Dual Eligibles Fall Forum: Care Coordination to Improve Health for High Need Members Across the Lifespan: Aging and Disability

Breakout Session B:
The Pursuit of Effective Care Coordination for Dual Eligible Members: Medicare – Medicaid Integration and Alignment Approaches

9:20 to 10:35am

Location: Building A: A61 & A62 Combo (@26 people capacity)

Panelists:

Lisa Fay, RN, MSN, Director of Clinical Operations, Atrio Health Plans

Patricia Gardner, RN, LCSW, Manager, Health Services Medicaid Care Management, PacificSource Community Solutions

Jennifer Valentine, MSPH, Oregon Health Authority

Session Description:

Dual-eligibles are a highly vulnerable population: they are among the poorest Medicaid beneficiaries, and compared to other Medicaid beneficiaries, they are substantially more likely to have multiple chronic physical conditions and/or co-occurring behavioral conditions. The largest number of dual eligible are either seniors over 65 or those with SS/Medicare disability status. Approximately 7% of OHP members have full dual eligible status, yet they have a higher proportion of disease, cost and often poorer health status. Panel members will discuss successes and challenges of care coordination across Medicare-Medicaid.

Speaker Bios:

Lisa Fay, RN, MSN, Director of Clinical Operations, ATRIO Health Plans
Lisa Fay was previously ATRIO's SNP Program Manager. She is a master's prepared registered nurse with a graduate degree in Nurse Executive

Leadership. Lisa has passionately been pursuing patient-centered care coordination for more than 14 years as a registered nurse. She can be reached at: lisa.fay@atriohp.com

Patricia Gardner, RN, LCSW, Manager, Health Services Medicaid Care Management, PacificSource Community Solutions, Inc.
Tricia Gardner is an RN and LCSW with thirty-three years of medical and behavioral health experience. She has worked extensively with individuals experiencing barriers to social determinants of health and those with complex health care needs in the provision and direction of case management teams in hospital, hospice, home health, out-patient behavioral health treatment, state mental health, and coordinated care organization settings.

Jennifer Valentine, MSPH, Operations and Policy Analyst, Duals Medicare-Medicaid Program, Health Systems Division, Oregon Health Authority
Jennifer joined the OHA in 2014 and has been focused on systems and policy issues to impact dual eligible beneficiaries. Jennifer has over 24+ years' experience working on health care, healthcare education, public health and health policy issues. Jennifer is passionate about working to impact health equity, address systems challenges, and work on Oregon's Triple Aim goals. Jennifer spent 16 years in Central and Eastern Oregon, including 12 years as OHSU's Cascades East Area Health Education Regional Center Executive Director at St. Charles Health System, and also a few years with Deschutes County Health Department. Jennifer led a statewide team building one of Oregon's first statewide Healthcare Interpreter Training programs, as well as Region 7 Healthcare Preparedness work for OHA. She was a member of the Oregon Health Policy Board Healthcare Workforce Committee from 2009 to 2014.

Communication with Dual Eligible Members: updated 9/21/2016

We've updated this CMS Alignment workgroup document to add the CMS 2390-F managed care rule released this spring to the list. The movement in general is to look at ways to improve focus on Medicaid Beneficiaries with complex needs, including the Dual Medicare- Medicaid members within managed care through "aligning Medicaid managed care policies to a much greater extent with those of Medicare Advantage and the private market" .

Topic	OHA Rules & Review-2015	Medicare Rules & Review--2016	OK for Same Parent Company CCO and MA	OK for CCO and MA affiliated through specific business affiliation and data sharing agreements
Communication About Care Coordination and Opportunities to Align Benefits for Dual Eligibles Between Affiliated MA and CCO	410-141-3300 Coordinated Care Organization (CCO) Member Education and Information Requirements: (6) The following shall not constitute marketing or an attempt by the CCO to influence client enrollment: (a) Communication to notify dual-eligible members of opportunities to align CCO provided benefits with a Medicare Advantage or Special Needs Plan; (b) Improving coordination of care; (c) Communicating with providers' serving dual-eligible members about unique care coordination needs; or (d) Streamlining communications to the dually-enrolled member to improve coordination of benefits. (8) CCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. As a CCO transitions to fully coordinating a member's care, the CCO is responsible only for	Follow any Medicare rules for HSD approvals on MA/DSNP communication **Medicare Marketing Guidelines** https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2016-Medicare-Marketing-Guidelines-Updated.pdf Items not considered marketing by Medicare: **Plan supplemental benefits you should be aware of for care coordination that could be included in MA benefits:** items such as outlined in MCM, Chapter 4, 30.2 and 30.3 including options such as Enhanced Disease Management, Bathroom Safety Devices, Counseling Services (beyond traditional Medicare), Educational Activities based on chronic disease/illness, Health Education, Vision and Dental services, etc. Converse directly with MA plan for details. **MCM, Chapter 4: 110.4– Rules for All MAOs to Ensure Coordination of Care** (Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15) **MCM Chapter 4: 200 – Part C Explanation of Benefits (EOB)**	YES, CCO letter approvals by OHA Integrated Communications such as EOB and IDN are option	YES, CCO letter approvals by OHA Data sharing agreements must contain provisions on beneficiary information sharing for care coordination/ care transitions/benefit coordination communication processes.

	including information about the care they are coordinating. CCOs shall update their educational material as they add coordinated services. Member education shall: (a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits; Additional rules to look at : 410-141-3270 Coordinated Care Organization Marketing Requirements (d) "Outreach" means any communication from a CCO to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the CCO's subcontractors and partners, and the CCO contractually required programs and services; and the promotion of healthful behaviors, health education and health related events.	(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01- 01- 15) The Part C EOB is an ad hoc enrollee communication that provides MA enrollees with clear and timely information about their medical claims to support informed decisions about their healthcare options. MAOs are required to issue EOBs that include the information reflected in the CMS-developed templates. For additional information, please see the final templates and instructions at: http://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html **MCM Chapter 4: 210** **Educating and Enrolling Members in Medicaid and Medicare** **Savings Programs:** MCM Chapter 4: 210.2–Relationship to D-SNP Eligibility / Enrollment (Rev. 120, Issued: 01-16-15, Effective: 01- 01- 15, Implementation: 01-01-15) This guidance on educating and enrolling enrollees in financial assistance programs in noway affects or relates to an MAO's responsibility for determining an enrollee's, or potential enrollee's, eligibility to enroll in the MAO's Dual-Eligible Special Needs Plan (D-SNP). Refer to the Medicare Managed Care Manual Chapter 2 for guidance on D- SNP eligibility and enrollment MCM Chapter 4 : 210.6–Required Elements of Education / Enrollment Assistance Programs (Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01 -01-15)		
Medicare Seamless Conversion	Not prohibited in OARS	Requires CMS approval and following required timelines and processes, minimum 60 day window for members to choose not to enroll		
Integrated Member Communication Tools:	State can approve plan IDN with OHA integrated NOA information on a case by case basis, holding off on statewide work on Oregon IDN until new Medicaid Managed Care rule is final.	CMS requires IDN use by MA/DSNP plans. New form released in November.		

New Managed Care Rule	New expectations on information sharing for members, new expectations for ensuring Medicare cross-over claims processing by all CCOs, new alignment of Medicare and Medicaid grievance and appeals timelines, other things!	We are still reviewing the new CMS 2390 F Managed Care Rule which has stages of updating rules, contractual language and other implementation steps for Oregon. CMS included opportunities to improve alignments for dual eligible members.		

THE PURSUIT OF EFFECTIVE CARE COORDINATION

DUAL ELIGIBLE MEMBERS

TABLE OF CONTENTS

BILLING & ENROLLMENT

- ATRIO SNP members receive a single ID card used for both Medicare and Medicaid purposes.

- ATRIO partners with the CCOs to identify and enroll qualifying members in a SNP.

CLAIMS PAYMENT

Once the claim processes for the Medicare (primary) benefit, the claim automatically will be sent to the secondary OHP plan for processing. Members and/or providers are not required to rebill the secondary.

CUSTOMER SERVICES

- ATRIO’s Customer Service Representatives are readily available to explain coverage and verify eligibility for SNP members.

INTELLIGENZ PROVIDER PORTAL

A self-service tool where providers and their staff can with one login look-up patients by name and see both the Medicare Stars and CCO metrics.

CMS Star Ratings Program

The Centers for Medicaid and Medicare (CMS) established the Star Ratings Program to measure and help improve the quality of care provided to Medicare Advantage(MA) beneficiaries. Health plans are rated on a scale of 1-5 Stars based on their score across these quality measures.

Measures

The 2016 Star Ratings Program includes 44 measures in 3 focus areas:

1. Clinical Quality (preventive and chronic care)

2. Patient Experience and Perceptions of Health

3. Health Plan Operations

What are CCO Metrics?

The Oregon Health Authority is using quality health metrics to show how well Coordinated Care Organizations (CCOs) are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care. OHA State Metrics and Scoring Committee has developed several outcome and quality measures for the CCOs to implement.

INTELLIGENZ PROVIDER PORTAL

CCO Metrics Manager
Provider CCO Metrics Scorecard
Provider CCO Metrics Community Scorecard
CCO Metrics Patient Point-of-Care Tools
CCO Metrics Incentive Estimator
What are CCO Metrics?

ATRIO STARS
Provider ATRIO STARS Scorecard
Provider ATRIO STARS Community Scorecard
ATRIO STARS Plan Scorecard
ATRIO STARS Patient Point-of-Care Tools
What are ATRIO STARS?

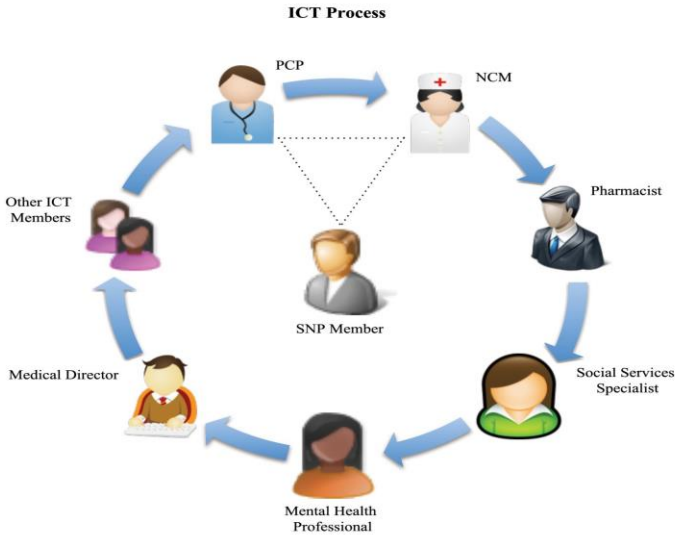
INTELLIGENZ PROVIDER PORTAL

Provider ATRIO STARS Community Scorecard updated from Altegra for dates of service through Jul 31, 2016

Provider Name	Active Member Count	Breast Cancer Screening	Colorectal Cancer Screening	Comprehensive Diabetes Care - Eye Exams	Comprehensive Diabetes Care - HbA1c Screening	Comprehensive Diabetes Care - Nephropathy	High Risk Medications	Taking Cholesterol Medication as Directed	Taking Diabetes Medication as Directed	Taking Hypertension Medication as Directed	Percent Met
[redacted]	2	n/a	n/a	n/a	n/a	n/a	✓	n/a	n/a	n/a	100.00 %
[redacted]	1	n/a	n/a	n/a	n/a	n/a	✓	n/a	n/a	n/a	100.00 %
[redacted]	10	✓	✓	n/a	n/a	n/a	✗	✓	n/a	✓	80.00 %
[redacted]	1	n/a	✗	n/a	n/a	n/a	✓	✓	n/a	✓	75.00 %
[redacted]	62	✗	✗	✓	✓	✓	✓	✓	✗	✓	66.67 %
[redacted]	73	✓	✗	✗	✓	✓	✓	✓	✓	✗	66.67 %
[redacted]	120	✓	✗	✗	✗	✓	✓	✓	✓	✓	66.67 %
[redacted]	10	✗	✓	✗	✓	✓	✓	✓	✗	✓	66.67 %
[redacted]	37	✓	✗	✓	✗	✓	✗	✓	✓	✓	66.67 %

CARE MANAGEMENT

- The use of Community Health Workers to assist with ED utilization and readmissions
- Transitions of Care program
- Interdisciplinary Care Teams
- The use of CCO flex funds
  - Vision exams, glasses
  - Dental
  - Hearing aids
  - Non-diabetic foot care
  - OTC medications
  - Gym memberships with transportation



HOME VISITS

The majority of ATRIO's SNP members are seen annually for a Comprehensive In-home Evaluation (CHE) visit conducted by MDs, NPs or PAs. Identified needs are referred to case management. Lab testing for A1C, nephrology and FIT and FOBTs are also made available. SNP members who have recently been discharged from the hospital are prioritized for a home visit within a few days in order to try to prevent a readmission.

WVP HH is also doing readmission prevention home safety visits.

LESSONS LEARNED

- Study with Salem Health—multiple entities doing the same post discharge phone calls
- Care coordination involves more than nurses
- The importance of knowledge sharing and communication across departments and partnerships. Understanding the full picture of healthcare within our communities, state and country.

ONGOING CHALLENGES

- Many different electronic health records and systems that lack interoperability.
- Access to Behavioral Health and long term support
- Need for increased Behavioral Health integration
- The need for a pay structure that makes coordination and collaboration feasible for full-time clinicians.
- Lack of patient engagement
- Transportation
- The increasing prevalence of chronic illness


ATRIO
HEALTH PLANS
Q & A
THANK YOU!

Integration & Alignment Approaches

Central Oregon and Columbia Gorge Regions

Tricia Gardner, RN, LCSW
Manager of Health Services
Medicaid Care Management

PacificSource Community Solutions

Traditional Health Care Plan Continuum of Care Functions

Billing and Enrollment: Early engagement surveys

Wellness: Generalized outreach and health promotion programming

Condition Support: Specific chronic illness programs

Utilization Management: Prior authorizations and concurrent reviews

Care Coordination/Case Management: Transitional support and F/U, limited case management

Complex Case Management/Intensive Care Coordination: Home and facility visits, telephonic F/U

CCO Dual Integration Enhancements

Focus on membership's identification of and engagement with a primary care clinician

- Data analysis allows flag for membership not engaged with a PCP, as well as risk stratification level
- CCO incentivized community health educators (CHEs) to be utilized in provider and hospital settings

Development of primary care homes (enhanced practices) as locus of team-based care coordination

PreManage Pilot resulted in decreased duplication of community care coordination services and provided role definition

CCO Dual Integration Enhancements

Population health and risk management strategies utilizing data analysis and HIE (health information exchanges)

Care management team uses risk stratification and assignment of health risk levels to drive care models

Entrenched and interdependent community partner relations

- In 2015, care management member support specialists (5) participated in and/or led more than 60 community meetings targeting social determinants of health and how to collaboratively address barriers
- Care management team developed and continue to facilitate the bimonthly “community resource huddle”

CCO Dual Integration Enhancements

Integration of behavioral, dental, and physical health care

Care management team is integrated and on-site; it is important to differentiate between co-located and integrated services

Innovative health care provision design and evidence-based practices, such as integrated care alignment plans and strategies targeting social determinants of care

- Integrated care alignment meetings provided in the community with the goal of provider engagement and service alignment
- Meetings are facilitated by care management team (behavioral health clinician, RN, pharmacist, member support specialist) as well as community partners, hospital, PCP RN/MDs, and CHEs

Integrated Care Alignment Meetings

Integrated Care Alignment meetings (January through December, 2015)

103 members (32 dual) captured with continuous enrollment:

- 6 months prior to the meeting
- 6 months post meeting (plus an additional 3 months of post meeting claims collection lag time)

Total net health care claims paid "pre" compared to "post" mtgs

- Average savings of 41.23%

"Pre" to "post" average stats

- Decrease of 46.9% in ER visits
- Decrease of 55.4% in IP stays
- Increase of 41.9% in BH OP visits
- Decrease of 50.5% in OP visits

Challenges to Integration

Communication must be built into all integrated services
billing/enrollment, customer service, QAI, care management, UM/UR

Best-in-class population health managers segment patients by risk level to manage three distinct patient populations
high, medium, and low risk groups, each with distinct goals and unique care models

Care models and Role Collaboration
attention to individual needs regarding social determinants of health; greater diversity in educational, cultural, physical, and other special needs; teams may have areas of expertise

Reconciling federal and state standards and quality measures
many of the existing, validated measures are not sensitive to the unique needs of dual populations and must be modified, amplified, and/or better targeted to make them more applicable

Working to Improve Alignments, Communication & Care Coordination For Dual Eligible Beneficiaries

Sept. 21, 2016

Jennifer Valentine, MSPH
Medicare-Medicaid Operations and Policy Analyst,
Health Services Division

Oregon Health Authority

Duals Alignment Work in Oregon

WHAT'S AHEAD & WITHIN OUR GRASP: Applying Coordinated Care Work to Beneficiaries with Complex Needs/Dual Eligibles

- Improved Care Transitions, Reduced Care Fragmentation
- Increased Care Coordination results in improved outcomes, reduced cost, better health and quality of life
- Increased Communication and Use of Tools to Support: Integrated Care Teams, Intensive Care Management, Care Continuity Planning for Patients and Families
- Reduction of Health Disparities, improved health for communities at large
- Increased focus on prevention, ensuring hard to reach populations get focus on preventive services/screenings, uniquely adapted health and wellness
- Universally Adopted Disability Competent Care –New
- New Managed Care rule work coming—expectations for cross-over claims, alignment of Medicare and Medicaid appeals and grievance timelines, expectations for plans to improve provider directories to include DCC access at providers for members and more, other rules under review now for implementation in 2017 and 2018 (CMS 2390 F)

What else do you see?

- How do we scale innovations to full system implementation and sustainability?

What We Don't Want & Our Goals Today to Create More Dialogue

- Lack of understanding on what can be done, versus worry about violating rules
- Eliminate fear on working toward increased care coordination and sharing information about how Medicare-Medicaid benefits work together for dual eligible beneficiaries
- High-cost and high-need members: smaller portion of population, but continued opportunity for impacting unique care challenges for dual eligible beneficiaries

See handout: Communication for Dual-Eligibles

Opportunities Exist

- A little bit like the initial worry about HIPAA and sharing information…when we look more closely, there are things that all plans can consider doing to better support communication to dual eligible
- Challenge ourselves to work toward administrative, care coordination and transitions and care continuity processes that improve outcomes –focus on process improvement
- Also some particular things that OHA can look at doing, and we are currently presenting those to leadership for consideration!

Oregon OARs--410-141-3300 Coordinated Care Organization (CCO) Member Education and Information Requirements

(6) The following shall not constitute marketing or an attempt by the CCO to influence client enrollment:

- (a) Communication to notify dual-eligible members of opportunities to align CCO provided benefits with a Medicare Advantage or Special Needs Plan;
- (b) Improving coordination of care;
- (c) Communicating with providers' serving dual-eligible members about unique care coordination needs; or
- (d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(8) CCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. As a CCO transitions to fully coordinating a member's care, the CCO is responsible only for including information about the care they are coordinating. CCOs shall update their educational material as they add coordinated services. Member education shall:

- (a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

410-141-3270 Coordinated Care Organization Marketing Requirements

- (d) “Outreach” means any communication from a CCO to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the CCO’s subcontractors and partners, and the CCO contractually required programs and services; and the promotion of healthful behaviors, health education and health related events.

Open Dialogue with Medicare Partners

Review what materials present opportunities to assist members in navigating the system, in understanding advantages of care coordination, or materials for providers on importance of coordinating benefits and services for dual eligibles

Medicare Seamless Conversion:

- Seamless conversion is an existing statutory and regulatory enrollment mechanism that permits organizations that offer both a Medicare Advantage (MA) plan and a non-MA health plan (e.g., Medicaid, employer) to seamlessly convert individuals in the non-MA plans into the MA plan when those individuals first become Medicare eligible.
- Provides members opportunity to let plan know if they prefer other choice, however majority seem to be happy that this is an “easy process” and seem happy with plans when they are enrolled
- Must be communicated at least 60 days in advance to provide member that choice –member must have time to review and decide!
- Medicare has to approve plan proposal/application for the Medicare plan. (Region X)

DSNP Contract Section 6: Information sharing to improve care coordination and care outcomes

- 6.1. The Health Plan shall work to ensure information sharing for Medicaid and Medicare benefits coordination, and **work to facilitate communication for care coordination and care transitions with network providers and facilities for all full dually-eligible members**.
- 6.2. **Information sharing about DSNP benefits and care coordination of benefits with Medicaid and Medicare for members or potential members are allowable under this Agreement and do not constitute marketing by the DSNP plan per provisions in OAR 410-141-3250 (5) and OAR 410-141-3300 (6)**. Provisions in this Agreement do not set-aside Health Plan's obligations or requirements for communication and marketing under Medicare rules.
- 6.3. Ensure CCO, MCO and FFS full dually-eligible members have information to **access care coordination services as needed** as defined in OAR 410-141-3170 **by connecting members with CCO care coordination leads or the State Medicaid Agency Fee-For-Service (FFS) contracted care coordination program for integration of care**.

DSNP Contract Section 6: Information sharing to improve care coordination and care outcomes

- 6.4. The Health Plan shall publish a contact phone number at each plan that will be available for members' questions around care coordination, provider access and responding to billing questions, and for providers to inquire about Medicaid or Medicare benefit coordination or billing.
- 6.5. Health Plan care coordination policies and procedures:
  - 6.5.a. In order to support coordinated care for all full dually-eligible members, the Health Plan shall develop written policies during Agreement year 2016 that will be used by Health Plan in contract year 2017 to ensure timely notification of the full dually-eligible member's Medicaid CCO, MCO, or State Medicaid Agency care coordination staff or contractors of Health Plan determined relevant 1) planned or unplanned inpatient admissions, 2) high priority health concerns identified through member health assessments, and 3) sharing of key provisions of discharge planning documents.
  - 6.5.b. Health Plan shall submit a summary of the adopted policy(s) to OHA as part of 2016 contract year reporting per Section 12.2.

DSNP Contract Section 6: Information sharing to improve care coordination and care outcomes

6.6. For all dually-eligible members receiving Medicaid covered Long Term Services and Supports (LTSS) through the Oregon DHS Aging and People with Disabilities (APD) programs, the Health Plan shall make "reasonable efforts" to coordinate benefits and services. **Reasonable efforts include outreach and coordination with regional work under CCO-LTSS Memorandums of Understanding (as on file with OHA), or a direct connection with regional Medicaid LTSS for care coordination.** A short written description of Health Plans "reasonable effort approach" shall be submitted to the State Medicaid Agency on an annual basis as outlined in Section 12.2. of this contract.

More Opportunities

- Not only opportunity, but moving toward integrated communications materials is something to aim for & begin planning around.

- Use of PRE-Manage to monitor real-time hospitalization/upload member information to receive notifications, now also piloting with APD for members with LTC or LTSS

- HIE where applicable

CMS Integrated Care Resource Center

- **Care Coordination Success Steps for Medicaid-Medicare members**
  - Evidence indicates that care management can, under certain circumstances, improve outcomes for certain people with chronic conditions by:
  - Improving provider-enrollee communication;
  - Increasing beneficiaries' adherence to recommended medication and self-care regimens;
  - Facilitating greater communication between physicians and other care providers; and
  - Encouraging greater use of evidence-based care

ICRC TA Brief, Using Lessons from Disease Management and Care Management in Building Integrated Care Programs, 2014

CMS Integrated Care Resource Center: Low Cost Strategies to Better Integrate Care for Medicare-Medicaid Enrollees

- Promoting self-management. Studies have shown that teaching beneficiaries about self-care, including recognizing symptoms, adhering to diet and exercise recommendations, and taking medications properly is a distinguishing factor of successful DM/CM programs.

- Facilitating timely communication of changes in health status and service use. Obtain Real-Time Access to Information on Hospital and Emergency Room Use.
- Improve the Flow of Information in Care Transitions

- Identify and remove any programmatic barriers to care management continuity that cause care managers to lose access to beneficiaries who have been admitted to institutional care.

- Convene meetings of behavioral health and LTSS care managers to start a dialogue and expand the knowledge and resource base of both groups. Offer LTSS and behavioral health providers the opportunity to participate in learning collaboratives on chronic medical conditions.

- Build in incentives and/or penalties for discharging entities to encourage sharing of information needed to guide care transitions. Improve discharge planning to include family and patient teach-back skills to reduce risk of readmissions (example from Coleman transitions model).

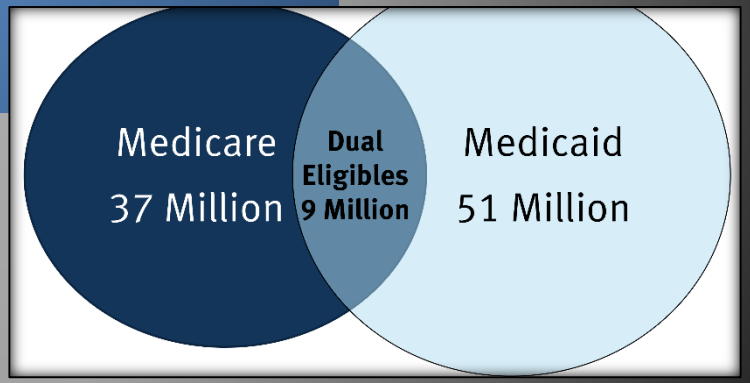
- Continue managed care enrollment for Medicaid-only beneficiaries receiving LTSS, or at least those in HCBS, in health plans for their primary and acute care services.

ICRC TA Brief, Low-Cost, Low-Administrative Burden Ways to Better Integrate Care for Medicare-Medicaid Enrollees, 2012

Commonwealth Care Alliance (CCA), a not-for-profit health plan participating in Massachusetts 'OneCare demonstration under the Medicare- Medicaid Financial Alignment Initiative for dually eligible individuals, has created a new setting of care:

An enhanced residential crisis stabilization unit (enhanced CSU) to fill a gap in the behavioral health continuum of care available to demonstration enrollees. The goal of the enhanced CSUs is to decrease the use of high-cost Medicare inpatient psychiatric facility hospitalizations and emergency department admissions by enrollees in psychiatric crisis who could be appropriately cared for in a community-based crisis stabilization setting.

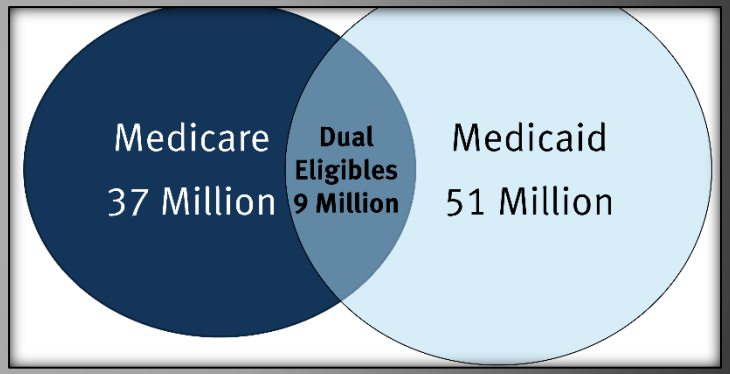
http://www.integratedcareresourcecenter.com/PDFs/ICRC_CCA_Case_Study%20%28002%29.pdf



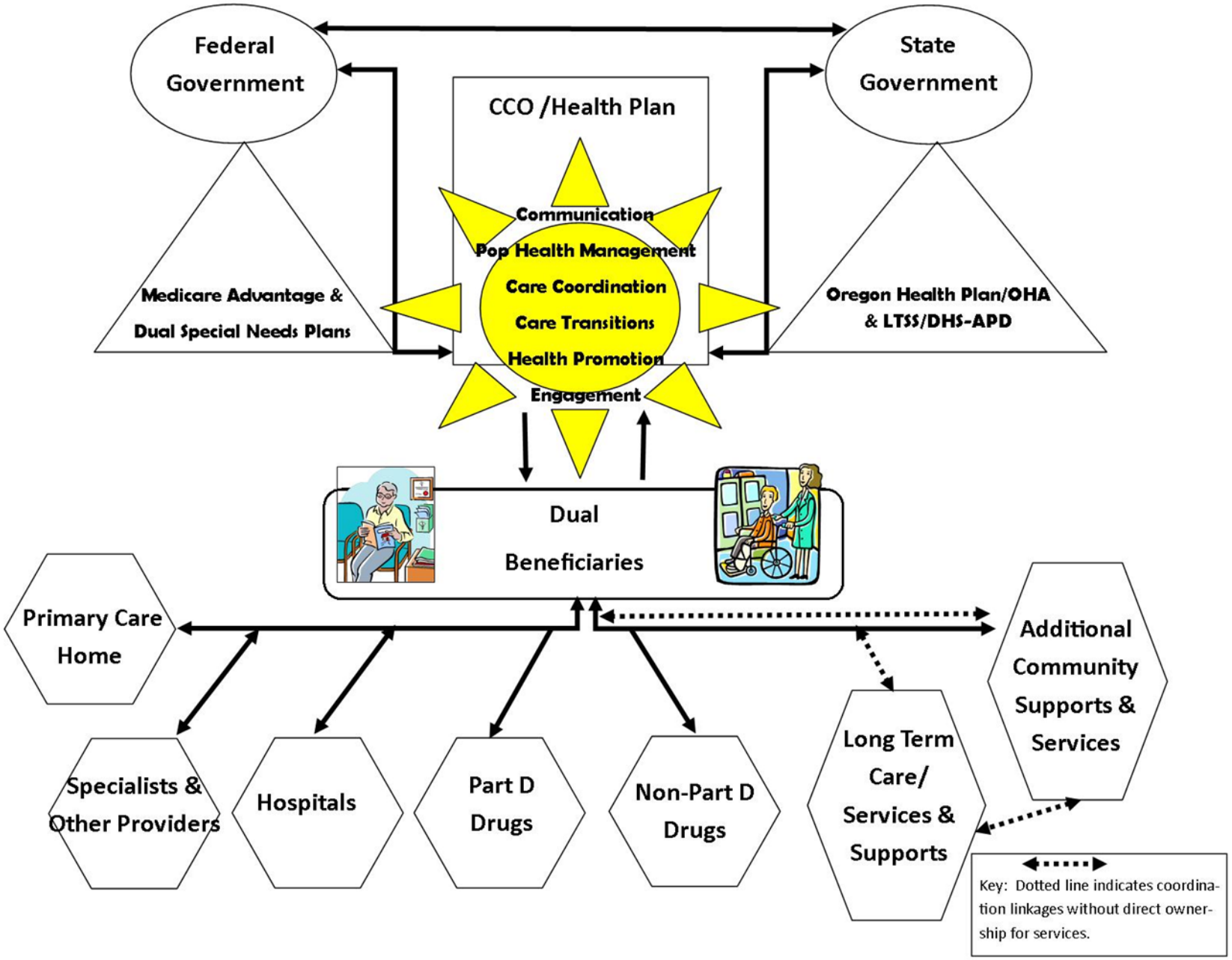
May 2016, ICRC Brief

ICRC Lessons from Duals Demonstrations

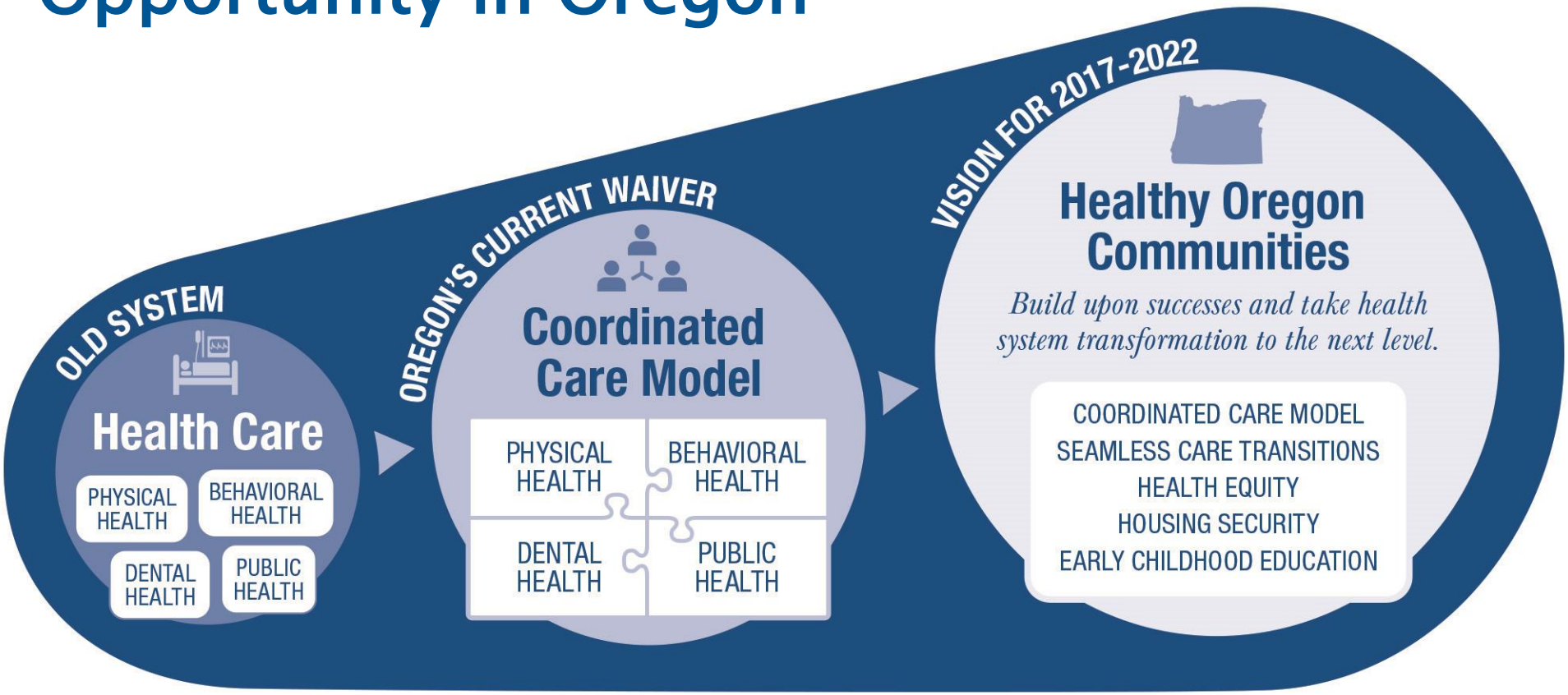
Virginia requires that Medicare-Medicaid Plans work with nursing facilities to promote adoption of evidence-based interventions to reduce avoidable hospitalizations, and include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the nursing facility benefit. Plans step in to ensure care coordination and work to improve seamless care transitions.



ICRC Lessons from Duals Demonstrations


Federal Government
State Government
CCO /Health Plan
Communication
Pop Health Management
Care Coordination
Care Transitions
Health Promotion
Engagement
Medicare Advantage & Dual Special Needs Plans
Oregon Health Plan/OHA & LTSS/DHS-APD
Dual Beneficiaries
Primary Care Home
Specialists & Other Providers
Hospitals
Part D Drugs
Non-Part D Drugs
Long Term Care/ Services & Supports
Additional Community Supports & Services
Key: Dotted line indicates coordination linkages without direct ownership for services.

Opportunity in Oregon



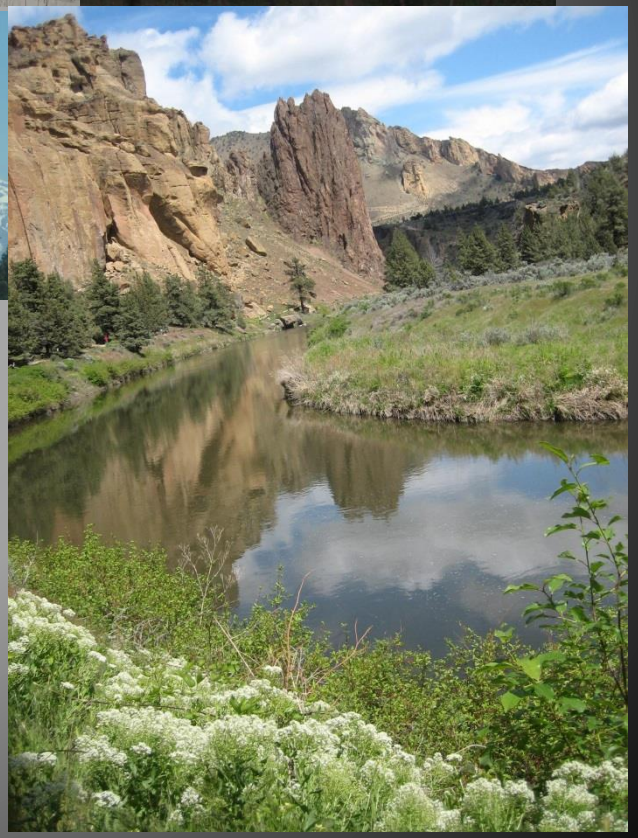
Oregon Health Authority

The essence of the waiver renewal application is for Oregon to build on our successes with CCOs AND to test community-based models to prevent homelessness and increase care integration for targeted populations

Mountain Climbing OREGON STYLE… Next UP: Impacting Oregon's Complex Need Beneficiaries:

- CCO's Formed, PCPCH Movement
- ACA Expansion
- Integration of Behavioral Health and Dental Health
- CCO & LTSS MOUs

In Oregon, we set our goals high!
Now Health Systems 2.0 !



Sharing? Questions?