements. Quality requirements will be integrated but will include some measures currently used by Medicaid and Medicare. The core set of measures will allow quality to be evaluated and compared with other plans in the model as well as other non-model plans.</p> <p>Prescription drug quality reporting measures will be at least consistent with Medicare Part D requirements.</p>
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<p>18. Quality – Performance Improvement</p>	<p>Performance Improvement Plan: The State must require, through its contracts, that each managed care entity have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. 42 CFR 438.240</p> <p>Role of External Reviewer: States must contract with an External Quality Review Organization for each contract. 42 CFR 438.350</p>	<p>Performance Improvement Plan: Medicare requires the development of an ongoing quality improvement program, including submission of chronic care improvement programs and quality improvement projects for each MA plan. 42 CFR 422.152</p> <p>Role of External Reviewer: CMS is permitted to use quality improvement organization data for various functions. 42 CFR 422.153</p>	<p>Pre-Established Parameter: CMS and State shall determine applicable standards, and jointly conduct a single comprehensive quality management process. (SMD MOU template sec. III.H.1 -3)</p> <p>Preferred Requirement Standard: Advance an integrated quality/performance improvement program for plans, and have a single entity receive and review this integrated report and other quality measures. This reduces administrative burden on plans to have integrated reporting requirements; further, in some States the same contractor fulfills the EQRO and QIO function.</p>
<p>19. Quality Incentives</p>	<p>States may provide for incentive payments if plans meet certain targets (including quality). 42 CFR 438.6</p>	<p>MA has quality bonuses based on star ratings. 42 CFR 422.260</p>	<p>Pre-Established Parameter: Participating plans will not be eligible for star bonuses. Plans will be subject to an increasing quality withhold (1, 2, 3 percent in years 1, 2, and 3 of the demonstration). Plans will be able to earn back the capitation revenue if they meet quality objectives.</p>
<p>20. Model of Care</p>	<p>Medicaid requirements do not specifically reference “model of care,” but do require State contracts with plans include primary care source, coordination of other services, and for special needs individuals, an assessment and treatment plan. 42 CFR 438.208</p>	<p>Under the MA program, a Special Needs Plan is required to have a model of care, in addition to standard MA requirements for care coordination. In addition, all plans that offer Part D are required to have a medication therapy management program. Starting in 2012, all SNPs’ models of care must be approved by NCQA based on CMS standards. 42 CFR §§ 422.4(a)(iv), 422.101(f), and 422.152(g).</p>	<p>Preferred Requirement Standard: Unified model of care requirements for participating health plans.</p>

<p>21. Oversight Monitoring Auditing Program Integrity</p>	<p>CMS Medicaid regulations require generally a plan must comply with the applicable certification, program integrity and prohibited affiliation rules and requirements. 42 CFR 438.600 et. seq. CMS Medicaid regulations require State agencies to monitor plan operations, including, at a minimum:</p> <ul style="list-style-type: none"> - Recipient enrollment and disenrollment. - Grievances and appeals - Violations subject to intermediate sanctions - Violations of conditions for Federal payment. <p>42 CFR 438.66</p>	<p>Medicare contracts with plan specify inspection and auditing rights.</p>	<p>Pre-Established Parameter: CMS-State contract management team to ensure access, quality, program integrity, and financial solvency, including reviewing/acting on data/reports; conducting studies/corrective action.</p> <p>Preferred Requirement Standard: Coordinated oversight, as negotiated and determined in MOU or contract. States may conduct auditing function and monitor plans for compliance with demonstration standards if they can establish to CMS’ satisfaction that its standards meet or exceed Medicare’s.</p> <p>Note: Part D requirements will continue to be applied; see #3 for details. States will be informed of results found and actions taken.</p>
<p>22. Encounter Data: Collection and Validation</p>	<p>States must collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees, through an encounter data system or other methods as may be specified by the State. 42 CFR 438.242 EQRO entities may perform encounter data validation functions for the State.</p>	<p>CMS has authority to collect information from MA plans to justify each item and service provided by plan, and has imposed specific encounter data reporting requirements on plans starting with contract year 2012. 42 CFR 422.310.</p>	<p>Preferred Requirement Standard: Uniform encounter reporting. Note: Part D requirements for reporting Prescription Drug Event (PDE) data will continue to be applied; see #3 for details.</p>
<p>23. Credentialing</p>	<p>Each State must establish a uniform credentialing and re-credentialing policy that each plan must follow. These must include anti-discrimination provisions for providers that serve high-risk populations or specialize in conditions that require costly treatment. 42 CFR 438.214</p>	<p>MA organizations must have written policies and procedures for the selection and evaluation of providers that conform to Medicare requirements. “Providers of Services” must have a Medicare provider agreement in place.</p>	<p>Preferred Requirement Standard: Medicaid standards apply, i.e., plans can use Medicaid standards for certifying that participating providers are credentialed.</p>

Appendix 2: Notice of Intent to Apply for Capitated Financial Alignment Demonstration Contracts

To ensure clear and timely communication with CMS, all organizations interested in offering Capitated Financial Alignment Demonstration plans starting in CY 2013 must notify CMS of their intent to apply to offer such a plan by completing this Notice of Intent to Apply (NOIA) form online at:

<http://vovici.com/wsb.dll/s/11dc4g4ddb7>

1) Applicant Organization’s Legal Entity Information.

NOTE: Organizations must provide street addresses for the location of the Legal Entity. PO Boxes are not acceptable and CMS will only process NOIAs with a street address.

Legal Entity Name: _____
Street Address 1: _____
Street Address 2: _____
City, State ZIP: _____

2) Select Parent Organization* from the pull down list provided in Web tool. [Note that if there is no applicable parent organization in the pull down list provided in the Web tool, you must select “Other”]

* CMS considers a parent organization to be the legal entity that owns a controlling interest in a contracting organization. The parent organization is the “ultimate” parent, or the top entity in a hierarchy (which may include other parent organizations) of subsidiary organizations which is not itself a subsidiary of any corporation.

3) The legal entity identified above has Contract Year 2012 Medicare Part C or D contracts (with or without Employer Group Waiver Plans (EGWPs) or Special Needs Plans (SNPs)) with CMS as follows (check all that apply):

- MA-PD HMO/HMOPOS
- MA-PD Local PPO (LPPO)
- MA-PD Regional PPO (RPPO)
- MA-PD PSO
- MA-PD PFFS (with Part D)
- Medicare Advantage Only – PFFS
- Medicare Advantage Only – MSA
- 1876 Cost Plan with Part D
- 1876 Cost Plan no Part D
- PDP
- Employer/Union Direct PFFS with Part D
- Employer/Union Direct PFFS no Part D
- Employer Direct MA-PD LPPO
- Employer Direct PDP
- Not Applicable - Legal Entity does not hold a 2012 Medicare Part C or Part D contract with CMS

- 4) **The legal entity identified above has Contract Year 2012 Medicare Part C or D contracts that include Dual Eligible Special Needs Plans (D-SNPs):**
- Yes
 - No
- 5) **[Complete only you selected “yes” for Question 4] Approximately how many full dual eligible individuals do all of the SNP products offered by the legal entity identified above currently serve?**
- [Enter total number of covered lives]
- 6) **The parent organization identified above has Contract Year 2012 Medicare Part C or D contracts that include Dual Eligible Special Needs Plans (D-SNPs):**
- Yes
 - No
- 7) **[Complete only you selected “yes” for Question 6] Approximately how many full dual eligible individuals do all of the SNP products offered by the parent organization identified above currently serve?**
- [Enter total number of covered lives]
- 8) **Does the legal entity identified above offer Medicaid managed care products in any State?**
- Yes
 - No
- 9) **[Complete only if you selected “yes” for Question 8] Approximately how many full dual eligible individuals do the Medicaid managed care products operated by the legal entity identified above currently serve in all States in which that legal entity operates?**
- [Enter total number of covered lives]
- 10) **Does the parent organization identified above offer Medicaid managed care products in any State?**
- Yes
 - No
- 11) **[Complete only if you selected “yes” for Question 10] Approximately how many full dual eligible individuals do the Medicaid managed care products operated by the parent organization identified above currently serve in all States in which that parent organization operates?**
- [Enter total number of covered lives]

12) Capitated Financial Alignment Demonstration Plan Contact Information.

Salutation: _____
 First Name: _____
 Last Name: _____
 Title: _____
 Street Address 1: _____

Street Address 2: _____
City, State ZIP: _____
Legal Entity Name: _____
Street Address 1: _____
Street Address 2: _____
City, State ZIP: _____

13) Select the type of NEW contract product type for which your organization will apply (refer to section 30 of Chapter 1 of the Medicare Managed Care Manual, <https://www.cms.gov/manuals/downloads/mc86c01.pdf>, for definitions of the product types below). Check ONLY one; interested organizations must submit separate Notices of Intent to Apply for each demonstration contract product type. Note that legal entities with 2012 contracts with CMS will be issued a new contract ID for their demonstration plans.

- Medicare Advantage-Prescription Drug Plan Health Maintenance Organization (MA-PD HMO) / Medicare Advantage-Prescription Drug Plan Health Maintenance Organization Point-of-Service (MA-PD HMOPOS)
- MA-PD Local Preferred Provider Organization (MA-PD LPPO)
- MA-PD Regional Preferred Provider Organization (MA-PD RPPO)

14) Select the State for which your organization intends to submit an application. Check ONLY one; interested organizations must submit separate Notices of Intent to Apply for each State for which they intend to submit an application.

- Arizona
- California
- Delaware
- Florida
- Hawaii
- Idaho
- Illinois
- Indiana
- Kansas
- Kentucky
- Massachusetts
- Michigan
- Minnesota
- New Mexico
- New York
- Ohio
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Vermont
- Virginia

- Washington
- Wisconsin

15) Does your organization intend to use a Pharmacy Benefit Manager (PBM) with experience administering the Part D benefit?

- Yes
- No
- Undecided

16) [Complete only if you selected “yes” for Question 12] What is the name of the PBM you intend to use to administer your Part D benefit under your demonstration plan?

- [Enter name of PBM]

17) Does your organization intend to utilize a CY 2013 Part D formulary submitted for any other non-demonstration Medicare Part C or Part D contract?

- Yes
- No

NOTE: Once you click "Submit 'Notice of Intent to Apply' Responses Now" you will not be able to return to this specific Capitated Financial Alignment Demonstration Notice of Intent to Apply.

If your organization has additional NOIAs (for different States), you must complete one NOIA for each additional State.

If you need to submit notices for additional Capitated Financial Alignment Demonstration applications, after clicking the "Submit Notice of Intent to Apply" button, return to the NOIA online form by following the link in the memo announcing the NOIA, or copy and paste this link in your browser:

<http://vovici.com/wsb.dll/s/11dc4g4ddb7>

OREGON MEDICARE-MEDICAID LISTENING GROUPS FINAL REPORT

INTRODUCTION

In support of its Design Contract to Integrate Care for Dual Eligible Individuals (“Design Contract”), the Oregon Health Authority (OHA) held five listening groups during the week of December 12, 2011 designed to solicit input from individuals dually eligible for both Medicare and Medicaid (“individuals who are dually eligible”). The purpose of the groups was to solicit input on OHA’s Design Contract proposal from those individuals who would be directly impacted. Listening groups were held in the cities of Portland, Eugene, Bend, Roseburg and Coos Bay. Alice Lind from the Center for Health Care Strategies facilitated all of the groups.

METHODOLOGY

The five communities were targeted because they represent statewide geographical diversity and are among the areas with the largest population of individuals who are dually eligible. These communities have also been identified as likely to have some of the first coordinated care organizations (CCOs) who will be responsible for integrating care and services.

To recruit participants, OHA mailed personal invitations to approximately 100 individuals who are dually eligible in each chosen community. OHA also engaged partner organizations, including AARP, health plans, local Senior and People with Disabilities and Area Agency on Aging offices, and local federally qualified health centers. Twenty-one individuals participated in the listening groups, including sixteen individuals who are dually eligible and five caregivers of individuals who are dually eligible. Thirteen of the participants were women, eight were men.

THE DISCUSSION GUIDE

OHA staff developed questions designed to get feedback on several key concepts and recommendations that came out of the Health System Transformation process, including the Medicare-Medicaid Integration of Care and Services Work Group (Work Group). The 30-member Work Group met from August through November and included consumers, providers, health plans and other stakeholders.

After gaining some background on participants' experiences with the health care system, they were then asked share their thoughts on five key concepts:

1. Person-Centered Care
2. Individual Care Plans
3. Interdisciplinary Care Teams
4. Health Care Coordinators and Other New Roles
5. Accountability

SUMMARY OF KEY THEMES

Participants contributed many insights that support both OHA's and the Legislative Assembly's vision of Health System Transformation. In general, participants supported the following elements reflected in the five key concepts they were asked to consider:

- Making care more person-centered through improved communication and consideration of individual's unique needs;
- Individualized care plans including participation by individuals in defining goals;
- Improved communication between providers of all types;
- Strong support for new roles (health care coordinators and health system navigators in particular) that would emphasize a personal connection between the individual and the health care system and include an advocacy component; and
- Both personal and system accountability for improving health.

EXPERIENCES OF CARE

As an introduction to the listening groups, participants were asked to share their experiences with the health care system, both positive and negative. Questions were asked to gain insight on participants' experiences of provider communication, hospitals and emergency departments, and care coordination.

Most participants expressed satisfaction with their individual providers and thought their providers were doing a good job of providing care and communicating with each other. Participants with in-home caregivers or family members who assisted in their care were grateful for the assistance those individuals provided.

“Caregivers are the backbone of the system...without [my caregiver] I would be dead.”

These participants noted that this support allowed them to continue to live at home and avoid more costly care. (Of note, several participants had greatly limited mobility and one was ventilator-dependent.) Two participants with caregivers expressed concern that the number of hours their caregiver is available is limited and the compensation paid to those caregivers may be inadequate.

Among the areas of dissatisfaction, the most common complaint was the coverage of, and access to, certain services and supplies through the Oregon Health Plan. Participants expressed almost unanimous dissatisfaction with the coverage of vision and dental health services, as well as coverage of DME. Complaints about denied services were sometimes related to concerns that these services could have prevented the need for more expensive treatment in the future. Additionally, lack of after-hours clinical care resulted in emergency room care at much more expensive rates. Participants varied on their satisfaction with the coverage of prescription drugs. Several participants were grateful for the prescription drugs they were receiving. Other participants expressed frustration that certain medications were not covered.

Several participants had encountered barriers in accessing mental health care services. In some cases these barriers resulted in the person giving up on trying to obtain the mental health care they needed.

“The first thing [the mental health provider] said to me is ‘Oh, you’re on Medicare, I’m not supposed to see you...’ There was no way I could discuss a problem with her...I was so rattled...I never came back.”

Other participants expressed frustration at being limited in the number of visits they could have to their mental health provider. Participants who had disengaged from the mental health system managed their mental health prescription drug needs through physical health providers such as their primary care physician or orthopedist.

While most participants had positive experiences with their care providers, participants who indicated they were enrolled in managed care organizations (MCOs) varied on their level of satisfaction with these organizations.

“There are things like suction catheters for his airway. Recently they were cut down to three a day...so we have been struggling...It is increasing his risk of infection which causes things like a risk of hospitalization.”
(Caregiver)

Common areas of dissatisfaction included concerns that MCO rules acted as barriers to care. Participants also mentioned poor communications, especially written materials that were unclear and not person-centered.

“Speak to me in Mom-eeze. As a caregiver, how can I make sure they understand the steps...if nothing else [we need], training for caregivers and family.”
(Caregiver)

Several participants shared negative experiences with hospitals, especially emergency departments. Some indicated that their primary care provider had not been notified of a hospital admission. The participants with limited mobility or who were ventilator-dependent felt that hospital staff were not equipped to deal with their individual needs. One of these participants noted a regulatory barrier that prohibits him from having his caregiver present during hospital visits. One participant noted a prescription error that resulted after a hospital discharge.

1. PERSON-CENTERED CARE

Participants were asked whether they thought the health care system is currently person-centered. Participants were also asked whether they would value a person-centered system and what could be done to get the system to be more person-centered.

Most participants felt that the current health care system is not person-centered enough. Several participants expressed that they thought the system “pigeon-holes” people and does not do a good job of considering people’s individual needs. Several participants cited examples of recent cuts to needed durable medical equipment or medical supplies. These participants thought

that the system should do a better job of considering the individual's unique situation and not just categorize them by health condition.

“I am on a ventilator and I am a larger guy...Getting the right stuff (is important)...Each case needs to be taken separately and not one rule for everybody.”

Participants felt that the current health care system does not do a good job of considering needs outside of immediate medical care, including social needs. Participants with provider access issues faced the burden and challenge of utilizing non-local providers. One participant raised the desire for the health care system to do a better job of considering a person's faith. In discussing disconnections between the health care system and the individual, participants felt that the system was difficult to navigate and that information regarding benefits and coverage was not often accessible.

“I think the reason we're having problems with our health care system...is that it is not a person-centered model, it's a medical model. It is like turning out a product and not...taking care of the individual as a whole...we need full-person care.”

Participants universally liked the idea of making care more person-centered. They noted that more person-centered care would assist individuals to be more involved and active in their care. Participants thought that good person-centered care would involve better listening from the health care system. They felt the system could do a better job of humanizing and personalizing communications to service recipients.

Those participants who felt their care was person-centered were very satisfied. This satisfaction was tied to a feeling that their providers cared for them as an individual.

“I have cancer and the team is tremendous...My friends were amazed with how well everything was coordinated. Everything went like clockwork.”

2. INDIVIDUALIZED CARE PLANS

Participants were asked whether they currently had a care plan developed in consultation with their primary care physician or care team. Participants who indicated they had a care plan

were asked about their experience. Participants who indicated that they did not have a care plan were asked if they thought it would be helpful.

Most participants with a care plan felt that they did not participate in its development. Those that did participate in developing their plan had very positive experiences. One participant shared her experience with developing a care plan with her nurse advocate. She said that they review the plan every week and her nurse advocate follows up on the goals outlined in her plan. Her story elicited responses of, “I want that” from several of her peers in the group.

Participants who did not have a care plan were receptive to the idea of participating in the development of one. Participants commonly tied the notion of a care plan to improving the person-centeredness of their care.

“Instead of things being so compartmentalized...we need individualized care for our main health problems...with preventative care.”

3. INTERDISCIPLINARY CARE TEAMS

Participants were asked about their experiences with the people involved in their health and other care needs, including primary care providers, specialists, mental health providers and case managers. Participants were asked if they thought that these individuals did a good job of communicating with each other to coordinate the participants’ care needs.

Nearly all participants had multiple providers involved in their care, including primary care providers and specialists. Several participants had experience with mental or behavioral health providers. As Oregon Health Plan beneficiaries, all participants have a case manager that helps with eligibility and social service needs. Participants shared mixed feelings about whether they thought their care was well coordinated. Provider communication played a key role in participants’ perception of how well their care was coordinated; those who felt their care was well coordinated noted consistent communication between their various providers, while those who felt their care was not coordinated perceived a lack of communication.

Participants who used family practice or multi-specialty clinics felt very satisfied with the level of coordination between their providers. These participants noted test results were quickly made available to all their providers. These participants also found that their prescription

medications were well coordinated amongst prescribers. One participant who felt her care was well coordinated said that prior to coordination she would utilize the emergency department to deal with her asthma. Several were aware of the impact that a system-wide electronic health record made to effective care coordination.

“I have several doctors...CAT scans, x-rays, they just pull right up. The technology has made a huge difference in tests not being ordered twice...and medication interactions being avoided.”

Participants with experience with mental or behavioral health systems commonly noted a lack of coordination between those providers and their physical health providers. One person commented that this lack of coordination left her feeling that she had no place to go once her mental health episode of care ended. Participants noted the interrelation between one’s physical and mental health and said that lack of coordination between the systems can negatively impact both physical and mental health.

As noted above, several participants felt that there was not good coordination between hospitals and their primary care providers. They commented that this made them feel responsible for coordinating with their primary care provider after a hospitalization or emergency department visit.

“There is real lack of communication between our local hospital and our doctors...getting the doctor the emergency information. They just assume the client is going to tell their doctor that such-and-such happened...as we get older and are broken and are falling apart we don’t always remember to mention that these things have occurred, we just assumed that our doctor has been communicated with by our hospital.”

4. HEALTH CARE COORDINATORS AND OTHER NEW ROLES

Participants were asked to react to the concept of having a single point of contact within the health care system that could help coordinate care. Participants were also asked about the qualities they would want this person to have. Participants were asked to react to three potentially new roles within a better-coordinated health care system: (a) personal health

navigator; (b) peer wellness specialist; and (c) community health worker. Participants were asked about how they would want to interact with the individuals filling these roles.

Health Care Coordinators: Participants were almost universally supportive of the idea of a health care coordinator within the health care system. They were very receptive to the idea of this person serving as a single point-of-contact that could help them navigate the health care system and could be contacted when health care issues or questions arise. Most participants felt very strongly that a health care coordinator should serve a patient-advocate function.

“There needs to be a component of the health care system where people can have an advocate as they need it, to speak for them.”

Participants felt that in order to be successful, a care coordinator would need to be knowledgeable of all of the components of the physical, mental and social systems. Participants responded positively to the “personal touch” that a care coordinator could provide. They thought that to be valuable, the care coordinator should be a good listener, patient, empathetic and respectful. A couple of participants felt that this person should be non-clinical.

While generally supportive of the concept of a health care coordinator, some participants did raise concerns. One concern raised by multiple participants was the potential caseload coordinators would be asked to take on. Participants noted the burdensome caseload that their case managers have as something that could reduce the effectiveness of a care coordinator. Participants were open to the idea that the case managers should prioritize their caseload to the highest priority or most acute members, and some expressed that they were “basically healthy” and not in need of constant monitoring.

“I don’t expect that person to call me once a month to see how I’m doing. I don’t need that.”

One participant expressed concerns about whether this role could be effectively filled by just one person. Another participant worried about coordinator availability and potential transitions between care coordinators and raised the idea of a two- to three-person team approach to care coordination.

Other New Roles: Participants were generally receptive to the roles of personal health navigator, peer wellness specialist and community health worker. Participants responded

positively to the idea of a navigator that could remind them of upcoming appointments and follow-up on treatment plans. Participants also liked the idea of a peer wellness specialist. Participants with mental and behavioral health experiences especially liked the idea of this role as someone that could be utilized after or between episodes of care (e.g. to lead group meetings).

“We’ve all heard of coaches that coach professional people. If there was somebody like that to go to, it would have been good.”

A common notion raised by participants was using these new roles to increase education to the individual. In particular, these roles could serve to educate individuals about their care options and help them reach their individual health goals. Several participants believed increased education would empower them to be more involved and active in their care.

“If there was someone I could go beyond with the things [my doctor] said, then maybe I could help myself more.”

5. ACCOUNTABILITY

Participants were asked to suggest ways that the state would be able to tell if the health care system was improving or maintaining a person’s health.

Personal Accountability: In three of the listening groups, participants raised the idea of individual accountability. They felt that if they were better educated and given support in the health and social systems, they could be more proactive and accountable for their overall health. Participants noted that it is the individual’s responsibility to listen to their providers and follow through when given direction.

System Accountability: In two groups, participants offered specific, detailed input on how the state would know if the health care system is improving or maintaining an individual’s health. Examples were: lower utilization of crisis care and emergency room; increased wellness and use of mental health; improved coverage and formulary.

To hold the system accountable for the goals of Health System Transformation, participants raised the notion that the state needs to ask beneficiaries directly about their experiences to find out whether system changes are helping. When asked specifically about

health care surveys, participants were largely supportive of this idea and preferred that the survey be conducted in person or over the phone rather than by mail.

“I was much more willing to come here [to the listening group], knowing that I was going to have an opportunity to talk about it, rather than filling out a questionnaire... Having somebody to talk to is much better than asking people to fill out a questionnaire that they might not feel related to the problem.”

ADDITIONAL COMMENTS

- Several participants felt very strongly that any change to their system of care needs to be transparent.

“Every level from the very lowest to the very highest of this change should be constantly assessed and... it should be very transparent...Members, nurses, doctors, phone receptionists, direct home care workers, insurance companies... There’s going to be bumps in the road ...and the only way to effectively get through them is to be aware of that ... We all have to come together and ... assess and address each one of those things that come up...and figure out real solutions”
(Caregiver)

- A few participants expressed anxiety about any change that might have an impact on their current set of services or providers. Participants felt strongly that any system change should not result in them having to change providers.

“I had a friend who wanted me to ask if she should stock up on her prescriptions in case this change takes them away from her.”

- Several participants would like to see more consumer voices involved in the operations of the health care system, in line with the Consumer Advisory Council envisioned in House Bill 3650 (2011).

- Several participants noted that they were willing to use lower cost alternatives to treatment (e.g acupuncture instead of surgery) if these services were covered by the Oregon Health Plan.